Professional indemnity policies – financial institutions

The intention of this presentation is to discuss the following topics:

- An analysis of recent developments in policy wordings, restrictions and extensions.
- What exclusions are under discussion or have been removed.
- What constitutes "civil liability" when determining loss.
- How does the policy:
    - Treat "circumstances which might give rise to a claim".
    - Define the "notification requirements".
- How to treat costs incurred by the Insured when mitigating a loss.
- What are the main policy differences between established and emerging FI markets.

Recent developments

Over a number of years professional indemnity polices for financial institutions have undergone significant changes whereby cover was initially provided in connection with a negligent act, negligent error or negligent omission to a broader form civil liability wording (which is arguably deceptive (see the definition of claimants/financial services to which a policy will respond and the significant increase in exclusions)). The new policy wordings (such as the NMA 3000) which may appear to be a significant "leap" forward were intended:

- To incorporate endorsements which had become common over the years.
- Emphasise the principle of fortuity i.e. it was not intended to cover events where the risk was planned, intended, anticipated or reasonably foreseen.
- To avoid the creation of moral hazard – so current civil liability wordings talk of good faith acts or omissions – so gross negligence may be covered but not recklessness (which may constitute fraud).

Whilst the classic division between first party property policies and policies addressing third party claims still exist there is increasing blurring of the distinction between, for example, crime and professional indemnity wordings. Some of this has been driven by the production of certain policies addressing Basel II operational risks (albeit the actual constituency of banks which can benefit from operational capital respite is very limited). It would appear that certain financial institutions are considering whether it is necessary to purchase PI cover and whether such risks can be managed as part of their operational risk rather than the risk being transferred to Insurers.

Nevertheless, it is apparent from the crime/property damage wordings we have reviewed that a number of them do pick up third party liabilities.

There has been a marked change in claims handling and notification procedures whereby a significant amount of responsibility has been delegated to Insureds for managing these “risks”. The delegation to senior management has enabled them to self assess the likelihood of claims arising but it does call into question whether claims are brought to Insurers’ attention in a speedy fashion given the importance of an early assessment of third party claims made against an Insured. One issue is whether the responsibility for notification should be pushed up to senior management where you have a financial institution with a global footprint or whether notification requirements should countenance local “hubs” for these purposes.

Further “whistles and bells” have become more prevalent recently in broker led policies:

- Preparation and verification costs (more so in connection with first party losses, but now increasingly with third party claims).

- Whilst innocent non-disclosure provisions have been incorporated into policies for a number of years they have traditionally provided for a reassessment of the risk in those circumstances. Latterly, the ability of underwriters to reassess the risk has been removed.

- Mitigation of loss costs. Whilst this is frequently to be found in marine policies, it is less common in connection with professional indemnity policies. Recently first party policies have addressed these issues (quite often by way of the subrogation provisions) and whilst they are not as common within PI policies it is somewhat curious that they are not more prevalent given that it is in these very situations where the input of the Insured can play a significant role in mitigating losses and I discuss this a little further in my presentation.

Exclusions/restrictions

If one looks at the empirical evidence in connection with exclusions/restrictions contained in FI/PI policies the evidence from a straightforward number count would seem to indicate that exclusions have increased i.e. NMA 2273-3000 from 23–30. However, many of these exclusions are a function of the changing regulatory environment, previous losses (e.g. pension mis-selling) and significant US exposures through investment banking insureds with the likes of WorldCom and Enron. Moreover, the policies are not intended to cover losses through senior management

intentional wrongdoings or risk taking, although senior management is often restricted to senior executives. Other reactive exclusions have been prepared (particularly on clash covers) to address the credit crunch, sub prime, Madoff and Stanford.

The exclusions are also a function of the high level principles which I identified at the start i.e. avoiding the creation of moral hazard and lack of fortuity.

The meaning of civil liability

What constitutes civil liability under generally available wordings is a matter of English Law and may be very different as to what constitutes civil liability under local laws particularly in civil code jurisdictions (and this is the major wrinkle when it comes to discussing claims and their indemnification).

- For example, certain liabilities may be expressed by way of reference to local criminal laws or penal codes which tend to cut across the understanding of civil liability being referenced to those liabilities which are not criminal. Indeed, if one considers the current Lloyd's wording (NMA 3000) the default position contained in that policy is by reference to civil liabilities existing in the United Kingdom. Naturally, when drafting these wordings the authors were envisaging a gradual extension of these covers into, primarily, other mature common law jurisdictions.

- Now it is axiomatic that civil liability must be a liability to a third party and does not include first party losses. Whilst it does not necessary countenance criminal liability there obviously is provision for covering such dishonest acts which give rise to third party liability through the dishonesty extension (and this element of additional cover is explored later).

- Civil liability does not include contractual liability. It is fair to say that this exclusion is one which causes most concern amongst Insureds given that the tendency for claimants is to bring a claim for breach of contract as this is the primary relationship: the claimant only needs to prove the existence of the contract, breach of the contract and the damages flowing therefrom (as opposed to establishing duties of care which may require extensive expert evidence) (and there can be no counterclaims for contributory negligence). However, it is fair to say in most circumstances, notwithstanding the presence of a contractual exclusion, one can identify some form of concurrent duty of care/tortious breach which would enable a claim to be pursued under the policy (and pursuant to MDIS v Swinbank simply because a claim is

- characterised as, say, breach of contract, does not mean that viewed objectively a concurrent duty cannot also exist).

- Whilst English Law Lloyd's policies (e.g. NMA 3000) provide cover for restitutionary awards there is still some debate in certain jurisdictions (e.g. US) where the ability to pay restitutionary claims has been questioned.

- Before considering how one establishes civil liability it is probably helpful to consider the mechanics of a claims made policy given the difficulties which have occurred in certain jurisdictions. As you may know in certain civil code jurisdictions, the ability to write a claims made policy was precluded, for example, in France, where they were rewritten as loss occurring policies - PI policies are now capable of being written on a claims made basis (since November 2003) underwriters should remember that additional clauses may be required to make them compliant e.g. sunrise and sunset clauses.

- And just by way of an aside certain jurisdictions do have quite strict requirements as to how a policy is constructed and what must be brought to an Insured's attention when the policy is produced for their benefit e.g. exclusions should be placed in block capitals.

When is "civil liability" established?

The requirement under a civil liability policy is that:

- The Insured must have a legal liability to a third party claimant (which seems to be a pretty obvious assertion, but less so in other non-common law jurisdictions).
- The liability is covered by the insurance.
- In the case of a settlement that any amount paid by way of settlement was reasonable.

It is obviously clear that where liability has been established by a court judgment or arbitration award then in most circumstances civil liability will have been deemed to have been established. In most circumstances Insurers will not be permitted to go behind the judgment or award unless it is shown to be perverse.

Whilst Insurers do not expect an Insured in most circumstances to litigate the matter fully (particularly given that they are likely to be underwriting the defence costs which quite often form the largest part of any claim for indemnification) nevertheless there are certain thresholds which an Insured needs to overcome to establish civil liability

to a third party claimant. For example, it is not sufficient to produce evidence to the English Court showing that an Insured is likely to lose in, for example, a Texas Court because it is likely that a Texan jury will be hostile to the Insured (or Insurer) nor is it

permissible to show that the settlement was business like and sensible – what the Insured needs to show in such circumstances is its legal liability to a third party claimant. In most cases Insurers and their legal advisers will take a pragmatic view in connection with liability but issues may occur when liability is driven by commercial rather than legal considerations.

One further issue to bear in mind is the application of the QC clause which, when invoked, enables an Insured not to contest a claim but may not be sufficient to establish its legal liability: thus the Insured may be placed in the invidious position that it has settled and paid the claim (for reasons other than there being an existing legal liability) and yet still have to prove that it has an actual legal liability.

In addition to establishing the legal liability, the Insured needs to show that it was liable to the third party claimant in an amount not less than that paid under the settlement agreement.

One issue which appears now to have fallen away is the decision of Lumbermans [ref] which provided that if there was no allocation in the settlement agreement between covered and uncovered losses then no indemnity could be recovered from Insurers. This decision, which was generally questioned in the market, was to all intents and purposes overruled by Enterprise Oil [ref] whereby a court will consider extrinsic evidence when considering questions of allocation and, not surprisingly, questions of allocation are now being considered in settlement agreements where the majority of the allocations are made in favour of the Insured. Therefore, the settlement agreements do require considerable scrutiny when assessing the allocations.

Whilst this question of allocation has now fallen away the new theme is that of notification requirements and what constitutes proper and satisfactory notification for a claim to be considered under a policy or at least for policy coverage to be triggered in due course where a notification has been made within a policy year but no substantive developments have occurred until the policy had expired. The Court of Appeal recently revisited these issues in the case of HLB Kidsons v Lloyd's Underwriters.

Given the rather nebulous nature of claims made policies it is perhaps not surprising that there is significant shading between claims which may be admitted under a policy and those claims which are not and this was apparent from the HLB Kidsons

decision. Clearly a balance has to be drawn between wholesale blanket notifications (quite often at the expiry of a policy) and targeted specific notifications which may not contemplate or encompass claims which might "spin off" a particular notification. A

number of issues come out of the HLB Kidsons decision some of which require some health warnings:

- From an insured's point of view the case does emphasise the importance of getting the notification "right" in the sense that notwithstanding the careful crafting of a notification letter it did not encompass all subsequent claims.

- It was suggested that there was a duty of good faith attached to the Insured in making a notification. Whilst the point was not decided (as the Court was not asked to give its opinion on this particular issue) it nevertheless seems to have been accepted that "the proposition that where a policy contains a provision for the Insured to notify a circumstance which may give rise to a claim and thereby attach the risk to the policy, it is impliedly incumbent on the Insured to see that any such notification is a fair, if summary, presentation of what the Insured knows".

- Interestingly, the majority of the Court of Appeal was not willing to take a further step in holding that a notification was subject to the duty of utmost good faith so that if the Insured chose to be deliberately misleading or economical with the truth the notification would be invalid, although the majority of the Court of Appeal saw merit in such an argument.

It is fair to say in analysing the degree of awareness of an Insured when making a claim that it very much "depends on the facts". The Court acknowledged that there were times where an Insured sought to notify a circumstance which was too vague or remote (as previously noted where a policy is about to expire and by way of a laundry list) and in those circumstances Insurers would be quite within their rights to reject the notification. The other end of the spectrum is a claim which clearly falls for notification and in those circumstances an Insured would be obliged to make such notification. (The NMA 3000 has sought to require specific information ostensibly to prevent the production of shopping lists and to explain why certain claims/notifications are not accepted). Naturally, it is those circumstances which fall within the middle of that spectrum where various parties might reasonably form different views as to whether the claim should be notified. In those circumstances an Insurer could not reject a notification of those circumstances, nor could an Insurer complain if the Insured did not give such a notification (it is questionable whether this analysis would still be applicable on renewal given the fairly broad ranging questions contained in FI proposal forms). A final interesting issue which came out of this case

is the requirement to notify claims within 15 calendar days of the expiry of the policy and the ability to notify claims "as soon as practicable". On the face of it this appeared to give two longstop dates for the notification of claims once a policy had expired i.e. within 15

calendar days or as soon as reasonably practicable and these where held to be two alternate longstop dates (albeit current FI policies do now provide "in any event" for, say, a 30 day longstop date).

Insurers will nevertheless be comforted that the suggestion by the Insured that if the Insured became aware during the policy period of a circumstance which might give rise to a claim it could validly notify it at any time, subject only to Insurers being able to refuse on the grounds of prejudice was dismissed as a "hopeless argument".

Insured's management of a claim

As previously noted there has been a trend to devolve claims management to Insureds which allow Insureds to take views as to whether a claim should be notified. Whilst this is easy to understand in large institutions which have significant risk management and insurance functions there is nevertheless the risk that where ownership of this particular function is elevated to senior management where there are institutions with a global footprint then notifications and the attendant steps which need to be taken to protect the Insured's (and Insurer's) position cannot be taken promptly.

We have seen significant difficulties arising in connection with PI policies which contain dishonesty extensions and also contain a termination provision once the dishonesty of a particular individual has been discovered i.e. lack of fortuity/moral hazard. Generally the attribution of this knowledge is to a director and/or officer of the Insured and naturally such definitions may change throughout applicable jurisdictions. Whilst a definition of a director and officer within the English jurisdiction is relatively well settled (albeit there may be some debate as to what constitutes an officer) in other jurisdictions there may be more open debate. From experience, directors and officers in certain Latin American jurisdictions may be, in effect, any individuals within that financial institution whilst, under Delaware law the procedures for the appointment of directors and officers may be more strict and the concept of a *de facto* director and/or officer is less well grounded or defined. Further, there are situations, where an individual might appear to possess all the functions of an officer but he may not fulfil the technical and legal requirements in that particular jurisdiction and whilst his knowledge on most occasions would be sufficient to terminate the policy in connection with the dishonest employee, it may not be in that particular jurisdiction. Moreover, it is often the case that whilst senior employees at the outset of the claim are given significant senior management responsibilities, when

termination arguments do arise it appears that their functions and seniority rapidly diminish.

Costs incurred when mitigating losses

The general rule (save for where there are contractual provisions and in marine contracts) is that the costs of mitigating losses are irrecoverable (see Yorkshire Water v Sun Alliance). Notwithstanding these general provisions there is no reason why in certain circumstances the cost of mitigating loss should not at least be viewed benignly by Insurers. There is no reason why such costs cannot be recovered (subject to a sub limit and/or Insurers' consent being required to effect such costs). Particularly in the financial sphere the Insured, whilst it may have been the author of its own misfortune, is likely to be the prime candidate for sorting out the mess.

Further, to a limited extent Insurers do recognise that mitigation costs can be recovered (really by way of subrogated claims) if one considers the subrogation, salvage and recovery provisions contained within certain bankers blanket bonds (see NMA 2626). Moreover, in certain crime and property damage policies which have been issued recently such mitigation costs have been expressly recognised (together with other "whistles and bells" such as preparation and verification costs).

Established v emerging markets

The obvious difference between established and emerging markets is that in relation to the former there is generally an established statutory framework and claims experience. In those circumstances jurisprudence is relatively predictable and mature. The result is that (seemingly) a broader form cover is available through civil liability polices and can be issued with a certain (high) degree of confidence as to what the outcomes would be.

In relation to emerging FI markets one is naturally concerned with nascent jurisprudence/local laws; perhaps a lack of claims experience and issues about risk management. In those situations it is quite often the case that Insurers' expectations are not aligned with local risks and therefore it is critical to understand local risks (particularly when using civil liability or similar wordings). As also previously noted definitions of who constitute directors and/or officers (which may be critical for the purpose of triggering claims under the policy and termination provisions) may differ considerably from jurisdiction to jurisdiction. Further, the implications of non-disclosure and avoidance may be markedly different from the United Kingdom. It is therefore important to drive change through the level of information sought, potentially conditions precedent contained within the policy (the conditions precedent

contained within the LPO 218 e.g. condition precedent requiring the employment of certain risk management techniques) and the policy wordings themselves.

John Barlow
Partner
Professional Risks

E: john.barlow@hilldickinson.com
T +44 (0)20 7280 9146
F +44 (0)20 7283 1144

John advises insurers and reinsurers of Financial Institutions in connection with their fidelity, computer crime, D&O and PI/Civil Liability programmes and on claims which arise under these programmes. John had handled a number of the most significant claims to find their way into the London insurance and reinsurance market.

In addition to his claims handling experience and dispute resolution, John has considerable experience in the development of leading Financial Institution insurance products and is currently working on a number of products which address the operational risk requirements and the current fall out from the credit crunch which has impacted Financial Institutions.

John also has experience of political risk, sovereign guarantee, credit default and protracted payment insurances and the development of captive programmes. He has advised British government departments on the insurance aspects of the Private Finance Initiative (PFI) and the Public-Private Partnerships (PPP) projects.

Work specialisms

- financial institutions insurance/reinsurance
- alternative dispute resolution
- arbitration
- commercial dispute resolution
- commercial insurance
- corporate crime
- directors and officers