Insurance Law Intensive: Cases and Claims

WEBINAR

Wednesday, 19 February 2025

2.00pm to 5.15pm

CLE/CPD ACCREDITATION

If this particular educational activity is relevant to your immediate or long-term needs in relation to your professional development and practice of the law, then you are eligible to claim one (1) 'unit' per hour of attendance, refreshment breaks not included.

PREPARED & PRESENTED BY
Grant Shand, Principal, Grant Shand Barristers & Solicitors
Toby Gee, Barrister & Mediator, Lambton Chambers
Julia Whitehead, Special Counsel, Meredith Connell
Bruce Gray KC, Barrister, Shortland Chambers

Gary Hughes, Barrister, Britomart Chambers - Chair

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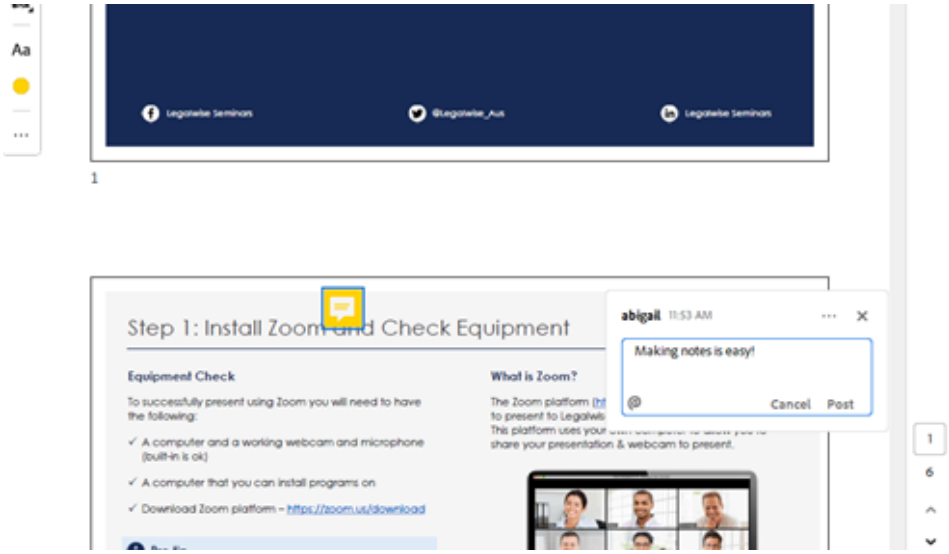

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Program

Insurance Law Intensive: Cases and Claims

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2.00pm	***Opening Comments by the Chair*** Gary Hughes, Barrister, Britomart Chambers
2.00pm to 2.45pm	***Property Insurance Round Up: Floods, Landslips, and Earthquake Issues*** Grant Shand, Principal, Grant Shand Barristers & Solicitors
2.45pm to 3.30pm	***Lessons Learned: Cyber Insurance Claims*** Toby Gee, Barrister & Mediator, Lambton Chambers
3.30pm to 3.45pm	***Break***
3.45pm to 4.30pm	***Climate Change and Business Insurance*** Julia Whitehead, Special Counsel, Meredith Connell
4.30pm to 5.15pm	***Developments in Insurance Law in 2024*** Bruce Gray KC, Barrister, Shortland Chambers
5.15pm	***Final Q&A and Closing Comments by the Chair*** Gary Hughes, Barrister, Britomart Chambers

Profiles

Gary Hughes, Barrister, Britomart Chambers

Gary is a leading independent lawyer at Britomart Chambers, specialising in all types of regulatory investigations, enforcement and disputes, advocacy and advice. His insurance practice has a focus on financial lines, D&O, or statutory liability cases. He has deep expertise in resolving issues with business crime regulators – especially the Commerce Commission, Financial Markets Authority, AML/CFT Supervisors, Serious Fraud Office, Privacy Commission, and other government agencies. Widely known for specialist work on Competition law and Anti-Money Laundering cases, Gary is a member of the NZ Law Society Law Reform Committee, Chair of the International Bar Association's AML & Sanctions Experts committee, and author of the Thomson Reuters textbook AML/CFT Workflows & Guidance for Lawyers. At the cutting edge of regulatory issues, his work includes the DIA's first AML/CFT pecuniary penalty case, Russian Sanctions Act issues, and defending the first criminal cartel prosecution in New Zealand. Gary has worked on insurance law disputes and problems throughout his 28-year career including at leading law firms (Clyde & Co, Chapman Tripp and Wilson Harle) and for a period in-house at Aon UK. That ranges from defending claims against directors/managers, to policy coverage disputes, to Commerce Commission or RBNZ prudential investigation of insurance companies. Gary's pragmatic strategic approach also makes him a sought-after trainer of Boards and Professional partnerships. Admitted in NZ (1996), also qualified in England & Wales and Supreme Court of NSW Australia.

Grant Shand, Principal, Grant Shand Barristers & Solicitors

Grant Shand is the principal of Grant Shand Barristers and Solicitors. He is New Zealand's leading natural disaster lawyer. Since 2012 he has done hundreds of cases arising out of the Canterbury earthquakes and is still involved in two earthquake class actions against EQC and many court proceedings. He is now involved in flooding and landslip cases around the country, including two class action flooding cases against local authorities.

Profiles

Toby Gee, Barrister and Mediator, Lambton Chambers

Toby Gee has more than 24 years' experience as a trial lawyer and specialist counsel. He completed his training as a barrister in the Inner Temple, London in 1992-1993. From 1993 until 2013, he practised as a barrister at Crown Office Chambers in London, instructed by many leading UK firms of solicitors to represent insurers, other corporate entities, government entities and individuals in civil claims at all levels up to and including the Court of Appeal. Toby's main specialisms are in insurance, commercial/contractual disputes, professional liability, medico-legal matters, product liability (medical and non-medical), engineering and construction, and health and safety. In 1997 Toby was a Pegasus Scholar at Chapman Tripp Sheffield Young (as it then was) in Wellington. While on a sabbatical from his London practice in 2005-2006, as well as working in the policy group at ACC he worked with several Wellington barristers on a variety of civil disputes. As well as being a barrister, Toby is an accredited mediator. He is also a member of the governance board of the New Zealand Choral Federation, and a trustee of St Mark's Church School, Wellington.

Julia Whitehead, Special Counsel, Meredith Connell

Julia has extensive expertise as an insurance lawyer acting for insurers and insureds. She has advised insurers and reinsurers on representative actions, complex professional indemnity issues, and product liability matters. With a wealth of experience as a defendant lawyer, Julia brings a unique understanding of the defence approach to civil cases, and the insurance drivers that often underpin them. Julia is an experienced civil litigator appearing in a wide range of courts and tribunals. Her subject matter specialisms include construction law (including product liability), health law, and regulatory matters. She has acted for leading New Zealand and global engineering and architecture firms for more than a decade.

Bruce Gray KC, Barrister, Shortland Chambers

Bruce is a King's Counsel, having been appointed in 2006. Bruce has extensive trial and appellate experience in a range of civil law areas. This experience includes appearing in respect of construction of policies of insurance and in respect of parties who are indemnified under policies of insurance. Bruce was a long-standing member of the Council of the Legal Research Foundation and was its Director of Research for 13 years. Bruce is the Provincial Chancellor of the Anglican Church in Aotearoa New Zealand and Polynesia.

Property Insurance Round Up: Floods, Landslips, and Earthquake Issues

Grant Shand,
Principal,
Grant Shand Barristers & Solicitors

Legalwise

Property insurance round up- Floods, landslips and earthquake issues- A discussion of recent cases and current litigation as well as issues arising post natural disasters.

Grant Shand

19 February 2025

Introduction

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Wairoa flood 2024

The first event in the table is the East Coast floods of late June 2024 that damaged properties in Wairoa & Hastings. It is already the subject of High Court proceedings *civ 2024-441-00053 Kopu Road Orchards Ltd & anor v Hawkes Bay Regional Council*. It is primarily about Council management of the Wairoa River bar. Hopefully this becomes a representative action for all affected properties. Apparently, insurers are also looking at a claim against Council.

There are likely to be more clams against Councils from Cyclone Gabrielle in Hawkes Bay where insured losses are close to $2B. There are also hundreds of millions of uninsured losses particularly to horticulture and viticulture.

Edgecumbe flood 2017

There are two proceedings commenced in 2023 against the BOP Regional Council out of the 2017 Edgecumbe floods that are yet to be certified as representative proceeding(s). The insured loss was about $113M. One by/for home and business owners (*Civ 2023-463-0006 MConnachie & ors v BOPRC*). The other by/for IAG (*civ 2023-463-0024 Rangiaho & ors v BOPRC & anor*).

IAG commenced its proceeding the day before the expiry of the 6 year limitation period. Since then it has persuaded the BOPRC to waive its limitation defence and consent to Tower, QBE, AA and Vero being in the Iag proceeding. All insurers would have been in the class of the earlier commenced McConnachie proceeding.

The application(s) for representative orders are yet to be heard. It will primarily be a contest about who should be in each class and involve issues about the rights of insureds and insurers to control what occurs and who gets first go at any recovery.

The High Court will have to consider the Australian judgment in *Johnston v Endeavour Energy [2015] NSWSC* 1117 about the rights of an insurer to successfully opt an insured out of a proceeding.

Johnston

Sean Johnston sued Endeavour in a representative capacity for loss damage caused in Blue Mountain bushfires in 2013.

Considerable property was lost. Houses were destroyed. The contents of houses, motor vehicles and other personal property were destroyed. Many of the residents suffered personal injury, particularly by way of post-traumatic stress disorder. Some, but not all of the houses which were destroyed were covered by insurance. Those that were covered by insurance were not always insured for the full value of the replacement cost. Some, but not all, of the personal property, being the contents of the houses that were destroyed, or motor vehicles or other personal property, were insured. Often, not all of the value of the contents or personal property was insured.

On 10 October 2014, the legal representatives for IAG and other related insurers filed notices purporting to opt out 565 identified individuals and entities that they insured from the Johnston proceeding.

The insurers then sent letters to the insureds noting the opt out and asserting that the insurers were entitled to, and better placed to, conduct the recovery action; and commenced a second representative proceeding against Endeavour Energy, with their insureds as group members, seeking recovery for both insured and uninsured losses arising from the bushfires (the Insurer proceeding).

The central issue before the Court was the validity of the opt out notices. The insurers asserted contractual rights under the policies which enabled them to authorise the execution and filing of the opt out notices and commence the Insurer proceedings for both insured and uninsured losses.

The Court determined that unless there is an express contractual right to do so, an insurer which has paid part of an insured's loss does not have authority to conduct and control the insured's right to recover their entire loss, both insured and uninsured. In this case, this meant that insurers were not authorised to file the opt out notices for over 550 of their insureds to remove them from the existing the Johnston proceeding class action and commence the insurers' own Insurer proceeding class action including the claims by those insureds.

This will be an issue NZ Courts will have to consider.

Class actions - NHC

In NZ, unless all class members consent, the Court must approve a class action under r4.24. There are currently two extant class actions against NHC being *Mathias v EQC* (civ 2021-009-2441) and *McEvedy & anor v EQC* (civ .

Mathias is a claim against EQC for what are known as “on sold” properties where subsequent purchasers of earthquake damaged houses say EQC breached its obligations to properly assess, scope, cost and repair damaged houses. It is an opt in class action with north of 200 class members. It is ready to be allocated a trial date.

McEvedy is a claim about land damage by the Canterbury earthquakes. It is currently certified as an opt out class action, but the High Court judgments are subject to appeal and cross appeal with a hearing in mid June 2025 in the Court of Appeal.

Resolution forums

Courts

Courts are the primary resolution forum. Now that the jurisdiction of the District Court is $350,000 it is getting more claims than previously.

Post the Canterbury earthquakes the High Court set up a specific list then run by Miller J. He adopted an interventionist approach and convened conferences early attended by parties and lawyers. It worked very well. Judges that have run the list since the appointment of Miller J to the Court of Appeal in 2013 have not run the list as effectively or efficiently. It exists in name only now.

CEIT

The Crown established the Canterbury Earthquakes Tribunal under the Canterbury Earthquakes Insurance Act 2019 to resolve outstanding earthquake claims. A recent report on the operation of the CEIT by staff of the University of Canterbury concluded it was a sub optimal system that did not provide sufficient access to justice.

GCCRS/NZCRS

The NZCRS is an evolution of GCCRS and RAS. RAS was established in 2013 to provide quake-affected Canterbury homeowners with access to free legal advice about unresolved insurance claims. Following the 2016 Kaikōura earthquake, RAS's focus expanded to include natural disasters in the rest of the country.

GCCRS was established in 2018 as part of a package of initiatives to address unresolved Canterbury insurance claims. It was developed as an expanded version of RAS, with an integrated service model (between NHC, Southern Response and the Ministry of Business, Innovation & Employment) to streamline the claims settlement process for claimants and insurers.

The NZCRS was established in 2023 as a national service to provide independent support to homeowners to resolve residential insurance issues resulting from natural disasters. It builds on the knowledge, experience and support provided by the GCCRS and the RAS. The NZCRS replaces both of these service organisations.

For homeowners affected by the Canterbury earthquake sequence NZCRS provides two options for resolving disputes relating to an insurance claim.

Mediation

Mediation is a voluntary and confidential process where you and your insurer agree to meet with an independent third party and attempt to reach a binding settlement on the insurance dispute.

Determination

Determination is a voluntary and confidential process where you and your insurer agree to appoint an experienced and independent decision-maker to make a binding decision on the insurance dispute.

How NZCRS dispute resolution services work

Participation in the NZCRS's dispute resolution services are voluntary. Both parties (insured and insurer or NHC) need to agree to take part in a mediation or determination, however, once you have started a determination, neither party can opt out of the process unless both parties agree.

The mediation/determination process Is not available for other claims.

Natural Disasters Tribunals

The view of the UC research team was that such a system should include an adjudicatory tribunal of some form providing a clear alternative to the court system. This tribunal should also incorporate mediation and case management services. The research team suggests that the following key features should be part of any such scheme:

1. The tribunal should be established by statute and compel insurers to participate;

2. The processes of the tribunal must be claimant-centred and consideration should be given to reducing legal representation;

3. The processes of the tribunal must address the power imbalance between the parties and be flexible enough to adapt to the specific particular needs of the claimant;

4. The tribunal should publish decisions to provide transparency and consistency in decision making.

Maybe such a tribunal emerges. Not seen anything yet.

Epoxy

Post earthquake(s) there has been conflict about whether repairing a building crack with epoxy meets the policy standard of “as new” or “when new”. That is now decided.

Moorhouse Commercial Park Ltd v Vero Insurance NZ Ltd [2024] NZCA 415

Judgment 3 September 2024

Moorhouse appealed from the decision of the High Court largely dismissing its claim for breach of contract against Vero claimed under its insurance policy with Vero for damage to its buildings at 33 to 41 and 43 Moorhouse Avenue, Christchurch, arising out of the Canterbury earthquakes in late 2010 and early 2011.

Before the High Court, Moorhouse alleged that Vero had breached the insurance policy in a number of ways. Dunningham J dismissed Moorhouse’s claims that the damage to its buildings had been more extensive than Vero had accepted.

Under the policy Vero had the ability to elect either to make payment or to undertake the reinstatement or repair required. Payment for reinstatement was conditional on actual reinstatement; otherwise the insured got indemnity value of reinstatement lost less depreciation and deferred maintenance. Tthe reinstatement work Moorhouse says is/was required would require the Buildings to be largely demolished and reconstructed given their integrated character

The main area of dispute arises from Moorhouse’s allegation that the Buildings suffered greater damage than Vero assessed, primarily arising out of what is called “bond loss” and that Vero’s “epoxy repair” methodology would not repair the Buildings to the Policy standard — namely that they be restored to a condition substantially the same as when new.

Moorhouse says that whilst this fills in the cracks caused by the earthquake, it does not address underlying damage.

An insurance policy is a contract. A plaintiff alleging that the contract has not been performed must prove that breach. Here, it is accepted that there has been damage to the Buildings which engaged Vero’s contractual obligations. Vero considers it those obligations are met by its epoxy repair solution. Moorhouse alleges that that is not so because the damage to the Buildings is more profound than Vero has assessed meaning that Vero’s proposed repair

solution is insufficient to repair the damage. To establish this, and thereby prove a breach of contract, Moorhouse must prove that this further damage occurred.

Vero said in its defence that its repair solution meets the policy standard, but that does not mean that it has a burden to prove it has not breached the contract by adopting that stance. Moorhouse still has the burden.

The burden of proof does not shift to the insurer because this is an insurance contract. The burden can shift to the insurer to show that any relevant exclusion of liability under the policy applies.12 But that was not the case here. The insurer's duty of good faith will also mean that it has certain obligations in relation to a claim. The insurer would be obliged to investigate the claim in good faith to assess what it considers the damage to the property to be. That will likely require the instruction of competent experts to provide their impartial opinion. But it is not the insurer's burden to prove that suggested damage did not arise. The insured must still prove its allegation that there was additional damage not accepted by the insurer.

Moorhouse was unable to prove, on the balance of probabilities and through the application of some recognised test or other technique accepted as reliable in the industry, that the damage occurred. The CA considered that ultimately means that the High Court was right to reject Ms Stanway's opinion

For Moorhouse to prove its claim, it needed to prove not only that bond loss had occurred, but also the detrimental effect that bond loss had in terms of the value, amenity, or usefulness of the Buildings.

Vero's proposed use of epoxy repair of cracks met the policy standard

Insurer payment timing

IAG NZ Ltd v Degen [2024] NZHC 397

Judgment 6 March 2024

An appeal from a decision of the Canterbury Earthquakes Insurance Tribunal about the timing of IAG's payment of reinstatement costs for a house damaged in the earthquakes. CEIT found the damage was repairable but IAG was obligated to pay the entire reinstatement cost on entry into a building contract .

Hinton J decided that the CEIT erred in ordering full payment upfront. Rather the CEIT should have ordered that IAG fulfil its obligations under the policy by paying the relevant contractor(s), or Mr Degen himself, the reasonable costs of repairs as they were actually incurred.

IAG is required to pay repair costs to Mr Degen only as and when Mr Degen has incurred the costs of such repair, submitted invoices to IAG, and IAG has assessed the invoices and is satisfied that the costs are reasonable and relate to the scope of work.

Co-insurer

The New India Assurance Company Ltd v Ziwi Ltd [2024] NZHC 2770

Judgment 26 September 2024

This is a judgment post Cyclone Gabrielle where an insured sought to recover $$ by statutory demand from a 30% co-insurer of its claim liability where the other co-insurers paid as calculated by the lead insurer.

Cyclone Gabrielle damaged three of Ziwi's Hawkes Bay pet food manufacturing plants leading to claims under material damage and business interruption policies. Ziwi's MD/BI insurance for the period from 1 October 2022 to 1 September 2023 was placed with four co-insurers in the following proportions: QBE 50 per cent, NIA 30 per cent, Ando Insurance Group Ltd 10 per cent and Offshore Market Placements Ltd 10 per cent.

The co-insurers appointed a loss adjuster, Thomas Pasley from Integra Technical Services (**Integra**). Integra issued reports to the co-insurers on 10 March 2023 and 19 May 2023. Based on these reports, NIA made three progress payments to Ziwi between 24 March 2023 and 29 August 2023 totalling $15,000,000 (plus GST).

Integra issued a third report on 13 December 2023, a fourth report on 18 December 2023 and a fifth report on 26 March 2024. While the other co-insurers made further progress payments based on these reports, NIA did not.

On 4 or 5 April 2024, Ziwi issued the statutory demand on NIA for an alleged debt of $8,625,000 (including GST).

On 21 June 2024, Ziwi reached an agreement with QBE to resolve Ziwi's claim for a total of $96,500,000 (plus GST). On 27 June 2024, Ziwi and the co-insurers under the 2022–2023 policy (except for NIA) executed a settlement agreement and discharge. The terms of the settlement agreement provide for NIA to pay $16,042,500.00 (including GST).

New India applied to set aside the statutory demand on the basis that:

1. There is a dispute about whether the policy covered specific sites only with specific limits;
2. It was not bound by the decision of the lead insurer (lead clause)

The Court accepted that New India had raised a genuine and substantial dispute about the policy interpretation and that it is at least arguable that the debt, even if owed, was not due when the statutory demand was issued.

The Court set aside the stat demand and awarded costs. In a later judgment 13 December 2024 New India sought indemnity costs of $101,356.40, plus costs of over $5,000 that are yet to be invoiced. Alternatively, New Indiia sought scale costs on a 3C basis with a 50 per cent uplift, in the amount of $85,779. The Court ordered Ziwi to pay costs and disbursements of $40,944.36 be cat 2 with a mix of items at B & C with then a 50% uplift.

Fire claim

Cloverbloom Company Ltd v QBE Insurance (Australia) Ltd & ors [2024] NZHC 2443

Judgment

Bad economic times invariably lead to an increase in the risk of insureds causing damage to insured property.

In *Cloverbloom* the Court considered a claim by the operator of the Barrelhouse Restaurant and Bar in Dannevirke for business interruption losses caused by fires on 28 February 2020 and 10 March 2020. The plaintiff (Cloverbloom) operated the restaurant and the associated liquor store. Its claim for business interruption insurance was declined by the defendants on the basis that one of Cloverbloom's directors, Mr Greenwood, was responsible for lighting both fires.

New Zealand courts have commonly approached the question by applying the "arson triangle". This involves asking whether the insured had the motive, means, and opportunity for committing arson. This provides a helpful framework within which to assess the evidence, while remaining mindful that the defendants bear the burden of proof.

The defendants said Mr Greenwood had a motive to commit arson because the business was under financial strain. They relied on Cloverbloom's financial circumstances in the first four months of trading, and outstanding debts due to Tasman & Allied Liquor (Tasman Liquor) and Bidfood Ltd, in making that allegation

When the evidence is considered in totality, the Court considered it established that Cloverbloom was under significant financial pressure at the time of both fires. It was more than "a short term cashflow squeeze" as characterised by counsel for the plaintiff. but even if that is all that it was, a cashflow squeeze still provides a motive for arson.

Mr Greenwood had knowledge of the extent of cover available under the insurance policies. The policies had been taken out a matter of months before the fires and he made claims immediately after each fire, signalling his familiarity with Cloverbloom's insurance cover. The cover provided by the insurance policies would have alleviated Cloverbloom's financial woes. That was sufficient evidence of motive to commit arson.

For both fires Mr Greenwood was the only person at the premises. Just prior to the first fire he was visible on CCTV carrying a BBQ lighter in the area of the location of the fire. Just prior to the second fire Mr Greenwood turned off the CCTV and he is in the area of the location of the fire. For both fires there was insufficient evidence to conclude that the cause of the fire was electrical. Each party called fire experts. The Court dismissed the Cloverbloom claim.

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Wairoa flood 2024

- The first event in the table is the East Coast floods of late June 2024 that damaged properties in Wairoa & Hastings. It is already the subject of High Court proceedings *civ 2024-441-00053 Kopu Road Orchards Ltd & anor v Hawkes Bay Regional Council*. It is primarily about Council management of the Wairoa River bar. Hopefully this becomes a representative action for all affected properties. Apparently, insurers are also looking at a claim against Council.
- There are likely to be more clams against Councils from Cyclone Gabrielle in Hawkes Bay where insured losses are close to $2B. There are also hundreds of millions of uninsured losses particularly to horticulture and viticulture.

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Edgecumbe flood 2017

- There are two proceedings commenced in 2023 against the BOP Regional Council out of the 2017 Edgecumbe floods that are yet to be certified as representative proceeding(s). The insured loss was about $113M. One by/for home and business owners (*Civ 2023-463-0006 MConnachie & ors v BOPRC*). The other by/for IAG (*civ 2023-463-0024 Rangiaho & ors v BOPRC & anor*).
- IAG commenced its proceeding the day before the expiry of the 6 year limitation period. Since then it has persuaded the BOPRC to waive its limitation defence and consent to Tower, QBE, AA and Vero being in the Iag proceeding. All insurers would have been in the class of the earlier commenced McConnachie proceeding.
- The application(s) for representative orders are yet to be heard. It will primarily be a contest about who should be in each class and involve issues about the rights of insureds and insurers to control what occurs and who gets first go at any recovery.
- The High Court will have to consider the Australian judgment in *Johnston v Endeavour Energy [2015] NSWSC* 1117 about the rights of an insurer to successfully opt an insured out of a proceeding.

Johnston

- Sean Johnston sued Endeavour in a representative capacity for loss damage caused in Blue Mountain bushfires in 2013.
- Considerable property was lost. Houses were destroyed. The contents of houses, motor vehicles and other personal property were destroyed. Many of the residents suffered personal injury, particularly by way of post-traumatic stress disorder. Some, but not all of the houses which were destroyed were covered by insurance. Those that were covered by insurance were not always insured for the full value of the replacement cost. Some, but not all, of the personal property, being the contents of the houses that were destroyed, or motor vehicles or other personal property, were insured. Often, not all of the value of the contents or personal property was insured.
- On 10 October 2014, the legal representatives for IAG and other related insurers filed notices purporting to opt out 565 identified individuals and entities that they insured from the Johnston proceeding.
- The insurers then sent letters to the insureds noting the opt out and asserting that the insurers were entitled to, and better placed to, conduct the recovery action; and commenced a second representative proceeding against Endeavour Energy, with their insureds as group members, seeking recovery for both insured and uninsured losses arising from the bushfires (the Insurer proceeding).

Johnston continued

- The central issue before the Court was the validity of the opt out notices. The insurers asserted contractual rights under the policies which enabled them to authorise the execution and filing of the opt out notices and commence the Insurer proceedings for both insured and uninsured losses.
- The Court determined that unless there is an express contractual right to do so, an insurer which has paid part of an insured's loss does not have authority to conduct and control the insured's right to recover their entire loss, both insured and uninsured. In this case, this meant that insurers were not authorised to file the opt out notices for over 550 of their insureds to remove them from the existing the Johnston proceeding class action and commence the insurers' own Insurer proceeding class action including the claims by those insureds.
- This will be an issue NZ Courts will have to consider.

Class actions - NHC

- In NZ, unless all class members consent, the Court must approve a class action under r4.24. There are currently two extant class actions against NHC being *Mathias v EQC* (civ 2021-009-2441) and *McEvedy & anor v EQC* (civ .
- Mathias is a claim against EQC for what are known as "on sold" properties where subsequent purchasers of earthquake damaged houses say EQC breached its obligations to properly assess, scope, cost and repair damaged houses. It is an opt in class action with north of 200 class members. It is ready to be allocated a trial date.
- McEvedy is a claim about land damage by the Canterbury earthquakes. It is currently certified as an opt out class action, but the High Court judgments are subject to appeal and cross appeal with a hearing in mid June 2025 in the Court of Appeal.

Resolution forums

Courts

- Courts are the primary resolution forum. Now that the jurisdiction of the District Court is $350,000 it is getting more claims than previously.
- Post the Canterbury earthquakes the High Court set up a specific list then run by Miller J. He adopted an interventionist approach and convened conferences early attended by parties and lawyers. It worked very well. Judges that have run the list since the appointment of Miller J to the Court of Appeal in 2013 have not run the list as effectively or efficiently. It exists in name only now.

CEIT

- The Crown established the Canterbury Earthquakes Tribunal under the Canterbury Earthquakes Insurance Act 2019 to resolve outstanding earthquake claims. A recent report on the operation of the CEIT by staff of the University of Canterbury concluded it was a sub optimal system that did not provide sufficient access to justice.

GCCRS/NZCRS

- The NZCRS is an evolution of GCCRS and RAS. RAS was established in 2013 to provide quake-affected Canterbury homeowners with access to free legal advice about unresolved insurance claims. Following the 2016 Kaikōura earthquake, RAS's focus expanded to include natural disasters in the rest of the country.
- GCCRS was established in 2018 as part of a package of initiatives to address unresolved Canterbury insurance claims. It was developed as an expanded version of RAS, with an integrated service model (between NHC, Southern Response and the Ministry of Business, Innovation & Employment) to streamline the claims settlement process for claimants and insurers.
- The NZCRS was established in 2023 as a national service to provide independent support to homeowners to resolve residential insurance issues resulting from natural disasters. It builds on the knowledge, experience and support provided by the GCCRS and the RAS. The NZCRS replaces both of these service organisations.
- For homeowners affected by the Canterbury earthquake sequence NZCRS provides two options for resolving disputes relating to an insurance claim.

GCCRS/NZCRS continued

- *Mediation*
- Mediation is a voluntary and confidential process where you and your insurer agree to meet with an independent third party and attempt to reach a binding settlement on the insurance dispute.
- *Determination*
- Determination is a voluntary and confidential process where you and your insurer agree to appoint an experienced and independent decision-maker to make a binding decision on the insurance dispute.
- *How NZCRS dispute resolution services work*
- Participation in the NZCRS's dispute resolution services are voluntary. Both parties (insured and insurer or NHC) need to agree to take part in a mediation or determination, however, once you have started a determination, neither party can opt out of the process unless both parties agree.
- The mediation/determination process Is not available for other claims.

Natural Disasters Tribunals

- The view of the UC research team was that such a system should include an adjudicatory tribunal of some form providing a clear alternative to the court system. This tribunal should also incorporate mediation and case management services. The research team suggests that the following key features should be part of any such scheme:

1. The tribunal should be established by statute and compel insurers to participate;
2. The processes of the tribunal must be claimant-centred and consideration should be given to reducing legal representation;
3. The processes of the tribunal must address the power imbalance between the parties and be flexible enough to adapt to the specific particular needs of the claimant;
4. The tribunal should publish decisions to provide transparency and consistency in decision making.

- Maybe such a tribunal emerges. Not seen anything yet.

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Epoxy

- Post earthquake(s) there has been conflict about whether repairing a building crack with epoxy meets the policy standard of “as new” or “when new”. That is now decided.

- *Moorhouse Commercial Park Ltd v Vero Insurance NZ Ltd [2024] NZCA 415*
- Judgment 3 September 2024

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Moorhouse Commercial Park Ltd v Vero Insurance NZ Ltd [2024] NZCA 415

- Moorhouse appealed from the decision of the High Court largely dismissing its claim for breach of contract against Vero claimed under its insurance policy with Vero for damage to its buildings at 33 to 41 and 43 Moorhouse Avenue, Christchurch, arising out of the Canterbury earthquakes in late 2010 and early 2011.
- Before the High Court, Moorhouse alleged that Vero had breached the insurance policy in a number of ways. Dunningham J dismissed Moorhouse's claims that the damage to its buildings had been more extensive than Vero had accepted.
- Under the policy Vero had the ability to elect either to make payment or to undertake the reinstatement or repair required. Payment for reinstatement was conditional on actual reinstatement; otherwise the insured got indemnity value of reinstatement lost less depreciation and deferred maintenance. Tthe reinstatement work Moorhouse says is/was required would require the Buildings to be largely demolished and reconstructed given their integrated character
- The main area of dispute arises from Moorhouse's allegation that the Buildings suffered greater damage than Vero assessed, primarily arising out of what is called "bond loss" and that Vero's "epoxy repair" methodology would not repair the Buildings to the Policy standard — namely that they be restored to a condition substantially the same as when new.

Moorhouse Commercial Park Ltd v Vero Insurance NZ Ltd [2024] NZCA 415

- Moorhouse says that whilst this fills in the cracks caused by the earthquake, it does not address underlying damage.
- An insurance policy is a contract. A plaintiff alleging that the contract has not been performed must prove that breach. Here, it is accepted that there has been damage to the Buildings which engaged Vero's contractual obligations. Vero considers it those obligations are met by its epoxy repair solution. Moorhouse alleges that that is not so because the damage to the Buildings is more profound than Vero has assessed meaning that Vero's proposed repair solution is insufficient to repair the damage. To establish this, and thereby prove a breach of contract, Moorhouse must prove that this further damage occurred.
- Vero said in its defence that its repair solution meets the policy standard, but that does not mean that it has a burden to prove it has not breached the contract by adopting that stance. Moorhouse still has the burden.
- The burden of proof does not shift to the insurer because this is an insurance contract. The burden can shift to the insurer to show that any relevant exclusion of liability under the policy applies.12 But that was not the case here. The insurer's duty of good faith will also mean that it has certain obligations in relation to a claim. The insurer would be obliged to investigate the claim in good faith to assess what it considers the damage to the property to be. That will likely require the instruction of competent experts to provide their impartial opinion. But it is not the insurer's burden to prove that suggested damage did not arise. The insured must still prove its allegation that there was additional damage not accepted by the insurer.

Moorhouse Commercial Park Ltd v Vero Insurance NZ Ltd [2024] NZCA 415

- Moorhouse was unable to prove, on the balance of probabilities and through the application of some recognised test or other technique accepted as reliable in the industry, that the damage occurred. The CA considered that ultimately means that the High Court was right to reject Ms Stanway's opinion
- For Moorhouse to prove its claim, it needed to prove not only that bond loss had occurred, but also the detrimental effect that bond loss had in terms of the value, amenity, or usefulness of the Buildings.
- Vero's proposed use of epoxy repair of cracks met the policy standard

Insurer payment timing

- *IAG NZ Ltd v Degen [2024] NZHC 397*
- Judgment 6 March 2024

IAG NZ Ltd v Degen [2024] NZHC 397

- An appeal from a decision of the Canterbury Earthquakes Insurance Tribunal about the timing of IAG's payment of reinstatement costs for a house damaged in the earthquakes. CEIT found the damage was repairable but IAG was obligated to pay the entire reinstatement cost on entry into a building contract .
- Hinton J decided that the CEIT erred in ordering full payment upfront. Rather the CEIT should have ordered that IAG fulfil its obligations under the policy by paying the relevant contractor(s), or Mr Degen himself, the reasonable costs of repairs as they were actually incurred.
- IAG is required to pay repair costs to Mr Degen only as and when Mr Degen has incurred the costs of such repair, submitted invoices to IAG, and IAG has assessed the invoices and is satisfied that the costs are reasonable and relate to the scope of work.

Co-insurer

- *The New India Assurance Company Ltd v Ziwi Ltd [2024] NZHC 2770*
- Judgment 26 September 2024

The New India Assurance Company Ltd v Ziwi Ltd [2024] NZHC 2770

- This is a judgment post Cyclone Gabrielle where an insured sought to recover $$ by statutory demand from a 30% co-insurer of its claim liability where the other co-insurers paid as calculated by the lead insurer.
- Cyclone Gabrielle damaged three of Ziwi's Hawkes Bay pet food manufacturing plants leading to claims under material damage and business interruption policies. Ziwi's MD/BI insurance for the period from 1 October 2022 to 1 September 2023 was placed with four co-insurers in the following proportions: QBE 50 per cent, NIA 30 per cent, Ando Insurance Group Ltd 10 per cent and Offshore Market Placements Ltd 10 per cent.
- The co-insurers appointed a loss adjuster, Thomas Pasley from Integra Technical Services (**Integra**). Integra issued reports to the co-insurers on 10 March 2023 and 19 May 2023. Based on these reports, NIA made three progress payments to Ziwi between 24 March 2023 and 29 August 2023 totalling $15,000,000 (plus GST).
- Integra issued a third report on 13 December 2023, a fourth report on 18 December 2023 and a fifth report on 26 March 2024. While the other co-insurers made further progress payments based on these reports, NIA did not.

The New India Assurance Company Ltd v Ziwi Ltd [2024] NZHC 2770

- On 4 or 5 April 2024, Ziwi issued the statutory demand on NIA for an alleged debt of $8,625,000 (including GST).
- On 21 June 2024, Ziwi reached an agreement with QBE to resolve Ziwi's claim for a total of $96,500,000 (plus GST). On 27 June 2024, Ziwi and the co-insurers under the 2022–2023 policy (except for NIA) executed a settlement agreement and discharge. The terms of the settlement agreement provide for NIA to pay $16,042,500.00 (including GST).
- New India applied to set aside the statutory demand on the basis that:

1. There is a dispute about whether the policy covered specific sites only with specific limits;
2. It was not bound by the decision of the lead insurer (lead clause)

The New India Assurance Company Ltd v Ziwi Ltd [2024] NZHC 2770

- The Court accepted that New India had raised a genuine and substantial dispute about the policy interpretation and that it is at least arguable that the debt, even if owed, was not due when the statutory demand was issued.
- The Court set aside the stat demand and awarded costs. In a later judgment 13 December 2024 New India sought indemnity costs of $101,356.40, plus costs of over $5,000 that are yet to be invoiced. Alternatively, New Indiia sought scale costs on a 3C basis with a 50 per cent uplift, in the amount of $85,779. The Court ordered Ziwi to pay costs and disbursements of $40,944.36 be cat 2 with a mix of items at B & C with then a 50% uplift.

Fire claim

- *Cloverbloom Company Ltd v QBE Insurance (Australia) Ltd & ors* [2024] NZHC 2443

- Judgment
- Bad economic times invariably lead to an increase in the risk of insureds causing damage to insured property.
- In *Cloverbloom* the Court considered a claim by the operator of the Barrelhouse Restaurant and Bar in Dannevirke for business interruption losses caused by fires on 28 February 2020 and 10 March 2020. The plaintiff (Cloverbloom) operated the restaurant and the associated liquor store. Its claim for business interruption insurance was declined by the defendants on the basis that one of Cloverbloom's directors, Mr Greenwood, was responsible for lighting both fires.

Cloverbloom Company Ltd v QBE Insurance (Australia) Ltd & ors [2024] NZHC 2443

- New Zealand courts have commonly approached the question by applying the "arson triangle". This involves asking whether the insured had the motive, means, and opportunity for committing arson. This provides a helpful framework within which to assess the evidence, while remaining mindful that the defendants bear the burden of proof.
- The defendants said Mr Greenwood had a motive to commit arson because the business was under financial strain. They relied on Cloverbloom's financial circumstances in the first four months of trading, and outstanding debts due to Tasman & Allied Liquor (Tasman Liquor) and Bidfood Ltd, in making that allegation
- When the evidence is considered in totality, the Court considered it established that Cloverbloom was under significant financial pressure at the time of both fires. It was more than "a short term cashflow squeeze" as characterised by counsel for the plaintiff. but even if that is all that it was, a cashflow squeeze still provides a motive for arson.

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Cloverbloom Company Ltd v QBE Insurance (Australia) Ltd & ors [2024] NZHC 2443

- Mr Greenwood had knowledge of the extent of cover available under the insurance policies. The policies had been taken out a matter of months before the fires and he made claims immediately after each fire, signalling his familiarity with Cloverbloom's insurance cover. The cover provided by the insurance policies would have alleviated Cloverbloom's financial woes. That was sufficient evidence of motive to commit arson.
- For both fires Mr Greenwood was the only person at the premises. Just prior to the first fire he was visible on CCTV carrying a BBQ lighter in the area of the location of the fire. Just prior to the second fire Mr Greenwood turned off the CCTV and he is in the area of the location of the fire. For both fires there was insufficient evidence to conclude that the cause of the fire was electrical. Each party called fire experts. The Court dismissed the Cloverbloom claim.

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Lessons Learned: Cyber Insurance Claims

Toby Gee,
Barrister & Mediator,
Lambton Chambers

Legalwise

Legalwise

This presentation does not currently have materials.

Climate Change and Business Insurance

Julia Whitehead,
Special Counsel,
Meredith Connell

Legalwise

Climate Change Litigation Update

MC.

Julia Whitehead | 19 February 2025

1

What are we covering today?

- Types of Climate Litigation: international trends
- NZ developments: *Smith v Fonterra*
- Impact on Insurance

2

Types of Climate Change litigation

- **Policy cases:** *Swiss Grannies, Forest & Bird*
- **Greenwashing cases:** *Super Cases (Vanguard, Mercer, Active Super), Advertising Standards*
- **Shareholder actions:** *Milieudefensie v Shell, ClientEarth v Shell plc*
- **Common Law Actions:** *Smith v Fonterra*

Policy Cases

- Wide range of approaches: Human Rights, Emissions Trading Schemes, Trade law, Permitting, etc.
- ***KlimaSeniorinnen v Switzerland*** *the "Swiss Grannies" case:*
  - Appeal from Swiss Supreme Court to ECtHR, for breach of Articles 2, 6 and 8 of the EU Convention on Human Rights. Heatwaves impacting life.
  - Wide discretion of Gvt noted. But breach of 6 and 8 (respect of private and family life) found.
  - Government Response: unhappy, partial and subject to direct democracy. Implementation Hurdle.
- Various NZ cases. E.g. Forest and Bird cases – Transport and Fisheries:
  - Challenges to ministerial decisions. Both partially successful, remitted for new decision.

Greenwashing

- Subject matter subset of existing trade law. Increase in cases, enforcement focus.
- ASIC enforcement focus (ACCC close behind). 3 greenwashing cases against funds:
  - *Vanguard Investments Australia Ltd:* Fund not screened as stated. $12.9m
  - *Mercer Superannuation (Australia) Ltd:* "Sustainable Plus" Fossil Fuels not excluded. $11.3m
  - *Active Super (LGSS Pty Ltd)*: Coal, Tar, Tobacco limited (false). Penalty tbd.
- ASA decision against HSBC:
  - Statement: $1 Trillion to move to net zero — True
  - Statement: 2 Million trees planted — True
  - Unstated impression: HSBC are helping fight CC — False

Greenwashing – NZ

- Commerce Commission:
  - Prosecutions. Kiwipure ($162k), Fujitsu ($310k)
  - Advice and warning letters ongoing
- NZ Civil Action: *Z Energy:*
  - FTA case. Re: accuracy of advertising on emission reduction initiatives. Seeking declaratory relief.
- Climate Change declarations: Part 7A Financial Markets Conduct Act 2013:
  - Compulsory reporting for banks, insurers, large securities issuers and large investment schemes.
  - Basis for future claims?

Shareholder Actions

- Using existing company law, targeting directors.
- ***ClientEarth v Shell plc***
  - UK Shareholder derivative action under Companies Act
  - *Unsuccessful: no scientific consensus for Directors to act on*
- ***Milieudefensie et al. v. Royal Dutch Shell plc***
  - Shareholder claim, based on Dutch tort, international law, and EU International climate law.
  - Hague DC decision: *duty of care found, ordered 45% emissions reduction by 2030;*
  - Hague CA overturned on appeal – *insufficient scientific consensus on appropriate reduction, and outcomes from actions sought.* Hurdle – insufficient science.

Shareholder Actions – NZ

- Not yet hit with actions in this vein. Grounds for such claims are available.
- *Companies Act s.131 (5):*
  - *To avoid doubt, in considering the best interests of a company or holding company for the purposes of this section, a director may consider matters other than the maximisation of profit (for example, environmental, social, and governance matters).*
- As with Greenwashing claims, Climate Change declarations: Part 7A Financial Markets Conduct Act 2013, compulsory reporting provides information for potential breaches.

Common Law Actions – Smith v Fonterra

Strike out decision of the SC allowed case to proceed to hearing: Basis: Public Nuisance, Tikanga, new tort re: climate change

Key points of decision:

- *Novel claims harder to strike out*
- *Tikanga relevant*
- *Public Nuisance:*
  - *Causation issues (and need for special damage) not fatal*
  - *If nuisance provable, only "substantial and unreasonable" emitters at risk*

Remedies impact potential success. i.e. financial claims require stricter causation vs declarations

Smith v Fonterra – Cont. My top takeaways

- *Existing RMA and Climate Change legislation no bar to a Common Law action.*
  - *Compliance with statute may be insufficient protection for Corporate actors*
- *Public interest impact on costs*
  - *High public interest limited cost awards against Smith. Traditional deterrents to testing litigation reduced*

Position Uncertain, but the door has been left open:

> *"A refusal to strike out a cause of action is not a commentary on whether or not the claim ultimately will succeed".*
>
> *"in this area, the common law must develop, if at all, in the fertile fields of trial, not on the barren rocks of a strike out application."*

Where next? Trends in litigation

- Strong growth, slowed recently:
  - *36 New Zealand cases to date. US (1,745), Australia (132), and the UK (139)*
  - *2022 and 2023 saw fewer cases than 2021. Increase in cases against Corporates.*
  - *Likely consolidation rather than true reduction.*
- Underlying driver: extinction. Impact: looking for levers, novel cases, and continued attempts likely.
- Impact widespread, so actions possible from unexpected places:
  - *Ella Adoo-Kissi-Deborah*

MC. 11

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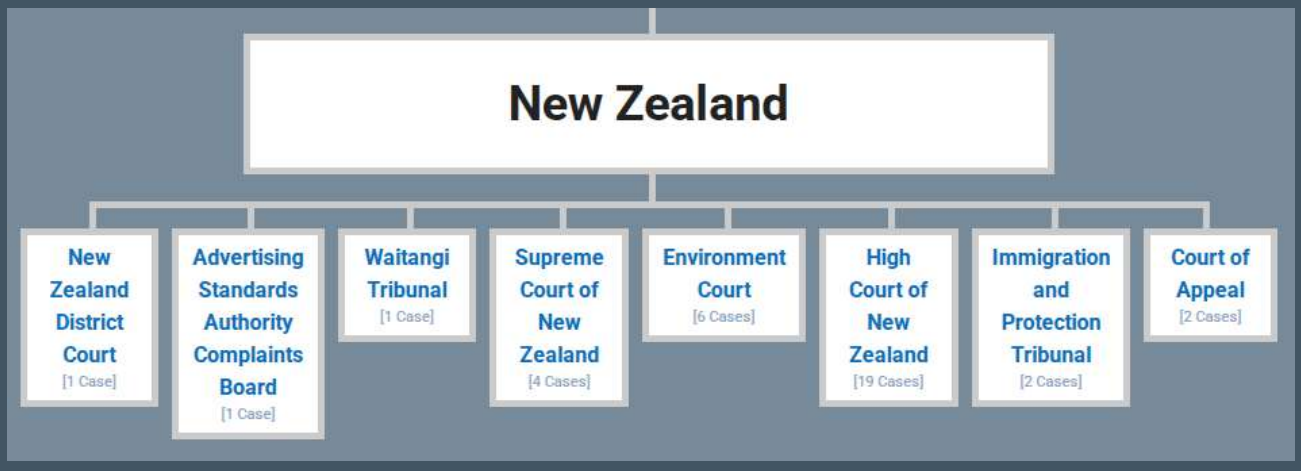
NZ Cases - Breakdown



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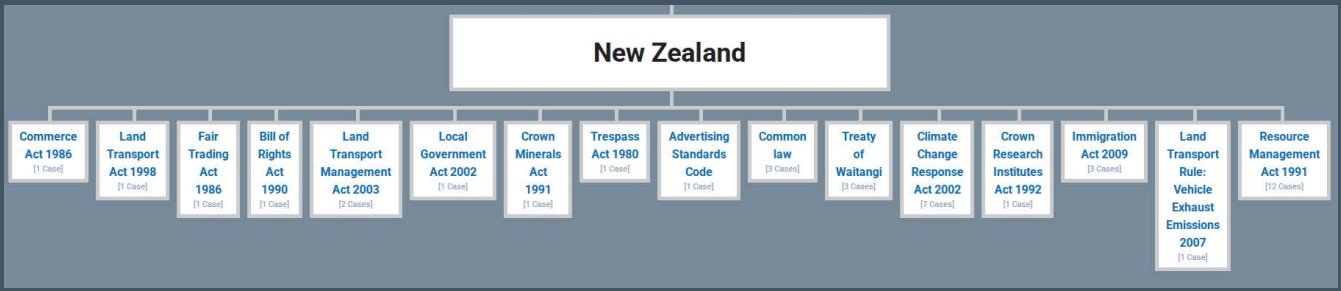
NZ Cases - Breakdown



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Hurdles and Solutions

Hurdle	Potential Solution/ Approaches
Standing	• Expanding scope of 'neighbourhood' • Tikanga • International approach to cause within country borders • Buying shares (less than successful)
Causation	• Court's previous willingness to overcome: *Fairchild* and Asbestos "materially increasing risk" test
Remedies/ Science of Action	• Declarations sought as easier remedy • Target Statue remedies (greenwashing) • Build case law, towards injunctive and financial remedies • Science improving

MC.

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Business Insurance Impacts –

- DnO policies: increased risk profile
- PL policies: responding to activist litigation
- Shareholder claims – same framework, increased actions new subject matter
- Greenwashing has seen the greatest success – high risk area, regulatory and private
- How might insurers respond?
    - Sub limits
    - Exclusions
    - Regulatory pressure

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Questions

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Thank You

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Developments in Insurance Law in 2024

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GENERAL INSURANCE OVERVIEW: CASES THAT SHAPED INSURANCE LAW IN 2024 AND LATEST UPDATES

BRUCE GRAY KC
SHORTLAND CHAMBERS, AUCKLAND
FEBRUARY 2025

1. Introduction

The last year has been marked by the enactment of the Contracts of Insurance Act 2024 and by one or two Court decisions which resolve the particular issues presented by their cases but, in doing so, touch on issues going to the very heart of insurance and the relationship between an insurer and the insured. Taken together, this legislation and these cases raise for consideration product differentiation within the industry and, ultimately, the affordability of insurance cover.

The legislation and one of the cases we will consider, in different ways, respond to the unequal knowledge and bargaining power of the parties to a contract of insurance and the lack of knowledge most policy holders have of how an insurer comes to agree to provide insurance and how the cover provided by different policies is not identical and may have important differences.

No doubt the sensitivity legislators and Judges are showing to the position of policy holders is informed by experience with major earthquakes and floods. The difficulty insurers had responding to the very large volume of claims resulting from these natural events, the considerable delays experienced in finally settling claims and the bewilderment of some policy holders when they learnt the limits of the cover they had purchased have made legislators and Judges sympathetic to them. But changes which respond to policy holder concerns may come to have a considerable influence over the range of products available in the market, to price and, ultimately, to affordability.

2. Contracts of Insurance Act 2024

a) Enactment

I begin with this piece of new legislation because it is likely that, over time, it will have the most far reaching impact on the law of insurance.

As the Contracts of Insurance Bill was introduced and proceeded through Parliament, law firms and commentators wrote extensively about it and about the reforms introduced by it. As well, the content of the Act is substantial and there are a number of changes. It is not possible in this paper to deal with all of them and practitioners will no doubt be taking time to acquaint themselves with the many reforms which have been made.

So, let us begin with a consideration of the purposes of the legislation.

When the Hon Andrew Bayly, the Minister of Commerce and Consumer Affairs, introduced the Bill and spoke at its first reading, he did so by observing that the Bill would "modernize insurance law and make it easier for everyday Kiwis to get insurance and make a claim"[1]. He said the Bill would "make it much harder for an insurer to avoid cover or to refuse to pay a claim" and that it would make "a really positive change to consumers by shifting the onus to insurers" if they proposed to avoid a policy. He said that there would no longer be "guesswork" for policy holders about what they needed to disclose when entering into a policy of insurance. Rather it would be necessary for the insurer to "ask the right questions". He said that insurers would be required to pay claims in a reasonable time.[2]

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[1] (2 May 2024) 775 NZPD 3050
[2] At 3051

All parties supported the Bill at its first reading.

Much of the preliminary work on the Bill had been done by the Hon Duncan Webb who had introduced many of the reforms in a Member's Bill during the prior Labour-led Government. In speaking to the Contracts of Insurance Bill he said:[3]

> "So I think the two key elements that we are looking at with this particular Bill is around fairness and …. good faith. I think, in this particular case, we are looking at the idea that, now, consumers will be expected to take reasonable care not to misrepresent as opposed to having their insurance become void, and particularly when it comes to that the remedies for any presentation must also be proportional to the breach. I think this is a really important move towards fairness for both parties".

The Finance and Expenditure Committee reported to Parliament on the Bill on the 20th of September 2024. As a result of its work, some changes to the Bill were recommended and Opposition Parties opposed several of those changes.

b) Description

The Bill passed its third reading in November 2024 and received Royal Assent on 15 November 2024.

The Act provides that its purpose is to reform and modernise the law relating to contracts of insurance.[4] It intended to do this by promoting the confident and informed participation of insurers, and other participants in the NZ insurance market, by ensuring that provisions included in contracts of insurance, and the practices of insurers in relation to those contracts operate fairly. The key phrases in the legislation are "informed participation", and "operate fairly". As we will see, "informed participation" is a reference to duties of disclosure and manner of disclosure between intended policy holder and insurer prior to the contract being formed. The Act embodies a view that many who bargain to enter into contracts of insurance do not understand well what their duties of disclosure are and that there is a substantial inequality of knowledge and therefore of bargaining power between the insurer and likely policy holders. The Act responds by transferring to insurers a duty to explain what information they seek while retaining an applicant's duty of disclosure – although this duty is somewhat diluted and the consequences of breach are modified. So far as fair operation of the policy is concerned, the principle reforms are the modification of consequences of non-disclosure that I have just mentioned, and provisions dealing with timeliness of payment of claims.

These statutory purposes are developed in a section providing an Overview[5] which explains how the purposes are intended to be achieved.

As I have said, it is not possible in this paper to detail all of the reforms. I will mostly focus on consumer contracts which are then entered into for mostly personal, domestic or household purposes.[6] However, important reforms include:

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[3] (2 May 2024) 775 NZPD 3053
[4] Contracts of Insurance Act 2024, S3
[5] Section 4 (b) Part 2
- (i) Requires a consumer to take reasonable care not to make a misrepresentation to the insurer before a consumer insurance contract is entered into or varied:
- (ii) Requires other policyholders to make to the insurer a fair presentation of the risk before a non-consumer insurance contract is entered into or varied:
- (iii) Provides fair remedies for a breach of those requirements.

[6] Section 10(1)

i. Disclosure by those wishing to purchase policies of insurance are now the subject of Part 2, Subpart 1 of the Act which applies to "consumer insurance contracts".[7]

The provisions which follow in Part 2, Subparts 1 to 4 replace the common law duties relating to disclosure or representations by a policy holder to an insurer.[8] This means that the former duty of utmost good faith no longer has the effect of imposing on a person wishing to purchase a policy of consumer insurance a duty other than to take reasonable care and to fairly present the risk. The power of an insurer to avoid a contract on the ground of breach of a duty of utmost good faith is abolished.[9]

ii. In substitution for the duty of utmost good faith owed by a policy holder, there is a new duty owed by the policy holder which is to take reasonable care.[10] The duty relates to any misrepresentation to the insurer before the insurance contract is entered into or varied.

iii. The scope of the duty to take what constitutes reasonable care must be determined with regard to "all the relevant circumstances".[11]

The Act specifies eight matters to be taken into account for the purposes of deciding what constitutes reasonable care.[12] Importantly, the type of insurance contract and its target market is relevant,[13] and the clarity and specificity of questions asked by the

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[7] This phrase is defined in Section 10 which provides:

(1) In this Act, consumer insurance contract –
  (a) Means a contract of insurance ordinarily entered into by a policyholder wholly or predominantly for personal, domestic, or household purposes; and
  (b) Includes a proposed contract that would be a contract of that kind if it were entered into.
(2) In this Act, non-consumer insurance contract –
  (a) Means a contract of insurance entered into by a policyholder that is not a consumer insurance contract; and
  (b) Includes a proposed contract that would be a contract of that kind if it were entered into.
(3) However, a contract of insurance of a particular kind defined in subsection (1) or (2) –
  (a) Includes a contract of insurance declared by the regulations to be a contract of that kind (and a proposed contract that would be a contract of that kind if it were entered into); but
  (b) Does not include a contract of insurance that is declared by the regulations to be a contract of a different kind (and does not include a proposed contract that would be a contract of that kind if it were entered into).

[8] Section 59 Effect of Part on utmost good faith rule of law

(1) The duties set out in subparts 1 and 4 replace any duty relating to disclosure or representations by a policyholder to an insurer that existed in the same circumstances before those subparts came into force.
(2) Accordingly, the utmost good faith rules does not have the effect of imposing on a policyholder, in connection with the disclosure of a matter to the insurer or a representation before a contract of insurance is entered into or varied, a duty other than –
  (a) The duty to take reasonable care not to make a misrepresentation (in the case of a consumer insurance contract); or
  (b) The duty of fair presentation of risk (in the case of a non-consumer insurance contract).
(3) Any rule of law permitting a party to a contract of insurance to avoid the contract on the ground that the utmost good faith has not been observed by the other party is abolished.
(4) The utmost good faith rule is modified to the extent required by this section.
(5) The utmost good faith rule means the rule of law to the effect that a contract of insurance is a contract based on the utmost good faith.

[9] Section 59(5)
[10] Section 13
[11] Section 13(2)
[12] Section 14
[13] Section 14(1)(a)

insurer also are relevant.[14] Failure to answer questions or the giving of obviously incomplete or irrelevant answers are not by themselves factors. Rather, the steps taken by the insurer in response to such a failure or the provision of an obviously incomplete or irrelevant answer are something which should be taken into account.[15] Presumably this requirement will be developed by Courts to become a duty of insurers to ask follow up questions. The clarity of insurer communications is relevant.[16]

Any guidance or assistance provided to the policy holder is relevant.[17] Finally, whether or not the duty applies when an existing contract of insurance is renewed or not, or is a variation of an existing contract or a reinstatement of a previous contract is relevant.[18] This last factor presumably sits alongside consideration of the type of insurance contract in question.[19]

A dishonestly made representation must always be taken as showing lack of reasonable care.[20]

Similarly, a failure by a policy holder to comply with an insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation.[21]

iv. The standard of care required of a policy holder is that of a "reasonable policy holder who enters into a consumer insurance contract".[22] There is an element of circularity between the requirement that a policy holder take reasonable care not to make a misrepresentation,[23] and the requirement that the standard of care that reasonable policy holder should take is that of a reasonable policy holder.[24] There must be some uncertainty at this stage how Courts will interpret and apply that provision.

v. In the case of an insurer, the standard of care is not the subject of a specific provision. However the Act does provide that any knowledge an insurer had or ought to have had of particular characteristics or circumstances of the policy holder will be relevant to determining what standard of care is appropriate.[25]

vi. Where a policy holder breaches the duty of disclosure, and the insurer proves that without the misrepresentation the insurer would not have entered into the contract at all or would have done so on different terms, then the insurer has a remedy.[26]

The remedy is affected by whether the misrepresentation relied on by the insurer is either deliberate or reckless, or is neither of them.[27]

vii. A determination is deliberate or reckless where the policy holder knew that it was untrue or misleading, or did not care about that or alternatively knew that the matter

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[14] Section 14(1)(c)
[15] Section 14(1)(b)
[16] Section 14(1)(e)
[17] Section 14(1)(g)
[18] Section 14(1)(h)
[19] Provided for by Section 14(1)(a)
[20] Section 13(3)
[21] Section 13(4)
[22] Section 15(1)
[23] Section 13(1)
[24] Section 15(1)
[25] Section 15(2)
[26] Section 23
[27] Section 24

to which the misrepresentation related was relevant to the insurer or did not care about that.[28]

viii. The insurer has the burden of proving that a misrepresentation is deliberate or reckless. There is a presumption that a policy holder knows what a reasonable policy holder would know and that, where the insurer asks a clear and specific question, that question is relevant to the insurer.[29]

ix. As an aside, I note that for non-consumer contracts of insurance, there is an additional duty on a policy holder to make a "fair presentation".[30] A presentation of a risk is fair when it discloses every material circumstance that the policy holder knows or ought to know or alternatively which provides the insurer with sufficient information to put the insurer on notice that it needs to make further inquiries.[31] As well, the policy holder must make disclosure in a manner that is reasonably clear and accessible to a prudent insurer and is a disclosure in which every material representation as to matter of fact is substantially correct and as to matters of expectation or belief is made in good faith.[32]

It is not necessary for a policy holder to disclose a circumstance if it diminishes the risk or is known or ought to be known by an insurer.[33]

Materiality is codified in reasonably familiar terms. A circumstance or representation is material if it would influence the judgment of a prudent insurer in determining whether to take the risk, and if so on what terms.[34]

Substantial correctness of a material representation is achieved where a prudent insurer would not consider the difference between what is said and what is correct to be material.[35] Of course the circularity of this provision will be apparent on its face.

Again, the remedy for a breach of duty of fair presentation turns on the insurer proving that but for the breach it would not have entered into the contract at all or would have done so only on different terms,[36] where the breach is deliberate or reckless,[37] with the insurer having the burden of proof of deliberateness or recklessness.[38]

An insurer is obliged to take reasonable steps to ensure that a policy holder is clearly informed of both the duties described above and the potential consequences of a failure to comply.[39]

x. For consumer contracts, the remedies available for a breach of the duties of disclosure and fair description by a policy holder are set out in Schedule 2 to the Act.[40] There are different remedies where the misrepresentation was deliberate or

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[28] Section 25
[29] Section 26
[30] Section 29
[31] Sections 30(1)(a) and 31
[32] Section 30
[33] Section 31(2)
[34] Section 32
[35] Section 33
[36] Section 48
[37] Section 50
[38] Section 51
[39] Section 52
[40] See Section 23(2) and Schedule 2

reckless, and where it was neither of those. In the former case the insurer is entitled to avoid the contract and refuse claims and need not return the premium.[41] In the latter case the remedies are based on what an insurer would have done if the breach had not occurred.[42]

xi. If the insurer would not have entered into the contract then it may still avoid that contract.[43] However, as with all other provisions, there is a special regime for policies of life insurance.

xii. However, if the insurer would have entered into the contract but on different terms, then there are provisions for pro rata charging of a higher premium, or pro rata payment of claims.[44]

xiii. There is a separate description of similar remedies where an existing contract of insurance is varied.[45] The Act introduces implied terms about timeliness of payment of claims.[46]

There are miscellaneous other provisions dealing with arbitration provisions, timeliness of making claims (with exceptions for claims made policies) and prohibitions on including pro rata conditions of average in certain policies.[47]

xiv. It is not necessary for the beneficiary of a policy to have an insurable interest, although this provision does not limit the Marine Insurance Act 1908.[48]

xv. Where an increased risk exclusion applies, and a policy holder proves that the loss for which indemnity is sought was not caused or contributed to by the happening of the event or the existence of the circumstance referred to in the increased risk exclusion, that exclusion does not apply.[49]

c) Comment

The Contracts of Insurance Act 2024 bears some similarity to legislative reform in other countries – most notably the United Kingdom, and Australia.[50]

As I commented earlier, experience with recent natural disasters will have informed concerns by the legislators that policy holders do not understand well the differences between cover provided by alternative policies, the comprehensive nature of the duties of disclosure before placing a policy and the true cost of replacing or reinstating damaged property. As well, insurers have struggled to respond quickly to disasters giving rise to a large number of claims – many of them complex and requiring careful discussions with stressed and troubled policy holders.

The reforms introduced by the Contracts of Insurance Act 2024 will not result in fewer claims being met. They are designed to impose greater burdens on underwriters, to reduce duties

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[41] Schedule 2 Clause 2
[42] Schedule 2 Clause 3(2)
[43] Schedule 2 Clause 4
[44] Schedule 2 Clause 5
[45] Schedule 2 Part 2, Clauses 6-14
[46] Section 66
[47] Sections 67, 68, 69, 72, 73, 74
[48] Section 75
[49] Section 71
[50] Insurance Act 2015 (UK) and the Insurance Contracts Act 1984 (Cth)

of policy holders and to alleviate the consequences of a breach of those duties and to encourage insurers to deal with different claimants in a consistent manner.

Insurers need to be financially successful – they need to be surviving and even thriving in order to pay claims. It is therefore inevitable that where more claims are payable and where differentiation in benefits available under different policies becomes more limited and more difficult to achieve, premium income must increase. Cheaper policies offering more limited cover may disappear.

It is questionable whether diminished diversity in available cover and available premiums is truly in the interests of all members of the community. At the margin, some people who may have been able to afford cover available only on cheaper terms, may come to find the cost of insurance is beyond them. For them the question would be whether less cover at a cheaper price is better than no cover at all.

Legislators may argue that when policy holders do not understand well the differences between the cover provided by alternative policies and their different premia, the insurance market is impaired and policy holders do not have an effective choice at all. There is no doubt that the requirements in the Act that insurers must take reasonable steps to ensure that an intended policy holder is clearly informed of the nature and effect of the information they must provide and the consequences of it. The failure to comply with that duty go some way towards ensuring that policy holders understand what is required before an insurance contract is formed. However, the provisions do not provide much help to a consumer who finds it difficult to decide whether to purchase less cover.

The legislation is consistent with a low trust model of commerce and increasing focus on consumer protection. Legislation is necessary because those involved in an industry cannot be relied upon to do what is regarded as the right thing – deal fairly, explain clearly what is being sold and respond to claims quickly and effectively. However, legislation to supplement ethical dealing often sets low standards. A low trust approach to an industry is part of a general erosion of trust within the community. It is a feature of modern society. This explains the need for legislation, but does not deal with adverse consequences of the approach – uniformity of product leading to increased prices and unaffordability for some.

3. The *Wayne Tank* Principle

(a) Risk Pool

The long running litigation Napier City Council v Local Government Mutual Funds Trustee Limited, known as "*Risk Pool*", has reached NZ's Supreme Court and been decided.[51]

The proceedings will be familiar to most conference participants.

Napier City Council (the Council) was sued by some apartment owners for negligently failing to inspect their properties while they were being built, issuing building consents and code compliance certificates when the buildings had defects.

Some of the defects related to weathertightness. Other defects related to other risks such as breaches of the Building Code relating to fire.

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[51] *Local Government Mutual Funds Trustee Ltd v Napier City Council* [2023] NZSC 97, [2023] I NZLR 184

The Council settled the claim. There was no apportionment in the settlement between claims based on weathertightness and claims based on breaches of other parts of the Code. However, expert evidence was available that it was possible to divide the losses and to separately identify those arising from weathertightness, and those arising from other breaches.

The Council made a claim on its insurer for the part of the settlement relating to non-weathertightness issues.

No claim was made for the part of the settlement relating to weathertightness because claims based on that exposure were excluded by a clause in the relevant policy of insurance.

Risk Pool argued that the exclusion for claims based on weathertightness meant that the entire settlement was excluded, including that part of it arising from other alleged defects.

The High Court found in favour of Risk Pool.[52] The Court of Appeal disagreed and found for the Council.[53]

The Supreme Court essentially upheld the Judgement of the Court of Appeal.[54]

The Supreme Court confirmed that the courts' approach to construction of contracts of insurance is the same as for any other contract. The general approach to contractual interpretation is objective and the purpose of the construction is to ascertain the meaning which the document would convey to a reasonable person having all the background knowledge which would reasonably have been available to the parties in the situation in which they were at the time of the contract.[55] The Court found that the exclusion relied on by Risk Pool did not extend to non-weathertightness defects. The Council faced liability for separate losses, which were divisible. Only some of them were excluded.[56]

The Court therefore found that Risk Pool was liable to the Council for that part of the settlement arising from or attributable to non-weathertightness breaches.

Risk Pool had also relied on what is known as the "*Wayne Tank*"[57] principle.

The Supreme Court found that this principle did not help Risk Pool. It applied where there were two "equally efficient" causes of loss, one excluded by the policy and the other not. However, the principle was irrelevant to cases where separate losses could be identified and quantified. In this case the losses were apportionable and so there was not the type of concurrence contemplated by *Wayne Tank*.[58] The Court noted that, as the principle was not of use to Risk Pool, there was no need to reach any concluded view on its merits.

(b) Wayne Tank

Wayne Tank was one of several cases arising from a tank being installed by engineers for storing and conveying liquid wax in a factory making plasticine. The installation included a

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[52] *Napier City Council v Local Government Mututal Funds Trustee Limited* [2021] NZHC 1477, per Grice J
[53] *Napier City Council v Local Government Mutual Funds Trustee Limited* [2022] NZCA 422, [2022] 3 NZLR 528 per Miller, Brown and Katz JJ
[54] *Local Government Mutual Funds Trustee Limited v Napier City Council* [2023] 1 NZLR 185
[55] Ibid at [37][38][41]
[56] *Wayne Tank & Pump Co Limited v Employers' Liability Assurance Corp Limited* [1974] QB 57 (CA)Supra, note 50 and [53]-[57]
[57] Supra, note 52 at [53]-[57]
[58] Ibid at [53]-[57]

pipe material called “durapipe” and a thermostat which were unsuitable for the purpose for which they were being installed.

As well, one of the engineers installing the equipment switched it on and left it unattended through the night before the installation had been tested.

A failure of the pipe and thermostat, left unattended while running for the first time, caught fire and caused damage.

The premises were owned by and the claim was brought by a company called Harbutt’s “Plasticine” Limited. That company sued Wayne Tank and Pump Company Limited, and the decision in that claim was an important one in relation to the topic of fundamental breach of contract at the time it was decided.[59]

The second claim was brought by *Wayne Tank* against its insurer seeking to recover the amount it had been ordered to pay Harbutt’s.

The insurer defended the claim including by arguing that it was excluded by a term of the policy.[60]

The insurer argued that, on the facts of the case, the proximate cause of the loss was the dangerous nature of the installation rather than the conduct of switching on the heating tape and leaving it unattended. It then argued that where there were two equal causes of a loss, one of which is excluded, then the whole loss is excluded. The claimant argued that the more important cause of the loss was the failure to take “thorough and careful tests, before leaving the plant unattended”. It argued that it was necessary for the Court to look at the various causes and select that which was “dominant in efficacy”. The counter to the proposition that where there are concurrent causes, one within an exception, and the other not, then the exception applies, was to make procedural arguments that the pleadings and Notice of Appeal were defective by failing to identify that the proposition was at issue.

Lord Denning MR and Roskill LJ found that the dangerously defective nature of the installation was the dominant cause. This was enough to resolve the appeal.

Lord Denning MR and Roskill LJ then proceeded to consider, if they were wrong in that conclusion, what the effect was of the exclusion where there were concurrent causes. The Court was unanimous that, in these circumstances, the exception applied.

Wayne Tank has been applied in New Zealand.[61]

(c) Other Cases

That is not a complete end to the matter. A step preliminary to applying *Wayne Tank* is identifying what is a “proximate cause” of a loss.

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[59] *Harbutt’s “Plasticine” Limited v Wayne Tank & Pump Company Limited* [1970] 1 QB 477

[60] The words of the exclusion are:

> “The company will not indemnify the insured in respect of liability consequent upon (5) death, injury or damage caused by the nature or conditions of any goods or the containers thereof sold or supplied by or on behalf of the insured”.

[61] *AMI Insurance v Legg* [2017] 3 NZLR 629 at [50]-[54]; *State Insurance Office Manager v Bettany* (1990) 6 *ANZ Insurance Cases* 76-818 (HC) at 76,821; *Countryside Finance Limited v State Insurance Limited* [1993] 3 NZLR 745 (HC) at 756; *Body Corporate 326421 v Auckland Council* [2015] NZ 862 at [340].

As we know, debates about causation can become somewhat arid. Cases which come before the Courts raising issues of causation tend to involve difficult choices about the correct rule of law, the relationship between the parties and the criteria for imposing legal liability.

Writing extracurially, Lord Hoffman has posited that Judges do not apply somewhat philosophical notions of what is a cause in fact or a cause in law, but instead follow a natural process of decision making – find the fact and decide as a matter of interpretation whether the law should impose legal liability.[62]

Context is important. Causation for the purposes of criminal liability, or for the imposition of a duty of care in tort, may require different analysis than in insurance law.

In insurance law, the question for the Court normally centres on the terms of the contract of insurance – identifying the bargain between the parties. Whether or not an event falls within an insured peril may require a different inquiry from that used in other areas of the law. Interpretation of the insured perils usually requires consideration of both the operative insuring clause, and exclusions. Both are relevant to deciding the nature of the bargain between the parties and the scope of indemnity available to an insured.

Arch,[63] a case arising out of Covid, was something of a test case intended to settle to the extent possible whether claims arising from the consequences of Covid and a lockdown imposed to deal with it were covered by policies of insurance. The Supreme Court distinguished between issues involved in interpreting the contract of insurance, and causation of loss. The Court made clear that whether a causal connection is sufficient to trigger an insurer's obligation to indemnify the policy holder is a different question from interpretating that of defining a particular risk or event.[64]

In this way, there may be a material difference between cases where there are two operating causes of loss, one insured and the other not, and those cases where there are two operating causes, one insured and the other expressly excluded.

In the former cases (where one cause is insured, the other not), cover may be available because loss may have been due to an insured peril, even if something else caused the loss.

In *The Miss JJ*,[65] the Court found that a yacht was damaged by two concurrent causes – poor design and poor construction of the vessel, and the actions of adverse sea conditions. Both causes were equal or nearly equal in their efficiency. The insured was entitled to recover because the loss was caused by an insured peril. The fact that the concurrent cause was not insured did not prevent recovery.[66]

In the latter cases (two causes, one excluded), because cover is expressly excluded in a circumstance which caused the loss, the exclusion may apply and there may be no cover.[67]

Similarly, it may become relevant to consider whether the concurrent operating causes of a loss are independent of each other, or are interdependent. The former case will mean a "but

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[62] Hoffman, "Causation" in Richard Goldberg (Ed.) Perspectives on Causation (2011), page 2
[63] *The Financial Conduct Authority v Arch Insurance (UK) Limited* [2020] ECWH2448, *The Financial Conduct Authority v Arch Insurance (UK) Limited* [2021] UKSC
[64] Ibid at [191]
[65] *The Miss JJ* [1987] 1 Lloyds Rep 32
[66] Ibid at paragraph 37
[67] This by application of the *Wayne Tank* principle

for" test is satisfied, but the latter may not.[68] Analysis whether the concurrent causes are independent of each other, or interdependent may bear upon construction of the scope of cover, and its availability.[69] Where there are interdependent causes, one of them excluded, *Wayne Tank* may apply. Where the causes are independent, and one or more are covered, there may be cases for the law arising. *Risk Pool*[70] may be seen as an illustration of this.

So much depends on the facts of particular cases. As noted earlier in *Miss JJ*[71], the loss of the yacht was due both to the action of adverse weather conditions and poor design and construction of the vessel. Both factors were necessary for the loss. They were independent in the sense that one did not lead to the other, but they were also interdependent because neither would have led to the loss but for the other.

This suggests that *Wayne Tank* does not so much establish a principle as constitute a set of facts which illustrate the approach taken by Courts to construction of the contract of insurance and analysis of the intention of the parties concerning cover in the particular circumstances.

But there are reasons to keep the applicability of *Wayne Tank* in view.

NZ academics have questioned its continued utility.[72]

The Supreme Court of Canada has decided not to follow the *Wayne Tank* principle.[73] It did so on grounds that there was no compelling reason to favour the exclusion of coverage where two or more concurrent causes are found. It held that a presumption that coverage is excluded in *Wayne Tank* circumstances is inconsistent with well established principles in Canadian jurisprudence that exclusion clauses in insurance policies are to be interpreted narrowly and generally in favour of the insured, particularly where there is ambiguity in wording.

On the other hand, the Federal Court of Australia continues to apply *Wayne Tank*.[74]

The Rohan Havelock article referred to earlier[75] was written in response to *University of Exeter v Allianz Insurance PLC*.[76] In that case, the English Court of Appeal considered whether loss and damage caused in 2021 by the controlled detonation of a bomb dropped during World War II was "occasioned by war" and therefore excluded under an insurance policy. The Court agreed that the two causes were of approximately equal efficacy and therefore were concurrent.[77] The Court therefore applied the *Wayne Tank* principle and held that cover was excluded.[78]

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[68] *Orient-Express Hotels Limited v Assicurazioni General Sp A (UK)(T/a Generali Global Risk*)[2010] ECWH 1186 (Comm); [2010] Lloyds Rep IR 531 at [32]
[69] For a discussion of causation principles in English insurance law see Meixian Song "Revisiting Concurrent Causation and Principles in English Insurance Law: A Legal Fiction?" (2021) JBL 457
[70] Supra, note 54
[71] Supra at note 65
[72] Henry Holderness "*Wayne Tank* on the Wane? Multiple Causes and Exclusions in NZ insurance Law: *NZ Fire Service Commission v Legg*" (28 Insurance Law Journal 161; Rohan Havelock "The Wayne Tank Principle – Still Bombproof in the case of concurrent causes": *University of Exeter v Allianz Insurance PLC* [2023] EWCA Civ 1484"(2024) 33 Insurance Law Journal 134
[73] *Derksen v 539938 Ontario Limited* [2001] SCC 72
[74] *McCarthy v St Paul Insurance Co Limited* [2007] FCAFC 28; 157 FCR 402; 239 ALR 527 at [103]-[109]
[75] Supra note 72
[76] *University of Exeter v Allianz Insurance PLC* [2023] EWCA Civ 1484
[77] Ibid at [49], [54]
[78] Ibid at [54]

The appellant had argued that the dropping of the bomb did not make the loss and damage inevitable. There were alternative possible consequences, including that the bomb had exploded on impact at which time the insured building did not exist and so could not have been damaged or that it might have been successfully rendered safe by military authorities subsequent to its discovery. This argument was rejected on causation analysis grounds.[79] The Court decided that neither the dropping of the bomb nor the intentional detonation could have caused a loss without the presence of the other. In this sense the causes were interdependent.

(d) Comment

Different cases' outcomes are largely dependent upon the Court's analysis of the contract of insurance and the interplay between various factors leading to the loss. Assessment of whether causes are truly "concurrent" rests in part on assessment of the extent to which each cause is an efficient cause of the loss.

It is likely but not yet determined that *Wayne Tank* is an illustration of cases involving interdependent causes rather than those which are independent of each other.

The approach taken by the Supreme Court of Canada[80] is a material change. *Risk Pool* left open whether such a reconsideration is appropriate in New Zealand.

4. Insurer Duty to Assess Damage Sustained by an Insured

IAG NZ v Degen[81] is a case arising out of the Canterbury earthquake.

Mr Degen held a policy with IAG NZ Limited. His house was badly damaged. He believed it was so badly damaged that it needed to be rebuilt. IAG believed the house could be repaired. It offered to pay for repairs rather than to do the repairs itself.

The parties could not agree on the extent of repairs required.

The Canterbury Earthquakes Insurance Tribunal (CEIT) found that the proposal from AIG would repair the house to the policy standard.[82]

CEIT held that IAG was required to pay Mr Degen a lump sum once he had entered into a building contract rather than to pay for costs as they were incurred. It also found that IAG was required to pay for professional reports obtained by Mr Degen during the claims process and subsequent litigation.

The insurer appealed to the High Court in respect of the orders that it pay a lump sum and for the professional reports.

The High Court held that IAG was only liable to pay the repair costs as and when they were incurred and only if it was satisfied they were reasonable and related to the scope of work required to effect the repairs.[83] In doing so, the High Court correctly analysed and applied *East v Medical Insurance Society*.[84]

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[79] Ibid at [49]-[50]
[80] Supra note 73
[81] *IAG NZ v Degen* [2024] NZHC 339, [2024] NZCCLR 91
[82] *Degen v IAG NZ Limited* (CEIT 0014 – 2020, 21 December 2022)
[83] Supra note 81 at [20], [23]
[84] *East v Medical Insurance Society* [2014] NZHC 3399

The payment for the professional services issue was interesting.

CEIT had found that assessments of the damage by IAG were inadequate, and that had Mr Degen accepted IAG's position on the damage, he would not have been fully indemnified. It therefore concluded that if Mr Degen had obtained a report to address this inadequate assessment, the reasonable costs of that report would fall within the cover provided by the policy.[85]

CEIT had gone on to conclude the IAG had breached a duty owed to Mr Degen by failing adequately to assess the damage to his property and failing adequately to scope and cost the repair strategy necessary.[86]

CEIT had reasoned that a duty existed by analysing the terms of the Fair Insurance Code requiring an insurer to act in good faith when handling claims and on both its own decision in *LS v Medical Insurance Society Limited*[87] and *Young v Tower Insurance Limited*.[88] Neither of these decisions supported the duty found. In *Young v Tower Insurance Limited*[89] Gendall J considered whether there was an implied duty of good faith in insurance policies and whether this should extend to an insurer's handling of claims. The Judge did find that an insurer is under a duty to disclose relevant information, to act reasonably and to process a claim in a reasonable time.[90] However, what is reasonable will depend on relevant circumstances, including whether reasonable grounds existed to dispute the claim.[91] In *LS v Medical Insurance Society Limited*[92] the CEIT had said that insurers have a duty to accurately assess claims and communicate details to the insured so that the insured could make the choices available to them under the policy.

This reasoning in turn relied on *van der Noll v Sovereign Assurance Co Limited*[93] which involved an income protection policy. The insured claimed he was suffering from a total disability. The contract conferred on the insurer a discretion to determine whether the medical condition exhibited by the insured qualified him for one or more of the benefits under the policy. Necessarily, the insurer was under a duty to inform itself when deciding how to exercise that contractual discretion.

Van der Noll v Sovereign Assurance Co Limited did not provide support for a general obligation by insurers of the type found by CEIT.

The High Court found that the duty imposed by CEIT represented a significant departure from existing insurance law. It noted that while there may be an opportunity for Courts to consider imposing a duty on an insurer to accurately assess claims, *Degen* was not a suitable case for doing so.[94]

The High Court accepted that there was no authority for a duty of the type found by CEIT and noted that it is a fundamental principle of insurance law that the insured bears the burden of proving loss, including its actual quantum.[95]

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[85] Supra note 81 at [280]
[86] Ibid at [281]
[87] *LS v Medical Insurance Society Limited* CEIT 0024-2020, 22 March 2021
[88] *Young v Tower Insurance Limited* [2016] NZHC 2956, [2018] 2 NZLR 291
[89] Ibid
[90] Ibid at [163]
[91] Ibid at [164]
[92] Supra note 87
[93] *Van der Noll v Sovereign Assurance Co Limited* [2013] NZHC 3051
[94] Supra note 81 at [38]
[95] ibid at [25]

5. Summary

I observed at the outset that the legislation and one of the cases we would consider, *Degen*, respond to the unequal knowledge and bargaining power of the parties to a contract of insurance and the lack of knowledge most policy holders have of how an insurer comes to agree to provide insurance and how the cover provided by different policies is not identical and may have important differences.

Those of us who practise in the field of insurance law can easily lose sight of how technical it can be and how those seeking to purchase insurance may have little or no understanding of the reason for which they are asked to make declarations and the ways in which the cover they are purchasing may differ from policy to policy. We do understand that policies, even when written in what is regarded as "plain" language, are difficult for those unfamiliar with the field to construe and how different clauses come to be read together.

The Contracts of Insurance Act attempts to deal with some of these realities. But the obligations it imposes on insurers may prove to be subtle, and far reaching. It is difficult to express the very nuanced relationship between an insurer and an insured in simple, succinct language. It is difficult to explain things which result from several different clauses being read together without creating documents which are very long and apparently repetitive. Underwriting decisions, resting on actuarial assumptions and years of experience are often not well understood even by those who are involved in the industry. Given that the purposes for which the legislation has been enacted include that it is necessary for the insurer to "ask the right questions", it can be expected that any unclarity or confusion will be resolved against insurers.

I have earlier made the point that product differentiation can be pro-consumer, but that many of the changes introduced by the legislation may ultimately prove to make product differentiation difficult. This is likely to mean that insurers will be required to price policies conservatively and may result in insurance becoming more expensive or even unavailable in some cases.

The novel duty introduced by CEIT in *Degen*, but rejected by the High Court on the facts of that case again responds to the unequal knowledge and bargaining position of insurers and their insureds. It will be necessary for practitioners to keep an eye on the possibility for claims of this type to be made in the future.

I spent a little time discussing *Risk Pool* and the way it dealt with *Wayne Tank*. As I noted, any case involving questions of causation is at risk of becoming formidably complex. I believe some clarity is emerging so that *Wayne Tank* is not so much a "principle" but an illustration of an approach to contractual interpretation and a clarification that interdependent multiple causes may be treated differently from those which are independent. If future cases provide an opportunity for our most senior Court to explain the appropriate approach to contractual interpretation and analysis of treatment of concurrent causes, that may be welcome.

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