An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0183
Sector:	Insurance
Product / Service:	Service
Conduct(s) complained of:	Rejection of claim Claim handling delays or issues Complaint handling (Consumer Protection Code)
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant, a limited company trading as a public house, hereinafter 'the Complainant Company', holds a Public House insurance policy with the Provider.

The Complainant Company's Case

The Complainant Company notified the Provider on **1 April 2020** of a claim for business interruption losses as a result of the temporary closure of its public house on **15 March 2020** due to the outbreak of coronavirus (COVID-19).

In making such a claim, the Complainant Company relies on '**Section 3: Consequential Loss**' of the applicable 'Public House Insurance Policy Document', as follows:

> *"The Company shall indemnify the Insured in respect of:-*
>
> *(A) The loss of gross profit during the indemnity period calculated by comparing the gross profit earned during the indemnity period with the gross profit earned during the corresponding period in the previous year, adjusted for the trend and other circumstances affecting the business.*
>
> *(B) Increase in the cost of working: the additional expense necessarily and reasonably incurred for the sole purpose of avoiding or diminishing the reduction in gross profit during the indemnity period, but not exceeding the*

sum which would have been payable under (A) had such additional expenditure not being insured.

(C) Professional auditors charges for producing and certifying the particulars or details by the Company in connection with the claim.

…

The Company will also indemnify the Insured in respect of (A), (B) or (C) above as a result of the business being affected by:-

1. Imposed closure of the premises by order of the Local or Government Authority following:- …

(d) Outbreaks of contagious or infectious disease on the premises or within 25 miles of same.

Following its assessment, the Provider wrote to the Complainant Company on **14 April 2020**, to advise that it was declining the claim, as follows:

"We have carefully considered your insurance policy to assess whether it provides cover in circumstances where your business had to close to assist nationwide measures introduced by the government to slow the spread of the COVID 19 pandemic. The business interruption section of the policy is normally triggered following physical damage to the premises or stock caused by one of the insured events listed in the policy. There is also an extension to the cover for enforced closure due to an outbreak of a notifiable infectious or contagious disease either at the premises or within 25 miles of the premises …

[The Provider] *have carefully considered your claim and do not consider that the claim falls within cover under the Policy. In particular,* [the Provider] *is satisfied that the claim notified is not covered for the following reasons, each of which apply independently of each other.*

1. A requirement of cover is that any closure would have to be a closure following outbreaks of contagious or infectious disease in the premises or within 25 miles of same. That requires that the closure be caused by outbreaks of contagious or infectious disease on or within 25 miles of the premises. The closure on any view was not caused by outbreaks of infectious disease on or within 25 miles of the premises, rather it was caused by national considerations resulting from the global pandemic including in particular, the requirements of social distancing.

2. It is clear that taken as a whole, clause 1(d) does not cover the Covid-19 pandemic and could not reasonably be interpreted as extending to such a situation. It is not clear from sub-clause 1(d) that the cover provided is cover in respect of outbreaks of contagious or infectious diseases particular to a

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locality. A pandemic manifestly does not fall within the scope of the clause. The WHO Covid-19 declared pandemic is by its nature, scale and consequences entirely different to localised outbreaks of contagious or infectious diseases that might reasonably have been contemplated by the parties when this policy was entered into.

3. *It is clear from clause 1(d) that the agreement to indemnify in respect of the risk at 1(d) is provided only where the business interruption loss has been caused by the matters specified at 1(d). It is quite clear having regard, inter alia, to social distancing practices (including now the restrictions on more than 4 people gathering together outdoors) and widespread public concern regarding the risk of infection, any business interruption loss has been caused by such social practices and public concerns and not by clause 1(d)."*

Following receipt of this correspondence, the Complainant Company appointed a Claims Manager to act on its behalf on **16 April 2020**. The Claims Manager wrote to the Provider on **21 April 2020**, stating that the Provider had erred in its decision to decline the Complainant Company's claim, as follows:

> *"There were cases of coronavirus in* [named] *University Hospital which is a distance of 4.4km from the insured's premises in* [location] *city. We attach herewith a link to two articles in the media confirming same. …*
>
> *The Central Bank in their letter to CEO's of Insurers dated 27th March 2020 … stipulated that the Government request for businesses to close was to be treated as a directive, and that benefit of any ambiguity in the wording of the policy should be given to the Policyholder.*
>
> *Nowhere in* [the Provider] *policy wording does it exclude epidemic or pandemic infections. …"*

By letter dated **25 May 2020**, the Provider advised the Claims Manager that it was upholding its decision to decline the claim, as follows:

> *"… a requirement of cover is that any closure would have to be closure following outbreaks of contagious or infectious disease on the premises or within 25 miles of same. In this instance, the closure of the business is part of a nationwide indefinite closure of all businesses and is not related to the premises covered by this Policy or the locality. The indefinite closure of businesses throughout the state would be considered as a risk of a completely different nature from the insured risk.*
>
> *The cover provided under clause 1(d) is cover in respect of outbreaks of contagious or infectious disease on or within 25 miles of the premises. The cover provided is in respect of outbreaks of contagious or infectious diseases particular to a locality and does not cover the Covid-19 pandemic. Cover for a pandemic is very different from cover for localised outbreaks of infectious disease that affect individual public houses.*

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The general underwriting risks and considerations arising in relation to cover for a pandemic are very different to those that arise in connection with the limited business interruption extension provided in this Policy free of charge. Apart from any other consideration, an insurer's exposure in circumstances of a pandemic is of an entirely different nature.

It is clear that any business interruption loss has been caused by social distancing practices and public concerns and not by matters specified that clause 1(d) of the Policy. The proximate cause of any losses in this case are the social and other practices adopted by the public and the various measures taken arising from the public concern about the risk of infection. These matters independently of the closure of the premises are the dominant and proximate cause of the losses in respect of which this claim is made.

Even if liability and causation could be established, further complicated issues arise in relation to the application of the trends clause in the Policy. Any claim for loss of gross profit under that clause will need to be adjusted to take account of trends and an indemnity period. In circumstances, where for reasons already set out, at present it is highly unlikely that any individuals would be attending public houses, a very significant adjustment would be required. Even if there is some easing of restrictions as regards individuals movements, issues will arise as to whether there could be sufficient revenues to justify opening a public house having regard to the number of persons either permitted to be present and/or likely to attend having regard to public concern by risk of infection and entirely changed economic circumstances are very relevant factors.

Other the relevant considerations will include the cancellation of sporting events and/or events which would otherwise affect the public houses' normal Clients and public houses' normal revenue stream.

You have referenced the communication of 27 March 2020 regarding policy cover issued by the Central Bank of Ireland to insurers and we can assure you that [the Provider] *is fully aware of its legal obligations and has acted and continues to act in accordance with them. The Central Bank outlined where there is a doubt about the meaning of a term that the interpretation most favorable to the customer should prevail. However, the Central Bank has not suggested that cover be provided if the Policy does not provide the same. Having considered this matter carefully and obtained the opinion of Senior Counsel,* [the Provider] *are satisfied that the Policy does not provide cover in this instance. Therefore we must advise that we are unable to make any interim payments as requested in your correspondence of 21 April 2020 and that our position remains as outlined in the letter of 14 April 2020 to the Policyholder declining cover for this claim.*

The Company fully appreciate that some policyholders may find the claims procedure frustrating particularly if it is unfamiliar to them. In this regard, I can assure you that the Company investigate and verify every claim and that each and every claim is approached with an open mind. Any inconvenience caused during the course of the

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claim is regretted however having considered this matter carefully I am satisfied that the correct decision has been made to decline this claim on the basis the loss presented does not fall within the scope of the cover provided under the Policy. …"

The Complainant Company considers that its claim for business interruption losses, as a result of its temporary closure due to the outbreak of COVID-19 is covered by the terms and conditions of its Public House policy. In this regard, the Complainant Company sets out its complaint in the **Complaint Form** submitted to this Office, as follows:

"[The Provider] *have declined to provide cover for Business Interruption Losses as a result of the business being closed by order of the Government following outbreak of contagious or infectious disease on the premises or within 25 miles of same – which is covered under the Consequential Loss section of the policy. …* [The Provider] *failed to advise me of any internal appeals mechanism as set out in Section 7.20 of the Consumer Protection Code 2012* [the Provider] *failed to offer any meaningful response to a detailed challenge letter from* [the Claims Manager] *dated 21 April 2020 … other than to point out the options set out in their declinature letter dated 14th April 2020 i.e. to refer the complaint to the FSPO or to go to Arbitration. …*

I want [the Provider] *to honour the claim. My business interruption losses are ongoing. We attach a copy of an interim claim for business interruption losses sustained for a period up to end June 2020, in the sum of €65,206.39, by which point we will hopefully have some further direction from the Government."*

As a result, the Complainant Company seeks for the Provider to admit its claim for business interruption losses as a result of its temporary closure in March 2020, due to the outbreak of COVID-19.

The Provider's Case

The Provider says it declined the Complainant Company's claim for business interruption losses *"resulting from its temporary and ongoing closure due to the outbreak of coronavirus"* because it is the Provider's position that the relevant policy, being a '**Public House Insurance Policy**' (the "Policy") does not respond in the circumstances that have arisen, for a number of reasons.

Before outlining those reasons, the Provider says it is important that this Office understands that it considered the position very carefully, including seeking legal advice from Senior Counsel (in respect of which privilege is maintained) before arriving at its position and declining cover.

In broad terms, the Provider says, the reasons why it declined claims under the Policy, including the claim of the Complainant Company, are

(i) there has been no insured event so as to trigger an indemnity; and

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(ii) even if there had been an insured event, the losses resulting from the event were also caused by an independent concurrent proximate cause of loss such that the insured event cannot be considered the cause of the insured's loss.

In setting out fully, the Provider's position on each of these issues, the Provider says it would be helpful in the first instance to set out in full, the relevant insuring clause (the "Clause"):

"The Company shall indemnify the Insured in respect of;-

(A) The loss of gross profit during the indemnity period calculated by comparing the gross profit earned during the indemnity period with the gross profit earned during the corresponding period in the previous year, adjusted for the trend and other circumstances affecting the business.

(B) Increase in the cost of working: the additional expense necessarily and reasonably incurred for the sole purpose of avoiding or diminishing the reduction in gross profit during the indemnity period, but not exceeding the sum which would have been payable under (A) had such additional expenditure not being insured.

(C) Professional auditors charges for producing and certifying the particulars or details by the Company in connection with the claim.

Resulting from the business being affected by loss or damage for which liability has been admitted and payment has been made under Section 1 and 2 of this Policy.

Less any sum saved during the indemnity period in respect of such of the charges and expenses of the business payable out of the gross profit as may cease or be reduced in consequences of the damage.

Provided that if the sum insured on gross profit be less than the sum produced by applying the rate of gross profit to the annual takings of the business, the amount payable shall be proportionately reduced.

The Company will also indemnify the Insured in respect of (A), (B) or (C) above as a result of the business being affected by:-

1. Imposed closure of the premises by order of the Local or Government Authority following:-
   (a) Murder or suicide on the premises
   (b) Food or drink poisoning on the premises
   (c) Defective sanitary arrangements, vermin or pests on the premises
   (d) *Outbreaks of contagious or infectious disease on the premises or within 25 miles of same. …"*

[Provider emphasis]

The Provider says that also of relevance was the definition of 'indemnity period' in the Clause, which is defined as follows:

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"The period beginning with the occurrence of the loss or damage and ending not later than the twelve months thereafter during which the results of the business shall be effected [sic] in consequence of the loss or damage."

In interpreting the clause, the Provider says it is obviously crucial to consider the relevant principles of contractual interpretation. An insurance policy is a contract like any other, and thus, its meaning falls to be interpreted by the well-established principles of contractual interpretation. Those principles, the Provider says, as confirmed by the Supreme Court in ***Law Society v. Motor Insurers Bureau of Ireland*** [2017] IESC 31 ("MIBI"), are primarily the principles set out by Lord Hoffmann in ***Investors Compensation Ltd v. West Bromwich*** [1988] 1 All ER 98. The Provider has cited a number of passages from these decisions.

The Provider submits that these authorities are clear that the agreement as a whole must be considered when seeking to interpret the clause in dispute. The Provider also submits that agreements are concluded against a background of facts which were known to, or which should have been known to, the parties as reasonable people, at the time when they concluded their agreement. In interpreting an agreement, regard must be had to this 'factual matrix' as referred to by Lord Hoffman and O'Donnell J.

The foregoing principles are relevant, the Provider says, in considering the appropriate interpretation of the Policy, including the Clause, and therefore, the validity of the Provider's declinature of the Complainant Company's claim.

Turning to the specific reasons for that declinature, the Provider says:

(i) <u>No insured event</u>

All insurance policies must define the circumstances in which an indemnity is triggered, referred to as the "insured event". This is the control mechanism by which an insurer can manage and assess its exposure to risk, and it is also the event that the insured understands is covered on their insurance policy.

In the context of this complaint regarding the Clause, the insured event is the *"Imposed closure of the premises by order of the Local or Government Authority following … (d) Outbreaks of contagious or infectious disease on the premises or within 25 miles of same."*

The Provider says a number of points were relevant about this insured event provision:

1. The insured event is the *"imposed closure of the premises"*, rather than the outbreak of disease *per se*.

2. The imposed closure most arise as a result of an order from the Local or Government Authority.

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3. The order of the Local or Government Authority most "follow" one of a number of potential triggers, including *"outbreaks of contagious or infectious disease on the premises are within 25 miles of same"*.

4. The term *"the premises"* can only sensibly be interpreted as meaning the premises of the insured under the individual insurance policy concerned. This is clear from the definition of "buildings" in Section 1 of the Policy and a cursory review of the remainder of the Policy.

5. The word "following" requires a causal link between the order of the Local or Government Authority and the outbreak of contagious or infectious disease on the premises or within 25 miles of same. Thus, it is not sufficient that there are outbreaks of disease on the premises or within 25 miles of same, and the Local or Government Authority has separately ordered the closure of the premises. The Provider says the imposed closure must be ordered <u>because of</u> the outbreaks of contagious or infectious disease on the specific premises concerned, or within 25 miles of same.

Applied in the context of the COVID-19 pandemic and the closure of the Complainant Company's premises, the Provider says:

1. It accepts that the closure of the Complainant Company's premises was *an "imposed closure … by order of the Local or Government Authority …."* The Government requested public houses to close on the evening of 15 March 2020, which the Provider says it accepted that this amounted to *"imposed closure"* for the purpose of the Clause.

2. The Provider accepts that COVID-19 is a *"contagious or infectious disease"* within the meaning of the Clause.

3. The Provider also accepts that there were, or plausibly may have been, outbreaks of contagious or infectious disease, in the form of COVID-19, within 25 miles of the Complainant Company's premises. The Provider also says it notes that no claim is made that there was an outbreak actually on the premises.

4. The crucial link is missing. The Government's request (or order) that public houses close was not caused by the *"outbreak of contagious or infectious disease on the [Complainant Company's] premises or within 25 miles of same"*. Indeed, the Government's request was not caused by the outbreak of contagious or infectious disease on or within 25 miles of the premises of an individual public house, whether insured by the Provider or otherwise. Instead, at the Government's request (or order) the public houses closed was caused by general considerations relating to the need to contain and limit the spread of COVID-19 in the State.

5. That this is so, is clear from the press release the Government issued on Sunday 15 March 2020 when public houses were requested to close. In particular, the press

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release made clear that the public houses were being asked to close for the following reasons:

> *"… The LVA and VFI outlined the real difficulty in implementing the published Guidelines on Social Distancing in a public house setting, as pubs are specifically designed to promote social interaction in a situation where alcohol reduces personal inhibitions.*
>
> *The government, having consulted with the Chief Medical Officer, believes that this is an essential public health measure given the reports of reckless behavior by some members of the public in certain pubs last night.*
>
> *While the government acknowledges that the majority from the public and pub owners are behaving reasonably, it believes that it is important that all pubs are closed in advance of St. Patrick's Day …."*

6. It is clear from the foregoing that the closure request had nothing to do with the outbreak of contagious or infectious disease on the premises of any particular public house, or within 25 miles of same. Instead, the closure related to the general risk of community transmission.

7. This is further evident from the fact that, on 7 April 2020, the Minister for Health signed the Health Act 1947 (Affected Areas) Order 2020 which designated the entire State as *"an area where there is known or thought to be sustained human transmission of Covid-19."*

8. As a result, there is no causal link between the *"imposed closure … by order"* and the *"outbreak of contagious or infectious disease on the premises or within 25 miles of same"*. Simply put, no insured event has occurred under the Clause and thus no indemnity is available under the Policy.

9. The foregoing is predicated on a textual analysis of the Clause, set against certain facts surrounding the closure and the reason for same. The Provider's position is further reinforced by the "factual matrix" against which the Policy was concluded.

10. With respect to the relevant "factual matrix", it is clear that, when the Complainant Company entered into the Policy, it never considered that it was purchasing general pandemic insurance. Similarly, the Provider does not consider that it was underwriting general pandemic insurance. While general pandemic insurance was available at the time the Policy was entered into, it was a bespoke and niche product, and was not offered by the Provider or, indeed, any general insurer in the State. It is clear, therefore, that the intentions of the parties at the time the policies were entered into did not include the intention that the Policy would cover a pandemic such as COVID-19.
11. This aspect of the "factual matrix" is reinforced by independent expert evidence which the Provider had commissioned from underwriting and insurance broking

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experts. In that regard, the Provider refers to an expert report from an expert in the area of insurance brokering and an expert report from an underwriting expert. The Provider says a number of points emerge from their reports:

a. The Clause must be considered in the context of the murder/suicide clause – i.e. it concerns perils associated with the specific premises as opposed to broader concerns.
b. Clauses of this sort are generally considered to relate solely to localised (as opposed to generalised) risks.
c. Specifically, such clauses would not be considered to relate to pandemic risk.
d. Pandemic cover is a highly specialised, exotic and expensive type of cover that is only available on specialised contingency markets and is generally provided as part of a bespoke offering.
e. Pandemic coverage is generally confined to risk surrounding cancellation of particular events.
f. Any policy that contains pandemic cover would have to be priced specifically to reflect same - in that regard it is significant that there was no premium charge for the additional cover provided by the Clause under consideration here.
g. Had the Clause being intended to cover pandemic risk then this would have given rise to specific regulatory considerations for the Provider.

12. A further aspect of the relevant "factual matrix" is that a pandemic is of an entirely different nature, scale and consequence to localised outbreaks of disease, and thus it represents an entirely different risk proposition. As adverted to in the expert reports referred to above, had the Provider intended to underwrite pandemic insurance, there would have been various regulatory implications for it, not the least being the need to hold additional regulatory capital against the risk. The Provider did not do so, nor was it required to do so in circumstances where it was simply not a risk that the Provider underwrote.

13. This aspect of the "factual matrix" is reinforced by independent expert evidence which the Provider commissioned from infectious diseases specialists. In this respect, the Provider refers to an expert report which describes the origins and development of current the pandemic. The Provider says it is clear on any view that a pandemic is an event (and a risk) of an entirely different scale and magnitude to localised outbreak. This is further reinforced by independent expert evidence which the Provider commissioned from insurance prudential specialists. At the time of submitting its Complaint Response to this Office, the Provider says this evidence was currently in draft form and the Provider was not in a position to furnish this report. However, the Provider would be in a position to furnish this report at a later date. In this respect, I note that additional information was subsequently supplied to this Office.

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14. A further relevant aspect of the "factual matrix" is that the actions taken by the government to order an imposed closure of almost every business in the State was entirely unprecedented, whether in response to the outbreak of contagious or infectious disease or otherwise. The parties simply could not have considered that the Clause was underwriting such an eventuality.

15. This aspect of the "factual matrix" is reinforced by independent expert evidence commissioned by the Provider from an expert in public administration which the Provider says sets out in considerable detail the nature of the State's response to the COVID-19 pandemic. The Provider submits that this was particularly relevant in the context of identifying the actual cause of the business losses claimed. It is clear from this report and the account of the governmental and public health response that, absent a government mandated closure of pubs, the other restrictions and extant public health advice would have rendered the continued operation of pubs wholly non-viable.

16. It is the Provider's position that each of these aspects of the relevant "factual matrix" were known, or were reasonably available to, the parties at the time the Policy was concluded, and thus it must inform the interpretation of the Clause, and the definition of the insured event therein. To the extent that there is any dispute about the foregoing, the Provider says it reserves its right to rely on such other evidence of the relevant "factual matrix" as may be necessary to establish its position.

17. In addition to the textual and "factual matrix" assessment above, the Provider's position that no insured event occurred, is further reinforced by the application of business common sense. It is a common-sense proposition that an extension in a general insurance policy for businesses involved in the hospitality trade relating to the outbreak of contagious or infectious disease is intended to cover localised events. The existence of a 25 mile radius, within which such an event could occur does not detract from that proposition. The alternative proposition (a) that the Clause could be interpreted to cover nationwide outbreaks of disease that could occur both within and outside the 25 mile radius, (b) that the Provider would have underwritten such insurance for over 1,000 public houses across the entire State, and (c) that the Provider would have provided such an extension free of charge, is commercially nonsensical.

In summary, the Provider says that having regard to the foregoing, it declined cover because no "insured event" occurred for the purposes of the cover provided by the Clause, taking into account its text, the relevant "factual matrix" and business common sense.

(ii) <u>Concurrent independent proximate cause of loss</u>

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The Provider says even if an insured event has occurred, it is necessary to consider what loss has been caused by that event. An insurance contract is a contract of indemnity, and it is only the loss that has actually been caused by the insured event that is covered by the insurance contract. Furthermore, the Provider says, it is only where the insured event is the proximate (i.e. the dominant, effective, or operative) cause of the loss that an indemnity could be provided, and this is a fundamental principle of insurance law.

When assessing the issue of causation, the Provider submits, it is a well-established principle that the appropriate approach is to utilise a "but-for" test - in other words, it was necessary to consider the counterfactual of what would have happened "but-for" the insured event occurring.

The Provider says, in certain circumstances, a loss may be caused by more than one proximate and concurrent cause, only one of which is insured. Where there are multiple concurrent independent proximate causes of the loss so that any of the causes of loss would, on their own, have caused the loss, then there is no indemnity available. The Provider says a good example of such a scenario was provided by the case of *Orient-Express Hotels Ltd v. Assicurazioni Generali* [2010] Lloyd's Rep IR 531 ("Orient Express Hotels"). In Orient Express Hotels, the Provider says, the appellant hotel, which was located in New Orleans, was insured against business interruption arising from damage to the property. It sustained significant physical damage as a result of Hurricanes Katrina and Rita in August 2005, and it was closed in September and October 2005. It sought to claim for the business interruption, and the claim was denied on the basis that the business interruption losses would in any event have been caused by the general damage to New Orleans by the Hurricanes, the resulting loss of attraction, and the publicly ordered evacuation that took place at the time.

The Provider says this argument was accepted by the arbitrator in the case, and upheld an appeal on point of law to the English High Court. The loss in question was caused by concurrent but independent proximate causes - either the damage to the hotel would have caused the loss, or the damage to the surrounding area, loss of attraction, and evacuation would have caused the loss. Only the former was insured, but in the circumstances the "but-for" causation test was not satisfied; "but-for" the damage to the property, the business interruption losses would have occurred anyway, and thus legally the damage to the hotel did not cause those losses.

In the context of Orient Express Hotels, the Provider says it is clear there was a requirement that the loss suffered be causally linked to the insured event. The Clause provides that: *"The Company will also indemnify the Insured in respect of (A), (B) or (C) above <u>as a result of</u> the business being affected by [the insured event]"*.

The Provider says, the term *"as a result of"* makes clear that the indemnity only extends in respect of the losses caused by the insured event.

Precisely the same reasoning as was used in Orient Express Hotels, the Provider says, applies in the context of the COVID-19 business interruptions claims under the Policy. The losses sustained by the Complainant Company in this case, and all of the other insureds under the

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Policy, would have been caused irrespective of whether the insured event (i.e. imposed closure) occurred. Even if there has been no imposed closure, the same losses would have occurred because all of the other aspects of the COVID-19 pandemic, and the government response to it, would still have occurred. The Provider also refers to the report of its public administration expert.

The Provider says that since **8 March 2020**, the Government has taken significant public health measures, both through the giving of guidance and advice, and the enactment of legally binding restrictions (together, the "Public Health Measures"). The adverse impact of the response of the Government, businesses and individuals, and the adverse impact of such response on economic activity and public confidence, was immense. The combined effect of the COVID-19 pandemic, the Public Health Measures (other than the imposed closure) introduced by the Government, social distancing practices, the widespread public concern regarding the risk of infection, on the economic slowdown would have resulted in the Complainant Company earning no gross profit during the period, and/or making a loss during the period such that it would not have been economically viable for it to open, irrespective of any enforced closure.

In summary, the Provider says, any loss suffered by the Complainant Company is caused by a concurrent independent proximate cause, and the Complainant Company would not be able to show that "but-for" the closure, it would not have suffered the losses that it is claiming are covered as a result over the occurrence of the insured event. In the circumstances, there is no cover under the Policy for the Complainant Company's losses.

Causation even if cover is triggered

The Provider says there is another important issue on causation that should be noted. Even if it is found that an insured event occurred, and even if it is accepted that insured event caused some losses to the Complainant Company that it would not have suffered anyway, it is clear that the Complainant Company could not claim for the entirety of its lost gross profit under the Clause.

The Provider says the same textual analysis of the Clause as set out above in section (ii) is relevant here; it is clear that the Clause only provides an indemnity in respect of loss caused by the insured event, and not *all* loss. Even if it is the case that some of the loss is caused by the insured event (i.e. the imposed closure), there is simply no basis for suggesting that the entirety of the loss was caused by the insured event. All of the other factors set out at (ii) above would have continued to operate on the Complainant Company's business, and would have caused loss, entirely independently of any imposed closure. This is a fact recognised by the industry itself. The Licensed Vintners' Association (the "LVA") and the Vintners' Federation of Ireland (the "VFI") published a report which demonstrated the level of reduction in capacity that publicans themselves say would occur on licensed premises as result of social distancing measures.

The Provider says it is accepted the Complainant Company closed its public house on instruction from Government. It is the Provider's position that the instruction from the Government was not causally connected to the outbreak of contagious or infectious disease on the Complainant Company's premises or within 25 miles of same, or indeed, to the

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outbreak on the premises or within 25 miles of any individual public house. Rather, the Government issued the instruction as part of a general suite of Public Health Measures that were designed and intended to limit the spread of COVID-19 throughout the entire State.

The Provider says the Complainant Company is correct insofar as it suggests that there is no specific exclusion of epidemic or pandemic infections in the Policy. That fact does not, however, mean that the Policy provides cover in respect of pandemics or epidemics. The Provider says the insured event under the Policy is the *"Imposed closure of the premises by order of the Local or Government Authority following … (d) Outbreaks of contagious or infectious disease on the premises or within 25 miles of same."*

For the reasons set out above, it is the Provider's position that this insured event has not occurred in the context of the general government order to public houses to close in response to the Covid-19 pandemic. The Provider says this clause means, and was only intended to mean, that an indemnity was provided for localised outbreaks of contagious or infectious disease (restricted to outbreaks on or within 25 miles of the premises insured). It was not intended to mean, nor does it mean, that general outbreaks of disease throughout the country, or globally, are covered. It therefore was not necessary specifically to exclude pandemics or epidemics in circumstances where they were not covered under the Clause.

The Provider says that it considers its decision to decline the Complainant Company's claim was fair and reasonable in circumstances where it believes, and has been advised, that the Policy does not cover the claim. The Provider, as a large publicly listed insurance company, has many different stakeholders, including its staff, its shareholders, and all of its 500,000 customers (many of whom are classified as consumers). Clearly, the Provider says, it cannot fairly and reasonably pay out claims in respect of which it believes it has no legal liability. Doing so, the Provider says, would have implications both for the Provider, and for every other stakeholder in the business, including its other customers.

The Provider says the amount of gross profit in respect of which an indemnity is provided must be adjusted for the *"trends and other circumstances effecting the business"*. This is clear on the face of the Clause:

> *"The Company shall indemnify the Insured in respect of;- (A) The loss of gross profit during the indemnity period calculated by comparing the gross profit earned during the indemnity period with the gross profit earned during the corresponding period in the previous year, adjusted for the trend and other circumstances affecting the business. …"*

The Provider says "**MacGillivray on Insurance Law**", one of the leading texts on insurance law, describes a term providing for adjustments for "trends and variations" as follows:

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> *"A further common term provides for "trends and variations". Under this, the period before the loss is to be examined in order to give an indication of the loss of profit but this can be adjusted to take account of trends and variations in the period before loss which render the profits in that period an unreliable guide to future profits and trends, and of variations in the indemnity period which show that higher or lower profits than in the period before loss could have been anticipated."*

The Provider says it is well established that, when applying a trends clause to adjust the lost gross profit for the *"trends and other circumstances affecting the business"*, it is necessary to have regard to matters that would have impacted the insured's gross profit during the indemnity period.

During the indemnity period, all of the other effects of the COVID-19 pandemic and the measures taken to mitigate it, including the Public Health Measures (other than the imposed closure) introduced by the Government, social distancing practices, the widespread public concern regarding the risk of infection, and the economic slowdown would have impacted the Complainant Company's business and its gross profit and, thus, the gross profit in respect of which an indemnity might be payable would have to be adjusted for those matters. In practice, this would have had a very similar impact to the causation adjustment required to be carried out as described above. Furthermore, various events, including the St. Patrick's festival, were cancelled, and there was no live sport available.

The Provider says its position is that, when those matters are applied to the gross profit little, if any, indemnity would in fact be payable under the Policy to the Complainant Company or any other insured. Once the gross profit of the Complainant Company, or any other insured, has fallen below a certain level, it would not have been economically viable for them to open irrespective of whether or not there was an enforced closure in place.

However, it is not possible to carry out this exercise in circumstances where (a) it must first be established that an insured event occurred and that it caused at least some loss to the insured (and the Provider disputes these propositions) and (b) even if these matters could be established, the actual indemnity to be provided could not properly be adjusted for the *"trends and other circumstances"* until the insured event has ended and it is clear what trends and circumstances during that period would have impacted the premises.

With respect to the length of the indemnity period, the Provider says, it is necessary to consider the relevant wording in the Policy, which defines *"indemnity period"* as follows:

> *"The period beginning with the occurrence of the loss or damage and ending not later than the twelve months thereafter during which the results of the business shall be effected in consequence of the loss or damage."*

The Provider says, the indemnity period can last for a maximum of 12 months (and the Provider has underwritten a number of policies with a period of 18 or 24 months in individual cases), but only so long as the *"results of the business shall be effected in*

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consequence of the loss or damage". The loss or damage in this context was the imposed closure, which is the insured event.

The Provider says its position is that the indemnity period commenced on the date of the imposed closure order, and it is highly likely that there would already have been a downturn in business in the period leading up to that date when the virus was already present, and people were modifying their behaviour as result. This demonstrates that there is likely to have been an element of uninsured loss which would have continued into, and beyond, the period up closure. In addition, upon reopening, the turnover of the business may well not fully recover but this is not the result of the closure order, and thus the indemnity period would not continue because the results of the business were no longer being affected by the closure order.

The imposed closure order (i.e. the "damage") related to COVID-19 will not have given rise to any ongoing loss of business. In practical terms, the Provider says the indemnity period under the Policy therefore ends when the order is lifted. To the extent that an indemnity is available at all under the Policy (and for the reasons given above, the Provider denies that an indemnity is so available), any loss subsequent to the date of reopening could not be recovered under the Policy. The Provider says public houses which served food reopened, and thus the indemnity period in respect of those businesses ended.

In summary, the Provider says that when the point is reached that the insured event was at an end and the Complainant Company could quantify the claim that it is making, the application of the *"trends and other circumstances"* provision in the Clause is likely to significantly or entirely reduce any indemnity to be paid under the Policy, even if it is established that an insured event has occurred and that event has caused the Complainant Company at least some loss. Furthermore, the indemnity period under the Policy ceased once the business was no longer the subject of an enforced closure.

The Provider says its position with respect to the declinature was and remains that there was no insured event, and even if there was, that insured event did not cause the Complainant Company's loss. However, even if an insured event occurred, and that event caused loss, the indemnity in question would need to be adjusted for trends and other circumstances. The Provider says the application of the *"trends and circumstances"* clause was not one of the matters relied on by it in declining the Complainant Company's claim.

The Provider says the matters relied on were clearly set out in its declinature letter of **14 April 2020**, and some additional information was provided to the Complainant Company in its further letter dated **25 May 2020**.

As set out in more detail above, the Provider says the trends and other circumstances with respect to which that adjustment would have to take place are all the other effects of the COVID-19 pandemic and the response thereto.
In all the circumstances, the Provider says, once an appropriate adjustment to the gross profit of the Complainant Company has been made to account for these impacts during the indemnity period, it is clear that little, if any, indemnity would be fact be payable under the Policy to the Complainant Company. Once the gross profit of the Complainant Company

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would have fallen below a certain level, the Provider says it would not have been economically viable for it to open irrespective of whether or not there was an enforced closure in place.

Thus, the Provider says, while the application of the trends and other circumstances clause is not relevant to the declinature, and was not relied on as a reason for the declinature, the Provider's position is that even if the claim is admitted, in the context of the adjustment process it is highly likely that the amount of indemnity available to the Complainant Company under the Policy would be negligible.

The Provider says that the issues arising in this complaint are legally complex and four policyholders initiated actions before the Commercial Division of the High Court (the "Test Cases"). The Provider says the judgment of the Commercial Court on the correct interpretation of the Policy, whether or not an insured event has occurred it, how causation is to be assessed and determined, and how the *"trends and other circumstances"* clause is to be applied, will be directly relevant to the complaint of the Complainant Company, and the circumstances of every other insured under the Policy. The Provider states that it will comply with the determination of the courts on the correct approach to the Policy, and that may entail revisiting its declinature position. However, the Provider says it is confident that the legal position it has adopted, and as set out in detail above, will be affirmed by the Court in the Test Cases, and thus no indemnity is available under the Policy to any policyholder, including the Complainant Company.

The Provider notes that disputes surrounding the proper interpretation of business interruption insurance in the context of COVID-19 are not unique to Ireland. In the UK, the Financial Conduct Authority (the "FCA") launched a test case against seven large insurers who have declined business interruption claims in that jurisdiction. The Provider says that the same issues as arise in this complaint and in the Test Cases, arose in the context of the FCA's case in the UK. The Provider says that a court in this jurisdiction will be dealing with the same issues and that the decision of the FCA case would inevitably be taken into consideration by an Irish court. The Provider submits that this Office cannot ignore the fact of the FCA case. The Provider says that as part of its response to this complaint, it relies on the legal submissions prepared by the insurers in the FCA case.

The Judicial Review Proceedings

By letter dated **22 June 2020**, the Provider wrote to this Office expressing the view that this Office should decline to investigate or make a decision in respect of this complaint pursuant to ***section 50(3)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** (the "FSPO Act") in circumstances where the issues in dispute in this complaint were subject to High Court proceedings; and pursuant to ***section 52(1)(f)*** of the FSPO Act as the issues the subject of this complaint were of such a degree of complexity, that the courts were the more appropriate forum.
Alternatively, the Provider suggested that in the event this Office decided to investigate this complaint, the complaint raised questions of law that would, in any such investigation, be appropriate for a referral to the High Court under ***section 66*** of the FSPO Act and that this Office should stay its investigation pending such referral.

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This Office responded to the Provider on **1 July 2020**, declining its various requests for the reasons set out therein. This was followed by further exchanges of correspondence on the matter. This culminated in the Provider commencing High Court Judicial Review proceedings in respect of this Office's decision bearing High Court record number 2020/588 JR. These proceedings were ultimately struck out on **18 February 2021,** with the consent of this Office, on terms agreed. Following this, by letter dated **18 February 2021**, this Office wrote to the Complainant Company and the Provider advising them of the striking out of the Judicial Review proceedings and that the investigation of the present complaint would continue.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly declined the Complainant Company's claim for business interruption losses as a result of the temporary and ongoing closure of its business in March 2020, due to the outbreak of COVID-19.

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 Company 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 on **9 April 2021**, 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 consideration of additional submissions from the parties, the final determination of this office is set out below.

The Complainant Company's Policy

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The Complainant Company held an insurance policy with the Provider. In this regard, I note that '**Section 3: Consequential Loss**' of the Complainant Company's 'Public House Insurance Policy' document wording stated at pg. 16, as follows:

> *"The Company shall indemnity the Insured in respect of:-*
> *(A) The loss of gross profit during the indemnity period calculated by comparing the gross profit earned during the indemnity period with the gross profit earned during the corresponding period in the previous year, adjusted for the trend and other circumstances affecting the business.*
>
> *(B) Increase in cost of working: the additional expenditure necessarily and reasonably incurred for the sole purpose of avoiding or diminishing the reduction in gross profit during the indemnity period, but not exceeding the sum which would have been payable under (A) had such additional expenditure not been incurred.*
>
> *(C) Professional auditors charges for producing and certifying the particulars or details required by the Company in connection with a claim.*
>
> *Resulting from the business being affected by loss or damage for which liability has been admitted and payment has been made under Section 1 or 2 of this Policy.*
> *Less any sum saved during the indemnity period in respect of such of the charges and expenses of the business payable out of gross profit as may cease or be reduced in consequence of the damage.*
> *Provided that if the sum insured on gross profit be less than the sum produced by applying the rate of gross profit to the annual takings of the business, the amount payable shall be proportionately reduced.*
> *The Company will also indemnity the Insured in respect of (A), (B) or (C) above as a result of the business being affected by:-*
> *(1) Imposed closure of the premises by order of the Local or Government Authority following:-*
> *(a) Murder or suicide on the premises*
> *(b) Food or drink poisoning on the premises*
> *(c) Defective sanitary arrangements, vermin or pests on the premises*
> *(d) Outbreaks of contagious or infectious diseases on the premises or within 25 miles of same.*
>
> (2) *Explosion or collapse of steam pipes and or vessels.*
>
> (3) *Prevention of access to or use of the premises following loss of or damage to property in the vicinity of the premises by a peril insured by Section 1 or 2 of this Policy.*
>
> (4) *Failure of the public supply following loss or damage by any peril insured under Section 1 or 2 of this Policy or to property at any:-*

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(i) Electricity generating station or sub-station
(ii) Land based gas works premises
(iii) Water works or water pumping station

of the Public Authority or supply undertaking from which the Insured obtains electricity, gas or water.

(5) Loss or damage by any peril insured under Section 1 or 2 of this Policy of or to any property at the premises of a supplier of the Insured."

Section 3 defines 'indemnity period' as:

"The period beginning with the occurrence of the loss or damage and ending not later than the twelve months thereafter during which the results of the business shall be effected in consequence of the loss or damage."

I note that the Complainant Company's '**Public House Multiperil Insurance Schedule**' describes the Complainant Company's business as 'Public House And 2 Apartments Occupied by Tenants'. I also note that the policy schedule provides, in respect of consequential loss, as follows:

*"**3. Consequential Loss***
On Gross Profit: €380,000
Indemnity Period: 12 months"

The Schedule also contains the following endorsement in respect of rental income:

*"**M001 Loss of Rental Income***

It is noted that loss of rental income €20,000 is included in the total Consequential Loss figure."

The Test Case

In reaching my decision in respect of this complaint, I am conscious of the recent decision of the High Court in ***Hyper Trust Limited trading as Leopardstown Inn v. FBD Insurance plc*** [2021] IEHC 78 (the **Test Case**), and the judgment delivered by Mr. Justice McDonald on **5 February 2021**. I note that the policy at issue in the Test Case and the wording of the relevant section, being 'Section 3: Consequential Loss', is identical to the wording of 'Section 3: Consequential Loss' of the policy the subject of this complaint.

When considering the proper interpretation of section 3(1), McDonald J. was of the view that it was necessary to read the entire extension:

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> *"**133.** … In order to ascertain what is covered under extension (1) it is necessary to have regard to the entire of the language of the extensions. It is important, in this context, to bear in mind that the opening words of the extensions state, in plain terms, that FBD will indemnify the insured as a result of the business being affected by any of the circumstances described in extensions (1) to (5). In the case of extension (1), it is clear, in my view, that what is covered is not an effect on the business by an imposed closure but an effect arising from an imposed closure by an order made by either a local authority or a government authority "following" one or more of the specific circumstances described in sub-paras. (a) to (d). …*
>
> [I]*t seems to me that the more natural and obvious way to describe the matters set out at sub-paras. (a) to (d) is that they constitute words of definition of the relevant risk or peril which is covered. Rather than breaking up the clause in the manner suggested by FBD, it seems to me that the clause needs to be read as a whole. In my view, that is how the clause would be read by a reasonable person standing in the shoes of the parties to these proceedings. While the plaintiffs here (with the exception of the Lemon & Duke plaintiff) did not give any great thought to the terms of extension (1) when reaching agreement with FBD, I must approach the matter by reference to how a reasonable person in the position of the parties would do so. When read in that way, it seems to me that one does not pause at the reference to imposed closure and regard everything which follows as a limitation or restriction on those words. One would read the clause as a whole in order to understand the precise perils which are covered by the extension. FBD is essentially telling the policy holder what it will indemnify under this extension. In order to understand what FBD will indemnify, it is necessary to read the entire extension. …* [E]*xtension (1) in s. 3 of the policy takes a different course. It does not use any language suggestive of a proviso or an exclusion. It simply describes the types of imposed closure which are covered. Any other types of closure that may arise are simply not within the ambit of cover."*
>
> [Underlining added for emphasis]

Following on from this, at paragraph 136, McDonald J. formed the view that extension 1, of section 3, *"must be read as a whole in order to understand the perils covered by its terms"*, and that:

> *"the relevant peril for present purposes as described in extension (1)(d) is a composite one in which (a) an imposed closure (b) by order of a local or government authority (c) follows an outbreak of a contagious or infectious disease either on the premises itself or within a radius of 25 miles."*

In considering whether the cover available under the relevant extension was confined to closures arising solely from localised outbreaks, which the Court was satisfied it was not, McDonald J. stated as follows:

> *"**145.** … I do not believe that FBD is correct in suggesting that reasonable persons in the position of the parties would have understood the cover available under*

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extension 1(d) to have extended solely to closures following an outbreak of disease in the specified localised area and not beyond that area.

146. *While it is clear that, for cover to be available under extension 1(d), there must be an outbreak of disease at least within 25 miles of the premises, there is no suggestion in the language used that outbreaks occurring simultaneously outside that radius would deprive the insured of cover. It would have been a simple and straightforward matter for FBD to so provide in its policy. As the plaintiffs argued, extension 1(d) could have referred to outbreaks of disease "on the premises or* ***wholly*** *within 25 miles of same". … Thus, it would have been a simple matter for FBD to make clear that extension 1(d) was intended to apply solely in respect of closures following an outbreak of disease in the specified localised area. It would equally have been a straightforward matter for FBD to expressly exclude cover where there was a nationwide outbreak or to exclude cover for pandemics …*

147. *In all of the circumstances, I have come to the conclusion that reasonable people in the position of the parties to the FBD policy would not have understood the cover available under extension 1(d) to have been confined solely to closures following a localised outbreak of disease within the specified 25 mile radius.*
Nonetheless, in order for the relevant peril the subject of extension 1 (d) to apply, there must be an outbreak of a contagious or infectious disease either on the premises or within a 25 mile radius. But, in my view, once that element of the peril is satisfied, the fact that there are also outbreaks outside that radius does not per se disapply the extension. The existence of such outbreaks outside the 25 mile radius may, however, make it more difficult to demonstrate a causative connection between the imposed closure and the localised outbreaks and that is an issue that is addressed in paras. 148 and following paras."

[Underlining added for emphasis]

Over the course of several pages, McDonald J. dealt with the meaning of the word 'following'. In considering the meaning of this word, McDonald J. posed the following question:

*"**148.** … The question which arises is whether the use of the word "following" means that an imposed closure of the premises by order of a government or local authority must have been proximately caused by an outbreak of contagious or infectious disease on the premises or within 25 miles of the premises or whether the word should be interpreted as imposing some lesser standard of causation."*

McDonald J. formed the view that 'following' was not intended to have a purely temporal meaning (para. 159). The Court also noted that FBD did not choose to use language (i.e. 'following') with an established or *prima facie* meaning in an insurance context (para. 166).

In coming to an interpretation of this word, McDonald J. held that:

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*"**173.** … I do not believe that the word "following" can be given a purely temporal interpretation. It seems to me that some element of causal connection is intended by the use of the word "following". However, when one considers the way in which the word is used in context, I believe that it is clear that the word "following" is not intended to denote proximate causation. This seems to me to follow from the way in which, in close juxtaposition to the use of the word "following", one finds the words "as a result of" and "resulting from". The words "as a result of" have a clear proximate cause connotation. …*

***174.** … I believe that it is reasonable to conclude that the choice of the word "following" was deliberately intended to signify something other than proximate cause. This is also consistent with the ordinary meaning of the word "following" even when used in a causative way. … The ordinary meaning of "result" or "resulting" is therefore much more consistent with a proximate cause requirement than the use of the less forceful word "following". For completeness, I should add also say that the use of the less forceful word "following" also supports a conclusion that the FBD policy does not require that the "but for" standard of causation … should be applied in so far as the causative link between the outbreaks and the imposed closure is concerned. …*

***175.** … I have come to the conclusion that the word "following" as used in extension (1) of the FBD policy should be construed as requiring that the matter described in para. (d) (namely the outbreak of disease within a 25 mile radius of the insured premises) should be a cause, but not necessarily the dominant cause, of the imposed closure. …"*

[underlining added for emphasis]

Following on from this, and in considering the ambit of the cover available under extension 1(d), McDonald J. stated:

*"**180.** Having regard to the conclusions which I have reached in relation to the constituent elements of extension (1)(d), I believe that the extension responds to business interruption claims where that business interruption is shown to have been proximately caused by a government imposed closure which, in turn, has had as one of its causes, an outbreak (as defined above) of an infectious or contagious disease within 25 miles of the insured public house premises. Although the proximate cause standard applies to that extent, it seems to me, for the reasons outlined above that it is not necessary for the insured to also establish that the outbreak was the proximate cause of the imposed closure so long as the outbreak was **a** cause. Furthermore, it is clear from the definition of "outbreak" that a single instance of a serious disease such as Covid-19 within the 25 mile radius would be sufficient to satisfy the definition, so long as the single instance can be shown to be have been a cause of the closure.*

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> ***181.*** *For the reasons explained in paras. 143 to 147 above, the fact that there are cases outside the relevant 25 mile radial distance which may also have been a cause of the government imposed closure does not seem to me to be relevant. The policy responds once the closure had, as one of its causes, an outbreak within a 25 mile radius of the public house in question. …"*

In terms of causation, the Court noted the first step was to determine whether the Government imposed closure followed the admitted outbreaks of COVID-19 within 25 miles of the insured premises. The Court addressed this question using two alternative bases for interpreting the word 'following': (a) the *looser causal connection*; and (b) proximate causation.

In considering the standard at (a), McDonald J. noted:

> *"**190.** … In circumstances where FBD accepts, for the purposes of these proceedings, that there were outbreaks within 25 miles of each of the plaintiffs' premises, those outbreaks were, at minimum, a cause of the decision to close each of the public houses the subject matter of these proceedings. …*
>
> ***191.*** *Thus, in circumstances where the word "following" means that an outbreak of disease must be a cause (but not necessarily the proximate cause) of a government imposed closure, that test is plainly satisfied on the facts. …"*

In considering the standard at (b), McDonald J. noted:

> *"**194.** I do not believe that the result would be any different if one was to interpret the word "following" as requiring proximate cause. …*
>
> ***198.*** *… Applying the approach outlined in the cases, it seems to me that the real or effective or dominant reason for the imposition of the closure of public houses in Ireland was the existence of the outbreaks. Those outbreaks made it necessary to move to the delay phase described in the minutes of the NPHET meeting of 11th and 12th March, 2020 and the need to impose social distancing measures.* [T]*he dominant cause was the underlying outbreaks of disease. …*
>
> ***199.*** *… As noted earlier, there is no provision excluding liability in so far as closure arising also from outbreaks outside the 25 mile radius are concerned. Thus, once the local outbreaks within that radius were an efficient cause of the closure, that is sufficient to satisfy the proximate cause test in relation to that issue even if each of the other outbreaks in every other part of the country were also efficient causes of the closure. … I am therefore of opinion that, even if the word "following" connotes proximate cause, that test is satisfied. …"*

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I note that leading on from this, the Court proceeded to consider *"whether the interruption of the plaintiffs' businesses as a result of the composite peril (comprising the imposed closure following the outbreaks) was the proximate cause of the plaintiffs' loss."* (para. 200) McDonald J. also noted that it was not possible, at that stage of proceedings to make any definitive findings as to whether the loss was proximately caused by the composite peril embodied in extension 1(d), and this was a matter for a quantum hearing.

However, McDonald J. opined that:

> *"**201.** … it is improbable that the closure following the outbreaks in question is not, at least, an effective (i.e. proximate) cause of some of the claimed losses. To state the obvious: if pubs are closed for business, they are unable to trade and make a profit. FBD has sought to argue that the effective cause of the loss is the public reaction to the emergence of the Covid-19 disease. It may be that the closure following the outbreaks in issue is not the only effective cause of loss but, as the approach taken in Miss Jay Jay shows, that will not necessarily mean that the plaintiffs are unable to recover under the FBD policy at least in those cases where the effective causes overlap and where it is not possible to distinguish between the effects of one from the effects of the other. As noted previously, there is no relevant exclusion in the FBD policy which rules out such an approach.*
>
> [underlining added for emphasis]

Addressing the situation where there is more than one cause of the loss, McDonald J. reconciled this issue as follows:

> *"**211**. … where it is not possible to determine whether a loss sustained by the plaintiff was caused but for the occurrence of the insured peril, on the one hand, or some other interdependent or interrelated non-insured (but not excluded) cause, on the other, it seems to me that the insured peril should be regarded as a sufficient cause for the purposes of the "but for" test. This seems to me to be the only fair and reasonable approach to take in the circumstances. If this approach is not taken, the application of the "but for" test could lead to recovery being denied to an insured under a policy notwithstanding that the insured peril was an effective cause of the loss sustained by the insured. That result would seem to be inconsistent with the approach taken in the concurrent cause cases …*
>
> ***213.** Accordingly, in this case, to the extent that there are overlapping proximate causes of the plaintiffs' losses, one of which is the composite peril and the other is the alteration of societal behaviour in response to Covid-19, it seems to me that, subject to what I say below in relation to the issues of the appropriate counterfactual and disaggregation, it is appropriate, in those cases where societal behaviour is shown to be as much a cause as the composite peril, to apply the approach suggested in the passage from Hart & Honore quoted in para. 210 above and to modify the "but for" test to that extent."*

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In considering the appropriate 'counterfactual' (i.e. what would have been the position of each of the plaintiffs' businesses but for the occurrence of the insured peril), McDonald J. held as follows:

> *"**215**. … FBD had sought to argue that imposed closure was the relevant peril. For the reasons previously discussed, I have come to the conclusion that the FBD argument should be rejected. In my view, the insured peril is the imposed closure which "follows" (in the sense previously explained) the outbreaks of disease within the 25 mile radius. Having regard to that finding, it follows that FBD is incorrect insofar as it has suggested that the appropriate counterfactual should be taken to be a situation where each of the plaintiffs' premises would remain open but the premises would continue to be affected by the impact of outbreaks of Covid-19. That would have significant consequences for the plaintiffs because it would have the potential to significantly curtail what they could recover under the policy. On FBD's hypothesis, the premises would continue to be affected by society's behavioural reaction to the outbreaks of disease including a desire of many people to limit their contacts and maintain physical distance from others. In my view, that would not properly strip out the composite nature of the insured peril. In this context, having regard to the terms of extension (1) (d), it is clear that the peril envisages outbreaks of an infectious or contagious disease which are sufficiently serious to warrant intervention by the authorities by means of an order to close public houses within a 25 mile radius.*
>
> *For as long as the closure endures, the outbreaks are an inherent element of the peril and, for that reason, it seems to me that, for the duration of the period of closure, both the closure and the effects of outbreaks of the disease must be stripped out of the counterfactual. …*
>
> ***222.** Thus, so long as the plaintiffs can establish that the closure following the outbreaks within the 25 mile radius was a proximate cause of their loss, their recovery under the policy will not be reduced just because the change in societal behaviour (whether within or outside that radius) as a result of the pandemic was also a proximate cause. In such event, the attitude of the general public will be stripped out of the counterfactual along with the specific elements of the composite peril. …"*

In the course of his judgment, McDonald J. observed in the context of the 'trends and other circumstances' provision at section 3(A), that the terms 'trend' or 'other circumstances affecting the business' were not defined in the policy (para. 233). Giving his view on the correct approach to this aspect of section 3(A), McDonald J. stated:

> *"**236.** … It seems to me that, in applying the trends and circumstances provisions of s.3 of the FBD policy, one must exclude the effects of the insured peril from the calculation. In the absence of clear language to the contrary, it would be contrary to the nature of an insurance policy as a contract of indemnity, to allow the effects of the insured peril to reduce the payment to be made to an insured who has the benefit of cover for that peril. As the FBD submissions acknowledged, the purpose of the trends and circumstances clause is to ensure, in so far as reasonably practicable, that the adjusted figures reflect the financial results which, but for the occurrence of the*

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peril, would have been achieved during the subsistence of the peril. For the reasons previously discussed in paras. 227 to 229 above, this approach seems to me to be applicable whether the losses were proximately caused by the events within the relevant 25 mile radius or by a combination of the events within and beyond that radius.

…

***248.** … It seems to me that one must start from the principle (which I believe to be accepted by FBD) that, in the absence of clear language to the contrary, an insured is entitled to recover under a policy of insurance in respect of any losses which are proximately caused by an insured peril and which would not have arisen in the absence of that peril. On that basis, it seems to me to be contrary to principle that an insured's right of indemnity under the policy should be reduced by a trend based on losses which have been caused by that peril. Similarly, in the case of a composite peril, it seems to me to be equally contrary to principle that an insured's claim should be reduced to take account of a trend proximately caused by any element of that composite peril once that composite peril has eventuated.*

…

***249.** Of course, as the plaintiffs have accepted, account has to be taken of any downturn in business caused by Covid-19 prior to 15th March, 2020. Everyone accepted at the hearing that the insured peril did not eventuate before that date. That has the consequence that the revenue for the relevant comparator period of twelve months prior to 15th March, 2020 must take account of the reduction in business which occurred in the days leading up to 15th March. … However, it is altogether a different matter to suggest that those losses must necessarily be carried forward as a trend for the duration of the insured peril. That would mean that losses which have, since 15th March, 2020, arisen as a consequence of an element of the insured peril would be taken into account in adjusting the indemnity owed even though those losses flow from the insured peril itself. In my view, that would completely undermine the fundamental principle that a policy of insurance is a contract of indemnity. In my view, such an approach would require explicit provision to that effect in the relevant policy of insurance. In this context, as discussed in an earlier section of this judgment, the policy must be read as a whole. The "trends and circumstances" provisions of the policy must be read in light of the clear promise made by the terms of Extension (1)(d) to provide business interruption cover in respect of business interruption arising as a result of a closure of the premises by government authority following outbreaks of a contagious or infectious disease within 25 miles of the premises. If the trends and circumstances provision of the policy was intended to cut down on the indemnity available in respect of such an explicit peril (rather than to estimate, as far as reasonably practicable, the results which, were it not for the insured peril, the business would have realised during the indemnity period) clear words to that effect would, in my view, be required. Those words are entirely absent in this case and I must therefore conclude that the trends and circumstances provisions of s.3 of the policy cannot be used to cut down the indemnity in that way. …"*

/Cont'd…

Analysis

On **1 April 2020**, the Provider was notified of a claim for business interruption losses arising from the temporary closure of the Complainant Company's business, due to the outbreak of coronavirus (COVID-19). The Complainant Company explained that

> *"*[i]*n the current circumstances it is no longer possible to have the business open due to the infectious disease – Covid 19."*

I note that on **14 April 2020**, following its assessment, the Provider wrote to the Complainant Company to inform the Complainant Company that it had declined its claim, and advised, amongst other things, that:

> *"*[The Provider] *have carefully considered your claim and do not consider that the claim falls within cover under the Policy. In particular,* [the Provider] *is satisfied that the claim notified is not covered for the following reasons, each of which apply independently of each other.*
>
> 1. *A requirement of cover is that any closure would have to be a closure following outbreaks of contagious or infectious disease in the premises or within 25 miles of same. That requires that the closure be caused by outbreaks of contagious or infectious disease on or within 25 miles of the premises. The closure on any view was not caused by outbreaks of infectious disease on or within 25 miles of the premises, rather it was caused by national considerations resulting from the global pandemic including in particular, the requirements of social distancing.*
>
> 2. *It is clear that taken as a whole, clause 1(d) does not cover the Covid-19 pandemic and could not reasonably be interpreted as extending to such a situation. It is not clear from sub-clause 1(d) that the cover provided is cover in respect of outbreaks of contagious or infectious diseases particular to a locality. A pandemic manifestly does not fall within the scope of the clause. The WHO Covid-19 declared pandemic is by its nature, scale and consequences entirely different to localised outbreaks of contagious or infectious diseases that might reasonably have been contemplated by the parties when this policy was entered into.*
>
> 3. *It is clear from clause 1(d) that the agreement to indemnify in respect of the risk at 1(d) is provided only where the business interruption loss has been caused by the matters specified at 1(d). It is quite clear having regard, inter alia, to social distancing practices (including now the restrictions on more than 4 people gathering together outdoors) and widespread public concern regarding the risk of infection, any business interruption loss has been caused by such social practices and public concerns and not by clause 1(d)."*
>
> [underlining added for emphasis]

/Cont'd…

I note that a formal complaint was made on **27 April 2020** by the Complainant Company regarding the Provider's decision to decline indemnity. A formal complaint response issued on **25 May 2020**, when the Provider maintained its decision to decline the claim.

The Complainant Company stated in the Complaint Form it completed for this Office, that:

> *"*[The Provider] *have declined to provide cover for Business Interruption Losses as a result of the business being closed by order of the Government following outbreak of contagious or infectious disease on the premises or within 25 miles of same – which is covered under the Consequential Loss section of the policy. …"*

I also note that a letter from the Complainant Company's Claims Manager to the Provider dated **21 April 2020**, advised of cases of COVID-19 within 25 miles of the Complainant Company's premises. As a result, the reason advanced by the Complainant Company for the closure of its business was its compliance with the Government direction to close, and due to the presence of active COVID-19 cases within a 25 mile radius of its business premises.

In its Complaint Response, the Provider's position was that there was no 'insured event' so as to trigger cover, and if there had been an insured event, the losses arising from this were caused by independent proximate causes such that the 'insured event' could not be considered to be the cause of the insured loss. Further to this, the Provider said that even if it was found that an insured event had occurred, and even if it was accepted that such insured event caused some of the Complainant Company's losses that it would not have suffered anyway, the Complainant Company could not claim for the entirety of the lost gross profit, under the extension 1(d).

Insofar as concerns the insured event, the Provider's position was that there was an absence of a causal link between the outbreaks of COVID-19 on or within 25 miles of the Complainant Company's premises and the imposed closure. The Provider argued that it was not sufficient that there were outbreaks of COVID-19 on or within 25 miles of the premises, and that the Local or Government Authority had separately ordered the closure of the premises. The Provider maintained that the imposed closure must be ordered because of the outbreaks of contagious or infectious disease on the premises or within 25 miles of the premises, and as far as the Provider was concerned, that link was missing.

In reaching my decision in respect of this complaint, I am cognisant of the fact that the circumstances of this complaint and the relevant wording of section 3, including extension 1(d), falls within the circumstances that were considered by the Test Case. I also note that the arguments advanced by the Defendant in this complaint were also made in the Test Case. As can be seen from the Test Case, McDonald J. of the High Court, did not accept the Defendant's interpretation of extension 1(d) and adopted the view that *reasonable people* in the position of the parties to the policy would not have understood cover under extension 1(d) to have been confined solely to closures following a localised outbreak of disease within the specified 25 mile radius. I also note the Court's remarks at the relative ease at which the Defendant could have confined cover to such localised outbreaks, should it have been its intention to do so.

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In terms of the use of the word 'following', I note that the Court found it was *reasonable* to conclude that the choice of this word was *deliberately intended* to signify something other than proximate cause (i.e. a looser causal connection) which the Court also believed to be consistent with the ordinary meaning of the word. Nonetheless, the Court found that the necessary test was met, even when applying a proximate cause standard. The Court also noted that in circumstances where there were overlapping proximate causes, of which the insured peril was one, the insured peril should be regarded as a sufficient cause. Further to this, in considering the counterfactual, the Court noted that recovery under extension 1(d) would not be reduced, simply because a change in societal behaviour as a result of COVID-19 was also a proximate cause.

I note that in considering the insured peril, McDonald J. determined that cover was triggered when:

(a) an imposed closure,
(b) by order of a local or government authority,
(c) follows an outbreak of a contagious or infectious disease either on the premises itself or within a radius of 25 miles.

In the course of his judgment, McDonald J. noted that the language of extension 1 was not suggestive of a proviso or an exclusion but rather, it described the types of imposed closures which were covered. The Court also took the view that the outbreak of COVID-19 must be a cause, but not necessarily the dominant cause, of the imposed closure. The Court further observed that cover is not lost where the closure is prompted by nationwide outbreaks of COVID-19, provided that there is an outbreak within the 25 mile radius of the insured premises.

Further to this, the Court remarked that:

> *"190. … it is clear that each outbreak of the disease in the State was instrumental in the government decision to close down all public houses wherever they were in the State. …*
>
> *193. In my view, while I entirely accept that extension (1) (d) of the FBD policy requires the plaintiffs to prove that localised outbreaks of the disease were a cause of the imposed closure, I believe that the necessary causal connection is plain. …"*

I note that on **20 February 2020**, the Minister for Health signed Statutory Instrument No. 53/2020 – Infectious Diseases (Amendment) Regulations 2020, to include the coronavirus (COVID-19) (SARS-CoV-2) on the list of *"Diseases specified to be infectious diseases and their respective causative pathogens"*.

I also note that on **15 March 2020**, following discussions with the Licensed Vintners Association and the Vintners Federation of Ireland and with their support, the Government requested that all public houses and bars, including hotel bars, close from **15 March 2020** to at least **29 March 2020**. I note that throughout his judgment in the Test Case, McDonald J. referred to this as a Government imposed closure.

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On **24 March 2020**, the Government adopted certain NPHET recommendations for the nationwide closure of non-essential retail outlets and services from **27 March 2020**. Since the preliminary decision of this Office was issued, the Provider has pointed out its view that on **27 March 2020** this Government requirement simply took the form of a request, and did not became a legal requirement, until **8 April 2020**, pursuant to the *Health Act 1947 (Section 31A -Temporary Restrictions) (Covid-19) Regulations 2020*.

When the Complainant Company notified the Provider of its claim at the beginning of **April 2020**, I am satisfied that the Complainant Company's business had been subject to an imposed closure since **15 March 2020**, which I also note is the date recorded as the 'Date of Loss' on the Provider's letter to the Complainant Complaint on **14 April 2020**. I am also satisfied, taking account of the comments of McDonald J. of the High Court, that this imposed closure was 'by order' of the Government. It is also clear that since **February 2020**, COVID-19 was a recognised infectious disease.

It is not clear from the evidence whether, at the time of submitting its claim under the policy, the Complainant Company provided any evidence of an occurrence of COVID-19 within 25 miles of its premises. In correspondence to the Provider dated **21 April 2020** in response to its decision to decline the Complainant Company's claim, the Claims Manager advised the Provider of cases of COVID-19 in a hospital approximately 4 kilometres from the Complainant Company's premises. Owing to the timing of this letter and the fact that it was in response to the Provider's declinature of the Complainant Company's claim, I am satisfied that the Complainant Company sought to present evidence of local outbreaks of COVID-19 within 25 miles of the Complainant Company's premises at the date of closure, being **15 March 2020**, and thus, show the presence of the virus to be a cause of the imposed closure.

I am satisfied that extension 1(d) required the Complainant Company to show that localised outbreaks of COVID-19 were a cause of the imposed closure. In its assessment of the claim however, I note the Provider did not dispute that there were local outbreaks of COVID-19, nor did the Provider as part of its consideration of the claim, require the Complainant Company to further demonstrate the presence of any such outbreaks or ask that it show that such outbreaks were a cause of the imposed closure. This appears to arise from the fact that the Provider simply did not consider that extension 1(d) would respond to a claim on the basis of a localised outbreak of COVID-19. However, in taking this position, it is my opinion that the Provider did not adopt the correct approach to the assessment of the Complainant Company's claim and, as a consequence, it incorrectly assessed the claim.

However, I note it is accepted by the Provider that the closure of the Complainant Company's business was an imposed closure by order of the local or government authority within the meaning of section 3(1)(d). It is also accepted by the Provider that COVID-19 is a 'contagious or infectious disease' within the meaning of section 3(1)(d) and that there were, or plausibly may have been, outbreaks of contagious or infectious disease, in the form of COVID-19, within 25 miles of the Complainant Company's business premises. It is also accepted that that there was no occurrence of COVID-19 on the Complainant Company's premises.

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While the Provider accepted there were, or plausibly may have been, outbreaks of contagious or infectious disease, in the form of COVID-19, within 25 miles of the Complainant Company's business premises, the date from which this is accepted to have been the case, is unclear.

Having considered the appropriate interpretation of extension 1(d) in light of the comments of McDonald J. and on the basis of the evidence submitted to this Office by the Complainant Company, at the time when this complaint was originally made, which includes newspaper clippings which strongly suggest that there were cases of Covid-19 within 25 miles of the Complainant Company's premises in early March 2020, it is my opinion that the Complainant Company is likely to have been in a position to show the presence of COVID-19 within 25 miles of its premises from **15 March 2020** and that this was a cause of the imposed closure. As a result, I am satisfied that the Complainant Company would most likely have been in a position to satisfy the relevant aspect of the insured peril, had the Provider sought the appropriate evidence at the time of the claim. It did not however do so, and in my opinion, it thereby failed to adequately assess the claim.

The position adopted by McDonald J. in the Test Case was clear and unequivocal in terms of whether claims under the policy should be admitted. The implication of this, in light of the circumstances pertaining at the time when the Complainant Company submitted its claim to the Provider and the matters accepted by the Provider in respect of the constituent elements of extension (d), bears out my opinion that the Complainant Company's claim should not have been declined, as the Complainant Company's circumstances fell within the plain meaning of the policy wording.

Therefore, having considered the matter in some detail, it is my opinion that, on a proper and reasonable construction of the policy, the Provider ought to have admitted the Complainant Company's claim under the policy, and it ought to have proceeded expeditiously with the assessment of the benefit payable, in accordance with the applicable policy provisions. The Provider's failure to do so in my opinion was inappropriate and unfair, and I take the view that it was unreasonable and unjust, within the meaning of ***Section 60 (2) (b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, and was improper, within the meaning of ***Section 60 (2) (g).*** Accordingly, for the reasons outlined above, it is my Decision, on the evidence before me that the complaint should be upheld.

I note that in the Provider's Complaint Response, to this Office, it intimated that it would comply with the determination of the Court in the Test Case(s) on the correct approach to the policy, and that this may entail revisiting its declinature position. However, although this Test case judgment was delivered on **5 February 2021**, neither of the parties advised this Office until after the preliminary decision of this Office had been issued in **April 2021**, that the Complainant Company's claim under the policy had been admitted by the Provider on 9 February 2021, very promptly after that judgment was delivered.

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The Provider's submissions since the preliminary decision, have commented in detail regarding the role of the Court in the Test Case, notwithstanding that the role of the FSPO is entirely different from that of the Courts. The Provider has referred to what indeed this Office accepts, was a very broad range of determinations, which the Court was called upon to make in the Test case in question.

The role of this Office however is more limited, insofar as this Office must determine only whether the conduct of the Provider which is the subject of this complaint, was wrongful within the meaning of ***Section 60*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

The Provider has pointed out, on a number of occasions, that once the High Court delivered judgment in the Test Case, it moved swiftly to confirm publicly that the Judgment of the High Court was accepted by it, and that it would not be appealing that decision. The Provider has made clear its opinion that the approach it adopted regarding the Test Case (including the fact that it elected not to bring an application to "*stay*" the Test Case proceedings) "*is very material when it comes to assessing the reasonableness of* [the Provider's] *conduct*".

The Provider has also pointed to the provisions of ***Section 60(2)(b)*** and ***(g)*** and it takes the view that its decision to decline the Complainant Company's claim in early 2020 was not unreasonable, unjust or otherwise improper. It has referred in that regard to its obligations pursuant to the Central Bank of Ireland's Consumer Protection Code 2012 (CPC), though I see nothing in the CPC provisions which entitled the Provider to decline a claim from the Complainant Company, which met the specified policy criteria.

The Provider has also referenced its Constitutional right of access to the Courts in respect of which it says it "*cannot be penalised for utilising its right*" and it points to the fact that almost all insurers in the UK and Irish markets "*reached the same conclusion in relation to similarly-worded policies, and it was only after significant litigation in different jurisdictions that the insurers were shown to have been incorrect in their interpretation of those policies."* The Provider suggests that any finding that it has acted unreasonably, unjustly or otherwise improperly in declining the Complainant Company's claim:

> "*…has much wider ramifications, as it suggests that an insurer which carefully considers a claim and decides it is not liable is automatically considered to be acting unreasonably, unjustly, or otherwise improperly if it subsequently turns out to have been incorrect. That simply cannot be correct*."

It is important to note that the FSPO has made no finding that an insurer which carefully considers a claim and decides that it is not liable to pay benefit, but this position subsequently transpires to be incorrect, *"is automatically considered to be acting unreasonably, unjustly or otherwise improperly*". This Office agrees that such a finding would not be appropriate.

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If an insurer assesses a claim and considers it appropriate to decline that claim, it is open however to an eligible complainant to pursue a complaint to the FSPO. Following an investigation by this Office, it may be determined that, in all of the circumstances, based on the individual merits of that complaint, the insurer's conduct was unreasonable. Likewise, it may be considered that the insurer's conduct was contrary to law, or that it was based wholly or partly on a mistake of law or fact. Such an outcome is not however in any way automatic and will always turn on a determination of the individual facts and events, taking account of the evidence available and the parties' submissions and observations. It may indeed be determined by this Office, depending upon the circumstances, that there was no element of wrongdoing by the insurer.

In offering comment on the preliminary decision of this Office, the Provider has pointed to the Test case, seeking to rely on the learned comments of Mc Donald J., which noted the "*sheer extent of the arguments advanced by both sides*" which had "*occupied the greater part of the eleven-day hearing*" and opined that *"few, if any of the arguments advanced …can be dismissed as wholly implausible …"* In that context, the Provider contends that a finding that it acted unreasonably, unjustly or otherwise improperly, in declining the Complainant Company's claim, is unsupportable.

The Provider has also suggested that within the preliminary decision issued by this Office in this matter, the "*sole basis on which* [the FSPO's] *finding of unreasonable conduct appears to be made is the references to* "*reasonableness*" *in the Judgment of McDonald J."* This comment is not accepted. The determination of this Office is as outlined above. The position adopted by McDonald J. of the Court, is however of interest and of relevance to the considerations of this Office in this matter, taking account of the particular circumstances of this complaint against the Provider, and indeed being cognisant of the reliance which the Provider has sought to place on the steps it took to engage in that process, as indicative of the reasonableness of its conduct.

The role of the FSPO however is to assess the conduct of a financial service provider, in the context of ***Section 60*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** and to do so "*in an informal manner and according to equity, good conscience and the substantial merits of the complaint without undue regard to technicality or legal form*" in accordance with ***Section 12(11)*** of the governing legislation.

In considering whether or not this complaint should be upheld, I have been conscious of the recent comments of Hyland J. of the High Court, on **19 February 2021**, in ***Danske Bank A/S v FSPO and Anor, [2020 121 MCA],*** when she addressed an argument from the Appellant Bank to the effect that, where there was no illegality identified by the FSPO in the conduct of the Appellant, this Office was not entitled to uphold the complaint which had been made. I note that in dismissing that argument, Hyland J. concluded that:

> *"… this argument fails to recognise the import of the jurisdiction being exercised by the respondent under s.60(2)(b) and (g) of the 2017 Act, which respectively permit him to uphold a complaint on the basis that the conduct was unreasonable, unjust, oppressive, or improperly discriminatory in its application to the complainant or that the conduct complained of was otherwise improper.*

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Having regard to this jurisdiction, it was open to the respondent to uphold the complaint under s.60(2)(b) and (g), irrespective of whether the appellant had acted in accordance with law.

Even where the complainants had signed up to the mortgage documentation and where the appellant had no black letter duty under statute, or "soft" law obligation under a regulatory standard, to give information in a specific form as to the redemption of the tracker mortgage and the inability to return to a tracker rate under the new mortgage, the respondent was still entitled to find an ambiguity and lack of clarity in the information provided. In short, the statutory scheme and the case law on same make clear that the mere absence of a breach of law does not immunise a financial services provider from a finding of unreasonable and improper conduct under s.60(2)(b) and (g)."

In addition, in considering this complaint I have been cognisant, as referred to above, of the provisions of section 12(11) of the ***Financial Services and Pensions Ombudsman Act 2017***, which prescribes that:

"… the Ombudsman, when dealing with a particular complaint, shall act in an informal manner and according to equity, good conscience and the substantial merits of the complaint without undue regard to technicality and legal form."

In determining whether this complaint should be upheld, pursuant to ***Section 60(2)*** of the FSPO Act 2017, I have been mindful that those provisions are identical to the then equivalent provisions in the governing legislation of the Financial Services Ombudsman, which came under the scrutiny of Mr. Justice Hogan (of the High Court at the time) in *Koczan v FSO* [2010] IEHC 407. Here, Hogan J., having referred to the powers given to the Financial Services Ombudsman, and in advance of quoting from those same provisions, observed that:

"The Ombudsman's task, therefore, runs well beyond that of the resolution of contract disputes in the manner traditionally performed by the Courts. It is clear form the terms of s.57BK(4) that the Ombudsman must, utilising his or her specialist skill and expertise, resolve such complaints according to wider concepts of ex aequo et bona which go beyond the traditional limitations of the law of contract. This is further reflected by the terms of s.57CI(2) …."

Likewise, some time later Hogan J. in *Lyons and Murray v. FSO and Bank of Scotland plc*, *Notice Party* HC[2011/22MCA] commented upon the decision of McMahon J. in *Square Capital Limited v. FSO* [2009] IEHC407, [2010] 2I.R.514, noting that:

"One may venture the suggestion that Koszan and Square Capital represent classic examples of the kind of complaints which the Oireachtas intended would be investigated by the Ombudsman, since they relate to instances of unfair dealing and perhaps even forms of sharp practice for which the ordinary judicial system and the law of contract may provide no adequate remedy."

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It is in those circumstances that, having considered the matter at length, and for the reasons explained above, I have determined, on the evidence before me, that this complaint should be upheld.

I am mindful of the fact that this claim was made to the Provider at the beginning of **April 2020**, it was declined within a two week period, and when the Complainant Company made a complaint, the Provider's Final Response letter was issued on **25 May 2020**. It was not until ten months after making the claim, on **9 February 2021**, that the claim was ultimately admitted. A limited advance payment of policy benefits was then made very promptly by the Provider to the Complainant Company, two days later on 11 February 2021. The Provider has confirmed that the full assessment of the claim will take additional time to finalise.

The Provider however takes issue with the intention of this Office, as signalled in the preliminary decision issued to the parties in April 2021, of directing the Provider in this legally binding decision, to make an advance payment of policy benefits to the Complainant Company of €50,000 (if not already paid) pending the final calculation of the total benefit payable, once the claim is fully assessed and agreed by the parties. It has pointed out that, in the case of this Complainant Company, the Provider's loss adjusters have currently assessed its net claim at c. €77,000, a calculation which it advises has:

> "*necessarily been made on the basis of a number of assumptions in the absence of detailed financial information from the Complainant, and will be refined as further information is obtained from the insured.*"

The Provider has confirmed, that the interim payment in the amount of **€19,000** made to the Complainant Company on **11 February 2021**, was on the basis that it represented an amount equal to 5% of the Complainant Company's annualised sum insured. A second interim payment had not yet been made, as of the date of its submission to this Office on 30 April 2021.

I have noted that the Complainant Company was insured at the relevant time with the Provider for Consequential Loss, for a maximum figure of **€380,000** for a 12 month indemnity period, and that its Annual Turnover to Year Ended 31 December 2019 was €577,486.00, with a gross profit of some €360,000 within that period.

In those circumstances, and taking account of the Provider's submissions in relation to this aspect of the matter, and also bearing in mind the Provider's comment that "*A further module* [of the Test case] *dealing with complex quantum issues will also now be heard, probably in this legal year*", I consider it appropriate, pending the conclusion of that loss adjustment process, to direct the Provider to now make an additional advance payment of policy benefits of **€28,500,** to the Complainant Company to bring the benefit level paid, to 12.5% of its annualised sum insured, pending the calculation of finalised figures (if it has not already done so). It will be important for the Complainant Company to actively engage with the Provider's loss adjusters in that regard, in order to progress that matter as expeditiously as possible.

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The Provider has also taken issue with the level of compensation which the Preliminary Decision of this Office signalled the intention to direct, in the sum of €20,000. In that regard, ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** prescribes that

> "*Where a complaint is found to be upheld, substantially upheld or partially upheld, the Ombudsman may direct the financial service provider to… pay an amount of compensation to the Complainant for any loss, expense or inconvenience sustained by the Complainant as a result of the conduct complained of."*

In assessing the inconvenience suffered by the Complainant Company, this Office does not seek in any manner to "*punish*" the Provider for exercising its right to litigate certain issues by way of a test case, as the Provider has recently suggested. Nor indeed would this Office ever consider it appropriate to direct compensation in a punitive manner.

This Office must be conscious however of the inconvenience suffered by the Complainant Company as a result of the Provider's decision to decline the Complainant Company's claim in early 2020. The Provider has commented on the position adopted by other insurers in the Irish and UK markets, but it is the conduct of the Provider only, which is the subject of this complaint investigation, rather than the conduct of any other insurer, which may have potentially guided the Provider in its approach to the Complainant Company's claim.

In my opinion, the inconvenience suffered by the Complainant Company was made no less, by virtue of the particular rationale of the Provider in originally declining the claim. Neither, in my opinion, was that inconvenience eliminated or even significantly reduced, by the updates sent by the Provider to policyholders (holding a policy of this nature) on 29 June 2020 or 30 November 2020. Similarly, in my opinion, the Provider's premium rebate payment of €2,873.88 to the Complainant Company did not, in any meaningful way, reduce the inconvenience it suffered, as a result of its inability in early 2020, or indeed throughout 2020, to secure payment of the policy benefits to which it was entitled. This Office is very conscious in this respect of what must have been a very significant impact on cashflow, during the months which followed closure of the Complainant Company's premises in March 2020.

It is in those circumstances that I consider it appropriate to direct the Provider to make a compensatory payment to the Complainant Company of **€20,000**, in order to compensate the Complainant Company for the tremendous inconvenience encountered throughout a very difficult period, as a result of the Provider's disappointing approach to this claim, and its unsatisfactory, unreasonable and unjust failure to recognise the claim as one which was very likely covered by the policy provisions, subject only to receipt of appropriate evidence of the existence of a case of COVID-19, within 25 miles of the premises.

Finally, I consider it appropriate to comment on the issue raised by the Complainant Company when it originally made its complaint to this Office. It stated on its Complaint Form that the Provider failed to notify it of any internal appeals mechanism and failed to provide a meaningful response to its Claims Manager's letter of **21 April 2020** other than the option to arbitrate or make a complaint to this Office. I note that the Provider's letter of **14 April 2020** was its declinature of the Complainant Company's claim.

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At the end of this letter, the Provider advised, as follows:

> *"Finally please note that if you are dissatisfied with the contents of this letter you have the right to refer your complaint further to the Financial Services and Pensions Ombudsman … or to Arbitration under the terms of the policy. …*
> ***Please Note:***
>
> ***Details of*** [the Provider's] ***feedback and complaint procedure is set out overleaf*** *…"*

It is not necessarily clear whether the Provider has an internal appeals mechanism as suggested by the Complainant Company. However, while the Provider's letter of **14 April 2020** was not in response to a formal complaint, it contained details of its complaints procedure. As a result, I am satisfied the Provider furnished the Complainant Company with sufficient information to allow it make a formal complaint or, in essence, appeal the Provider's decision to decline indemnity. I note that a formal complaint was subsequently made on **27 April 2020**.

I note that the Complainant Company is also dissatisfied with the Provider's response to the letter of **21 April 2020,** in that the Provider failed to provide a meaningful response. In this respect, I note the Provider emailed the Claims Manager on **24 April 2020**, as follows:

> *"Your letter of 21st April to our Chief Claims Officer has been passed to the writer for reply.*
>
> *We are not able to make any interim payments and our position on policy cover remains as set out in our letter of 14th April. The aforementioned correspondence also sets out your client's options in the event they wish to make a formal complaint or challenge the cover declinature."*

In response to this, the Claims Manager wrote to the Provider on **27 April 2020**, as follows:

> *"*[The Provider] *have failed to answer the points raised in our letter dated 21st April 2020 challenging its declinature."*

The Complainant Company has not set out exactly how the Provider failed to provide a 'meaningful response' to the letter of **21 April 2020**. While this letter refers to local incidents of COVID-19 and correspondence from the Central Bank of Ireland, I am satisfied that the Provider was reasonably entitled to refer the Complainant Company/the Claims Manager to its earlier correspondence as the basis for declining indemnity.

I note that the Provider issued further correspondence to the Complainant Company's Claims Manager on **25 May 2020** in response to the formal complaint made on **27 April 2020** which addressed the points raised in the **21 April 2020** letter. Accordingly, having considered the Provider's correspondence in detail, I do not accept the Complainant Company's contention that the Provider failed to meaningfully respond to its April correspondence.

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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 making a further advance payment of policy benefits to the Complainant Company of **€28,500** to bring the advance benefit level paid, to 12.5% of the Complainant Company's annualised sum insured (if it has not already done so) pending the calculation of finalised figures, to conclude the claim. I also direct the Provider to make a compensatory payment to the Complainant Company in the sum of **€20,000**, (entirely separate from the policy benefits payable under the policy) to an account of the Complainant Company's choosing, within a period of 35 days of the nomination of account details by the Complainant Company to the Provider.

- I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- 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.

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

9 June 2021

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—

(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.**