

ANALYSE

PREPARE

**PROTECT**

Cover to Cover

Issue 32

Our publication for New Zealand insurance professionals

MinterEllisonRuddWatts.

# Contents

- 02 Foreword
- 03 The rise of the Ombudsman:  
A significant new risk for insurers and intermediaries
- 06 The growing risks of 'ESG-washing' and the new risk of 'AI-washing'
- 09 The LA wildfires:  
Devastating losses with minimal insurance
- 12 Getting ready for the Contracts of Insurance Act:  
A summary of key workstreams for insurers and intermediaries
- 16 Case study  
Court of Appeal (England and Wales) provides clarity in construction policy coverage
- 19 Case study  
Brokers find it hard to strike out weak negligence claims *Norman Hay plc (in Members' Voluntary Liquidation) v Marsh Ltd [2025] EWCA Civ 58*
- 22 Case study  
Bear-faced cheek

# Foreword

Welcome to our first issue of *Cover to Cover* for 2025.

In this issue we explore several critical topics shaping the insurance landscape including the rise of the Ombudsman: Insurance & Financial Services Ombudsman Scheme (IFSO) and Financial Services Complaints Ltd (FSCL) expanding powers, offering practical insights into these schemes and the new risks for insurers and intermediaries. We discuss how they should plan to manage more high-value claims and disputes before the Ombudsman schemes.

We also highlight the growing risks of 'ESG-washing' and the emerging risk of 'AI-washing,' explaining what makes AI-washing different from other forms of ESG-

washing and how insurers can best prepare for these changes. Additionally, we cover how insurers must guard against fraudulent claims, detailing the various forms they can take, including a particularly audacious case from the United States early last year.

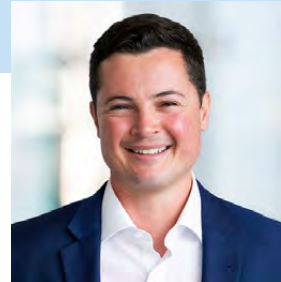
We offer insights on preparing for the Contracts of Insurance Act, summarising key workstreams. This Act helpfully consolidates and modernises New Zealand's disparate and, in some cases, antiquated insurance legislation, aligning it better with statutory regimes in the United Kingdom and Australia.

Our case studies include a detailed look at a Court of Appeal (England and Wales) decision that clarifies construction policy coverage, and another case outlines the challenges brokers face in striking out weak negligence claims, as seen in *Norman Hay PLC (in Members' Voluntary Liquidation) v Marsh Ltd* [2025] EWCA Civ 58.

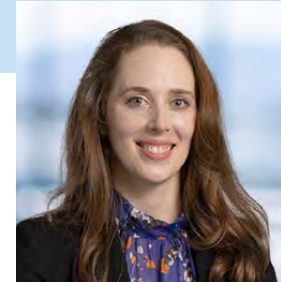
We hope you find this issue of *Cover to Cover* both interesting and informative. If you would like to discuss any of the themes, please get in touch.



**Andrew Horne**  
Partner



**Nick Frith**  
Partner



**Olivia de Pont**  
Senior Associate



**Hannah Jaques**  
Senior Associate



## The rise of the Ombudsman: A significant new risk for insurers and intermediaries

Authored by Nick Frith and Andrew Horne

### The mandatory schemes

Insurers, brokers and other intermediaries that provide financial services to retail clients must join one of three approved dispute resolution or ombudsman schemes (there is a fourth but it services only banks). These schemes provide an avenue for consumers and small businesses to have their claims and complaints rendered or determined for free in an informal setting.

### Increased limits

Originally, the schemes applied only to relatively low value claims. The risk they presented to insurers and brokers was therefore limited.

Last year, however, the two main schemes that serve the insurance industry, Insurance and Financial Services Ombudsman or (IFSO) and Financial Services Complaints Limited or (FSCL), dramatically increased their maximum claim limits. They can now issue determinations that are binding on insurers and intermediaries (but not on complainants) to a maximum value of \$500,000 (or, in the case of regular payments, \$2,730 + GST per week). Remarkably, the \$500,000 jurisdictional limit is more than the \$350,000 maximum jurisdiction of the District Court.

This has been a rapid and recent development. When IFSO (then named the Insurance and Savings Ombudsman Scheme) was established in 1995, it had a financial cap of \$150,000, which increased to \$200,000 in 2009. As recently as 2023, IFSO's jurisdictional limit was still only \$200,000, increasing to \$350,000 that year. FSCL had raised its limit to \$350,000 later that year. The recent increase to \$500,000 is a significant development.

For consumers and small businesses, access to a free, binding dispute resolution scheme is very useful as their claims would otherwise often be uneconomic to bring in a court. Schemes of this nature are appropriate for relatively straightforward, low value complaints.

## The rise of the Ombudsman: A significant new risk for insurers and intermediaries

However, they are not appropriate for disputes that involve complex disputed facts or those that require medical, engineering or other technical evidence, or concern serious matters such as fraudulent claims or other dishonesty. Financial services firms are exposed to considerable risk when claims and disputes of this nature are determined by a body that does not have the discipline of the rule of law, the rules of court, the rules of evidence, the ethical obligations of advocates and a right of appeal.

Insurers pointed out these concerns when Ministry of Business, Innovation & Employment (MBIE) engaged in consultation with respect to the proposed changes. They pointed out that the schemes were not suitable for resolving complex insurance disputes. The Insurance Council of New Zealand made submissions that:

*In relation to the 'fairness' criterion, we believe that there should also be reference to the quality of decisions. If the process is not fair to insurers, then it will impact on the insurance pools they manage and on the costs to customers more broadly. We also note that the focus of the review seems to be solely on the consumer, yet fairness and good faith in particular, are concepts involving both parties.*

### Those concerns were not heeded

We initially thought that the increase from \$200,000 to \$350,000 in 2023 was positive.

That increase brought the schemes into line with the District Court. For consumers, the schemes provided an alternative to court proceedings, which almost invariably result in entrenched positions, delay and cost. The schemes addressed complaints without the need for them to be escalated, generally satisfying consumers and participants. However, the additional increase coming only two to three years later moves the schemes into a different frame.

### How the schemes operate

The schemes are funded by levies on their members, with no Government funding. IFSO and FSCL have as their stated purpose the accessible resolution of complaints. However, the schemes have become increasingly active in determining disputes. FSCL's terms of reference refer to "resolving" disputes by making "final decisions".

In addition to the greatly increased jurisdictional limits, we have recently seen an increased willingness by the schemes to move quickly to a determination, sometimes in draft or on a preliminary basis, as a means by which to encourage

settlement. Schemes are also now more frequently considering complaints that are more serious in nature, including those relating to technical issues requiring competing expert reports. While their terms of reference permit this approach, it is not consistent with their originally intended purpose of being a relatively informal resolution service. These factors make them risky for insurers and intermediaries, particularly when coupled with a jurisdictional limit that exceeds the District Court, in a decision-making environment where the fact finder is not bound by the rules of law and fair process.

None of this would be particularly concerning if scheme outcomes were non-binding. But complainants may accept and enforce a determination if it suits them, which will be binding on the participant and enforceable by a threat of a reference to the Financial Markets Authority (FMA) or Reserve Bank of New Zealand (RBNZ). Participants' appeal rights are extremely limited. In contrast, if a consumer is dissatisfied with a decision, they are not obliged to accept it and may issue court proceedings. The schemes are therefore essentially unbalanced.



## The rise of the Ombudsman: A significant new risk for insurers and intermediaries

### The proposed merger

It was recently proposed that IFSO and FSCL merge as at 1 July 2025. As they resolve 90% of financial services complaints (excluding banking) between them, they would have in effect become a monopoly. Not only would insurers and intermediaries have been bound to membership of a scheme, they would have had little choice as to what that scheme is. There is only one other scheme that provides services to insurers and intermediaries, Financial Dispute Resolution Service.

Government supported the proposed merger, claiming that it would help streamline services, create operational efficiencies and remove duplication. That could be said of any monopoly. The reality is that an absence of choice does not usually result in better outcomes for consumers or participants.

### What now for insurers and intermediaries?

So where does this leave insurers and intermediaries? And what can they do to maximise the prospects of positive outcomes with their retail customers?

Insurers and intermediaries must now focus on how best to manage these schemes and achieve acceptable outcomes.

- It goes without saying, but participants need to ensure that their internal complaints systems are robust and comprehensive. We see many complaints that stem from a failure to keep customers up to date with claims processes and decisions. Further into the complaints process, communication problems and a lack of due process often see customers losing patience, resulting in deadlock. Honouring commitments and adopting consumer friendly, as opposed to overly formal, approaches can often make customers feel heard, minimising the prospect of referral to a scheme.
- Make reasonable and early settlement offers where appropriate, considering the legal and reputational risks involved. FSCL, but not IFSO, can refuse to consider a complaint where it is satisfied that a reasonable settlement offer has been made. It seems logical that IFSO would encourage complainants to its scheme to accept a reasonable settlement offer by a participant, but that is not a specified reason for it not to consider a complaint.
- Consider whether the issue raised by the complaint should become a test case in the courts. IFSO's terms of reference prevent complaints from being considered further if the participant undertakes to prosecute a test case diligently and pay the complainant's costs of participating in the case. FSCL does not appear to have this relief valve.
- Use the scheme's terms of reference to best advantage. Carefully comply with the notification and timeframe requirements for deadlock letters to engage the three-month limitation period for complaints.
- Insurers providing liability cover for financial advisers may wish to consider the extent and cost of cover they provide in light of this risk.



Insurers and intermediaries should plan to manage more high value claims and disputes before the resolution schemes. They should ensure that they avoid allowing claims to proceed to a determination where possible and that they are equipped with the skills and resources to obtain the best possible outcome when they do.

# The growing risks of 'ESG-washing' and the new risk of 'AI-washing'

Authored by Olivia de Pont

Regulators' interest in so-called 'greenwashing', where firms overstate their sustainability related conduct or credentials, continues unabated. Most recently, in March of this year, gas company Clarus voluntarily withdrew an advertisement in which it said that renewable gas was flowing in its pipelines, after complaints were made to the Advertising Standards Authority. Clarus was indeed mixing in biomethane from a composting plant, but the complainants said that the statement was misleading because the majority of the gas delivered to customers was fossil fuel.

Private activists are also bringing actions, such as the proceedings Greenpeace recently issued against Fonterra, claiming that Anchor butter packaging with the words "100% New Zealand grass-fed" is misleading when grass typically makes up 80% of the cows' diets. The latter was perhaps not an obvious litigation risk, which demonstrates the extent of the exposure for companies and their insurers.

"Washing" risks, including not only "greenwashing" but also other misleading claims of social benefits intended to appeal to consumers, investors, or workers which are sometimes referred to as "social washing", continue to pose one of the

greatest risks to businesses and their statutory liability insurers arising from ESG related obligations. Added to this is an emerging risk that may be described as "AI washing", where firms overstate the extent to which they are designing, producing, or using, artificial intelligence tools and impliedly overstating their commercial prospects as a result.

The laws prohibiting ESG-washing and AI-washing in New Zealand are primarily the prohibitions upon misleading and deceptive conduct in the Fair Trading Act 1986 and the fair dealing provisions of the Financial Markets Conduct Act 2013. The application of these laws is far from



simple, and breaches may be unintentional or inadvertent. Organisations may make statements about their ESG or AI credentials which on their face are true, but could be considered misleading and deceptive if they create a misleading impression overall.

While the risk of regulatory action in response to ESG-washing, and particularly 'greenwashing', has been a known risk for some time, such action is becoming more frequent and significant in the context

of both increasing global regulation requiring mandatory disclosure, and the importance placed by consumers on these representations in making purchasing decisions. Organisations that publicise their ESG credentials or make similar statements about their use of AI, and their statutory liability insurers, face an increasing risk of claims and penalties.

## The growing risks of 'ESG-washing' and the new risk of 'AI-washing'



### 'AI-washing'

AI-washing may be described as the practice of overstating an organisation's or a product's AI use, capabilities or prospects for the purpose of gaining a competitive advantage or improving its reputation. Misstatements may appear in the way in which an organisation describes its use of AI, the efficacy of its AI over existing techniques, the flexibility of its AI, or the extent to which its AI is fully operational. In turn, these misstatements can prejudice consumers by landing them with goods or services that do not meet expectations. More broadly, this type of conduct can mislead the market as a whole and erode consumer trust in AI and AI related goods or services.

What makes AI-washing different from other forms of ESG-washing is that some of the features that make AI beneficial can also amplify the risks of misleading statements. AI systems can change their performance over time and adapt by learning from data, but if that data contains inaccuracies, this can result in unwanted bias and misleading or entirely erroneous outputs, known as 'hallucinations'. This risk is amplified with AI systems that are designed to make decisions independently, without human intervention at any stage of the decision-making process. As an AI product or service can evolve, representations made before the time of sale may no longer be true when the product or service is sold or shortly thereafter.

AI-washing has recently become a particular focus of the US Securities and Exchange Commission or (SEC). Last year saw the SEC bring cases against investment advisers for their statements regarding AI, marking the first instance of regulatory action against the practice in the United States. In many of those cases, the SEC found that the investment advisers had neither developed nor implemented the AI capabilities they advertised.

The United States is not alone in taking action against AI-washing. The European Union's new AI Act includes strict transparency requirements to protect consumers and markets from deceptive AI usage.

### Greenwashing

Greenwashing claims continue to grow both domestically and internationally. In New Zealand, we are awaiting the outcome of the first greenwashing case, in which Consumer NZ is seeking declarations from the High Court that an energy company breached the Fair Trading Act with misleading statements about emissions reductions in a public advertising campaign.

In Australia, both the Australia Competition and Consumer Commission (ACCC) and the Australian Securities and Investment Commission (ASIC) have continued to focus on ESG-washing as a top enforcement priority. In its 2024–25 Compliance and Enforcement Policy and Priorities, the ACCC identified consumer, product safety, fair trading and competition concerns in relation to environmental claims and sustainability as one of its ten compliance and enforcement priorities for this year.

## The growing risks of 'ESG-washing' and the new risk of 'AI-washing'

This follows proceedings commenced by the ACCC in the Australian Federal Court against Clorox Australia Pty Ltd, the manufacturer of GLAD-branded kitchen and rubbish bags, for making allegedly false or misleading representations that certain kitchen and rubbish bags were partly made of recycled 'ocean plastic'. At the time of writing, we are still awaiting a judgment. On a related note, at the end of last year the ACCC released its final guide on sustainability collaborations and Australian competition law. The guide is designed to help businesses understand the competition law risks that may arise when contemplating working together to achieve positive sustainability outcomes.

Meanwhile, ASIC has had good enforcement success in the past 12 months pursuing greenwashing cases. This focus has been renewed in its priorities for 2025, with ASIC suggesting that its greenwashing focus this year will be broadened to include listed entities, managed funds and superannuation funds. Two recent examples of successful regulatory proceedings are those against Vanguard Investments

Australia and Active Super. The Australian Federal Court ordered Vanguard to pay a AUD12.9 million penalty for making misleading claims about ESG exclusionary 'screens' which were used to select only investments that complied with its ESG criteria. Vanguard admitted that it had misled investors into believing that certain funds would be screened to exclude bond issuers with significant business activities in certain industries, including fossil fuels, when this was not always the case.

In Active Super, the Federal Court found that LGSS Pty Limited, as trustee of the superannuation fund Active Super, contravened the law in connection with various misleading representations concerning its ESG credentials. Active Super claimed in its marketing that it eliminated investments that posed too great a risk to the environment and the community, including gambling, coal mining and oil tar sands. However, the Federal Court found that Active Super invested in a number of securities that it had claimed were eliminated or restricted by ESG investment screens.



### Social-washing

Similar to greenwashing, social washing occurs when organisations make misleading claims about their goods, services, or organisational practices in relation to social issues. Social washing often occurs in the context of statements made about an organisation's supply chain and the absence of human rights abuses, forced labour, modern slavery, child labour and/or the impacts on the communities in which their supplies operate.

Last year, institutional investors in Boohoo Group Plc, a United Kingdom-based fashion retail company, filed a claim against the company seeking compensation for allegedly misleading disclosures relating to its ESG responsibilities, which are alleged to have resulted in a financial loss for its shareholders. This claim is one of the first of its kind in the United Kingdom

and relates to an failure by Boohoo to disclose labour rights violations at its suppliers' factories, which were exposed by the United Kingdom media, leading to Boohoo's share price falling significantly. The media exposed the mistreatment of workers, including some who were being paid well below the minimum wage and forced to work in unsafe and unsanitary conditions during the Covid-19 pandemic.

Given the increased risks of penalties for ESG washing and AI washing, and the difficulty of accurately pricing emerging risks, insurers may wish to make more extensive inquiries of their customers' processes for ensuring that any ESG statements they make are factually accurate, as well as any statements made about the use of AI in their goods or services and their capabilities.

## The Los Angeles wildfires: Devastating losses with minimal insurance

Authored by Andrew Horne

The devastating wildfires that swept through Los Angeles in January this year resulted in widespread property losses. More than 10,000 houses and other buildings were damaged, many being completely destroyed. Alarmingly, fewer than a quarter of these were insured against fire, highlighting a growing crisis in the property insurance industry.

Why such limited coverage? The main reason is insurers' growing reluctance to write cover for a risk they view as uninsurable within the frameworks set by California's highly regulated insurance market. In addition to several destructive fires in recent years, insurers are concerned that the areas consumed by summer wildfires in California each year are increasing dramatically and that the number of high-risk "fire weather days", when the weather is hot, dry and windy, is also increasing.

Some major insurers left the Californian property insurance market well before the fires. Chubb and its subsidiaries stopped writing new policies for high-value homes with higher wildfire risk in Los Angeles County in 2021. Another major insurer, Allstate, stopped writing new policies the following year. California's largest insurer, State Farm, stopped writing new policies in 2023, and AmGuard, Falls Lake, Travelers and Farmers Direct Property withdrew entirely. Tokio Marine America withdrew in 2024.



## The Los Angeles wildfires: Devastating losses with minimal insurance

Especially heartbreaking for some homeowners only a few months before the fires, some major insurers chose not to renew thousands of home insurance policies in fire-prone areas such as Pacific Palisades and Altadena. This left a number of longstanding customers without cover only a few short months before they lost their homes. State Farm announced in March 2024 that it would not renew 72,000 policies across California. Over the summer, it also withdrew cover for more than 1,500 homes in Pacific Palisades and more than 2,000 policies elsewhere in Los Angeles, saying that its decision was a response to inflation and its rapidly growing catastrophe exposure. It was a prescient call; Pacific Palisades was the location of the first of the major fires of 2025 and many homes and buildings were destroyed there shortly after their insurance was withdrawn.

The rising costs of premiums and insurance cancellations left many property owners without adequate cover, or “going bare”, highlighting a deepening crisis in California’s property insurance market.

### The state-backed alternative

When a Californian homeowner cannot obtain private insurance, the Fair Access to Insurance Requirements (FAIR) plan provides a last resort. FAIR is organised by the government but is funded by private home insurers. FAIR will cover houses that private insurers will not, but the cover is limited, often requiring private top-up cover, and the cost is typically more than double that of private policies.

Notwithstanding these drawbacks, the number of policies written by the FAIR Plan has more than doubled in the past four years. This has left it increasingly exposed to wildfire risk. FAIR Plan’s website reports that its exposure to the January fires is nearly USD6 billion in Pacific Palisades alone. Politicians have expressed concern that another bad fire season could result in its insolvency.



### The role of regulation

So why did insurers not price in the risks? To some extent they did. Many people did not insure their properties simply because the premium cost was too high.

However, there was also a regulatory problem which prevented insurers from pricing cover to reflect wildfire risks. Until California’s insurance regulations were revised last year, insurers were prohibited from using catastrophe models to forecast wildfires losses – they were only permitted to make assessments based upon historical losses, which was too restrictive in circumstances where wildfire risk was increasing. Compounding the problem, they were also barred from increasing premiums to reflect increased reinsurance costs. These interventions had a predictable effect. Prevented from increasing premiums to reflect increased risks and costs, insurers withdrew from the market.

Now, under a new Sustainable Insurance Strategy announced in January by California’s Insurance Commissioner, insurers will be required to offer cover to homeowners in wildfire risk areas. They will also be required to hold, in risk areas, a minimum market share equivalent to 85% of their state-wide market share, with that number increasing over time.

This new rule is the latest legislative attempt to assist Californians to obtain insurance at a reasonable cost. A trade-off for the obligation to write cover in higher risk areas is that companies will now be permitted to recover increased reinsurance costs as well as using forward-looking catastrophe models to calculate and charge higher rates for high-risk areas. Cover will increase, but at the cost of rising premiums that reflect increased risks and costs.

## The Los Angeles wildfires: Devastating losses with minimal insurance

### Implications for New Zealand's insurance industry

Since 2023, New Zealand has experienced a number of severe weather events, including major storms, flooding, and cyclones. While our fastest-changing insurance risk is coastal floods, we cannot be complacent about wildfire. Wildfire experts say that climate change is expected to make some areas of New Zealand higher risk. This may make it challenging to insure houses in the hottest and driest places. Property owners in areas such as Christchurch's Port Hills are likely to face difficulty obtaining insurance in the first instance.

Some trends suggest that New Zealand could see insurance problems not entirely dissimilar to those in Los Angeles.

- Insurance premiums have surged in high-risk areas: Following Cyclone Gabrielle and other severe weather events, insurers have raised property insurance rates significantly, particularly for properties in flood-prone areas.
- Insurers have reduced participation: some property owners are reportedly finding it increasingly difficult to obtain coverage as insurers reassess risk models. There are indications that insurers are increasingly using risk-based pricing.
- Underinsurance: some reports indicate that around a third of damage from Cyclone Gabrielle and the Auckland Anniversary floods was uninsured.

Given the parallels in natural disaster exposure, a scheme like the Californian approach may become necessary in New Zealand. New Zealand has the statutory Natural Hazards Commission – Toka Tū Ake (NHC) scheme, but cover for structures is limited to NZD300,000.

Addressing underinsurance and ensuring the availability of affordable property insurance in the face of increasing natural disaster losses will require coordinated efforts involving policy changes, public awareness campaigns and innovative insurance solutions.

Some potential solutions include:

- **An enhanced national disaster insurance programme:** The scope of NHC coverage may require expansion to provide a more useful limit and include broader weather-related risks. Government and private insurers may need to collaborate on shared-risk models to ensure widespread coverage while keeping costs manageable for homeowners.
- **Public awareness campaigns:** Some homeowners may not understand the risks they face or the limitations of their insurance policies. Government agencies and insurers could invest in education campaigns.
- **Collaboration for resilience:** The insurance industry may need to work with government bodies and communities to invest in mitigation and adaptation measures, enhancing overall resilience to natural disasters. Mandating flood-resilient and storm-resistant construction standards could help mitigate risks. This may include 'managed retreat' where the population withdraws from areas where no reliable remediation strategy is possible.
- **Risk-based pricing:** Insurers may continue to adjust premiums based on individual property risk assessments, leading to increased costs for high-risk areas.
- **Insurance retreat:** In some cases, insurers might withdraw coverage from areas deemed too high-risk, necessitating intervention or alternative solutions to ensure coverage availability.

The underinsurance crisis revealed by the Los Angeles wildfires of 2025 highlights the growing challenge of securing property insurance in an era of climate change. As New Zealand grapples with increasingly severe weather events, similar issues are emerging, with rising premiums, reduced coverage availability and growing gaps in insurance protection. To avoid this, New Zealand will need to consider proactive measures such as extending the NHC insurance scheme, implementing resilient construction standards and making public awareness efforts.

Getting ready for the Contracts of Insurance Act:

## A summary of key workstreams for insurers and intermediaries

Authored by Hannah Jaques and Sean Dolan

The much-anticipated Contracts of Insurance Act received Royal Assent late last year. It helpfully consolidates and modernises New Zealand's disparate and, in some cases, antiquated insurance legislation. The Act also better aligns New Zealand insurance law with the statutory regimes in the United Kingdom and Australia.

Many insurers and intermediaries will need to make changes to their processes and procedures. Staff training, process changes and IT transformation projects will need to be implemented within a relatively short timeframe, with the Act coming into force in November 2027 at the latest.

We summarise the key practical issues arising from fewer key changes in the Act and how insurers and other industry participants will be preparing for the new regime.



### Change 1

New distinction between consumer and non-consumer insurance contracts

#### Substance of the change

Definition of consumer and non-consumer insurance contracts in section 10:

- Focus on the purpose of the contract rather than the identity of the policyholder.
- Contract of insurance must be "ordinarily entered into by a policyholder wholly or predominantly for personal, domestic, or household purposes".

#### Practical considerations and steps

Insurers will need to identify which category each of its policies will fall within. This may be done at a product level. However, some existing products may fall within both categories.

Insurers will need to assess whether product design changes are necessary to ensure clarity of categorisation.

## Change 2

### Consumer insurance contracts – a diluted disclosure obligation

#### Substance of the change

- Policyholder must “take reasonable care not to make a misrepresentation to the insurer”.
- Effectively shifts the burden of ensuring adequate disclosure to insurers by requiring insured only to answer questions asked of them.

#### Practical considerations and steps

Insurers will need to make changes to proposal forms to ensure questions cover all material points and are sufficiently specific and clear to put them in the best position to argue a breach of the disclosure duty. For insurers with online proposal and application forms, this will

require technology solutions as standalone work stream or part of a broader tech transformation project.

It may be useful to review historical claims and declinature information to inform the design of:

- a. the types of additional information that should be specifically requested; and
- b. factors that may have contributed to claims disputes in the past.

There is a balancing act required; so that forms do not become unwieldy for the insurer or policyholder.

Significant amendments will also be required for disclosure statements and warnings in standard policy documents including proposal and application forms, renewal reports and policy wordings, and template letters and emails.

## Change 3

### Non-consumer insurance contracts – a different expression of the disclosure duty

#### Substance of the change

- Duty to make a fair presentation of the risk, which is reliant on the policyholder’s knowledge.
- This knowledge will include that of the policyholder’s brokers and their employees.
- Policyholders ought to know what could be revealed by a reasonable search for information available to them including information held by their broker.

#### Practical considerations and steps

Insurers and insurance intermediaries will need to amend policy documentation and other communications to ensure that the description of the duty of disclosure is accurate. This will include language designed to clearly explain the obligation on the policyholder and the potential consequences of not complying with fair presentation obligations. This includes undertaking a search for material information.





## Change 4

### Insurer's right to claim against a specified intermediary for failing to pass on disclosure information

#### Substance of the change

- A specified intermediary will be required to take reasonable steps to pass on a representation by a policyholder of a consumer insurance contract.
- A specified intermediary will be required to take all reasonable steps to disclose every material circumstance known by them or in relation to a non-consumer insurance contract.
- Where the specified intermediary, rather than the policyholder, has breached the duty of disclosure, an insurer will not be entitled to exercise a remedy against the policyholder for breach of duty. But the insurer can apply to be indemnified by the specified intermediary.

#### Practical considerations and steps

Important to ensure specified intermediary arrangements are fit for purpose, including in relation to policyholders' obligations to make a fair presentation. For example, information a broker has should be required to be disclosed, to the extent it is relevant to a fair presentation of the risk.

The Act allows a specified intermediary to contract out of this liability with the relevant insurer. Specified intermediaries will need to consider whether to attempt to negotiate such an arrangement or limit their liability. We expect that this would meet resistance. It will likely be easier to do so in circumstances where the specified intermediary has a binder relationship with a specific insurer.

This should be a catalyst for brokers to ensure they have adequate file management systems in place so that information can be provided to insurers, accessed and readily recalled.

## Change 5

### New proportionate remedies for non-disclosure (Schedule 2, Part 1)

#### Substance of the change

Provides an alternative to avoiding the policy. Subject to certain conditions, allows for a proportionate reduction in the amount paid in response to a claim or for the insurer to treat the policy as if it had been placed on the terms that the insurer would have been willing to provide had there been proper disclosure.

#### Practical considerations and steps

Check that policy terms are consistent with the new regime and do not contain avoidance rights that are wider than or inconsistent with the Act. This should be amended as part of the disclosure piece in policies.

Insurers may find it helpful to include tables in their documentation explaining the various rights on breach of the disclosure duties.

Check that systems are equipped to help with counterfactual analysis – so that the insurer can prove what it would have done.

## Getting ready for the Contracts of Insurance Act: A summary of key workstreams for insurers and intermediaries

### Change 6

#### Abolition of third party statutory charge (Schedule 1, Part 1)

##### Substance of the change

Third parties now have a direct claim against a specified policyholder's insurer(s), rather than a statutory charge.

##### Practical considerations and steps

Consider whether insurer rights/protections in relation to control of litigation are adequate in insurance policies.

Insurers will need to allow for policyholders being less likely to seek separate defence costs cover because the sum insured will not be subject to a statutory charge (which prevents access to the sum insured to pay defence costs).

Insurers and insurance intermediaries will need to consider processes to address third party requests for insurance information pursuant to Schedule 3 of the Act.

This may involve:

- criteria against which to assess whether the third party's request for information provides sufficient particulars of their reasonable belief that an insured liability has been incurred and it may be able to recover the amount of that liability under the Act;
- ensuring compliance with the 28 day period for response; and
- a policy addressing when, if at all, to charge the third party for the cost of providing the information.

### Change 7

#### Unfair contract terms regime

##### Substance of the change

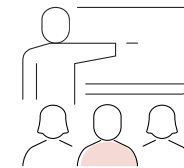
Extends the unfair contract terms regime in the Fair Trading Act 1986 to non-consumer insurance contracts with an annual premium value of \$20,000 or less.

##### Practical considerations and steps

Insurers will need to consider whether this financial cut-off will create uncertainty where standard form insurance contracts are used in policies under and above the annual value. The result will be that the unfair contract terms regime applies to some relationships but not others on the same wording/terms.

Insurers will need to review non-consumer and consumer standard form contracts for unfair contract terms risk.

In-house legal teams may need to conduct further training to ensure wide understanding of this issue to non-consumer and consumer standard contracts.



#### Time is ticking

The earlier insurers and intermediaries consider these and other issues, the more time they will have to design and implement solutions. In our experience, those changes requiring technology transformation projects will be difficult to achieve if not started this year.

# Court of Appeal (England and Wales) provides clarity in construction policy coverage

*Sky & Mace v Riverstone Managing Agency & Ors*

Authored by Olivia de Pont

The Court of Appeal of England and Wales recently considered the scope of coverage under a “construction all risks” (CAR policy). The Court’s decision provides welcome clarity on a number of issues and a useful precedent for insureds. One of the key findings concerns whether a time-limited ‘occurrence’ policy provides cover for deterioration and damage that occurred beyond the period of insurance, for initial damage that first occurred within that period.

The case is *Sky & Mace v Riverstone Managing Agency* [2024] EWCA Civ 1567.

## What the case was about

Sky UK Limited and Mace Limited were co-insureds under a CAR policy. It provided cover in relation to Mace’s construction of Sky’s West London headquarters in 2016, known as Sky Central. During construction, Mace failed to erect temporary roofing over a newly constructed wooden roof, which was made up of 472 individual cassettes. Water ingress resulted in swelling of internal timber and structural decay during the period of insurance. Efforts to remediate the initial moisture ingress proved unsuccessful and further damage occurred after the period of insurance due to the spread of moisture internally.

Sky and Mace claimed an indemnity under their CAR policy, which read:

*“The Insurers shall, subject to the Terms of this Contract of Insurance, indemnify the Insured against physical loss or damage to Property Insured, occurring during the Period of Insurance, from any cause whatsoever ....”*

*“In settlement of claims under the Section of the Contract of Insurance the Insurers shall, subject to the terms and conditions of the contract of insurance, indemnify the Insured on the basis of the full cost of repairing, reinstating or replacing property lost or damaged (including the costs of any additional operational testing, commissioning as a result of the physical loss or damage which is indemnifiable hereunder) even though such costs may vary from the original construction costs...”*

Sky and Mace also sought an indemnity for the costs of investigating the extent of the damage.

Insurers declined the claim on the basis that only damage occurring during the period of insurance was covered under the insuring clause. They argued that the deterioration and further damage occurring after the period of insurance was not covered. The insurers also contended that the cassettes needed to have deteriorated to a condition requiring immediate replacement and repair to meet the threshold of damage in the CAR policy. Sky and Mace’s claim for its full investigation costs was declined on the basis that only investigation costs that revealed damage that occurred during the period of insurance were insured.

Following a 5-week hearing in 2023, the Commercial Court found largely in the insurers’ favour, determining that:

1. Sky and Mace were entitled to be indemnified for damage occurring within the period of insurance, but not the deterioration and damage occurring after the period of insurance.
2. The roof had suffered damage within the meaning of the policy.
3. The policy required the insurers to indemnify Sky and Mace for investigation costs only insofar as those investigations revealed damage during the period of insurance.

Sky and Mace appealed the Commercial Court’s findings in (1) and (3) above, while the insurers cross-appealed the Court’s findings in (2).

## Court of Appeal (England and Wales) provides clarity in construction policy coverage

### Court of Appeal decision

The Court of Appeal allowed Sky and Mace's appeal on items (1) and (3) above and dismissed the insurers' cross appeal on (2).

### Cover for deterioration and damage

In the Commercial Court, the Judge had applied the House of Lords' decision in *Wasa International Insurance Co Ltd v Lexington Insurance Co* [2009] UKHL 40, which held that in occurrence-based policies, the indemnity does not extend to cover damage occurring before or after the period of insurance. On this finding, deterioration or damage to any cassette that could not be shown to have occurred during the period of insurance, even where the initial damage in the form of water ingress had occurred during the period of insurance, could not be covered.

The Court of Appeal overturned that decision on the following grounds:

1. The Court held that an insurance claim is a claim for liquidated damages. On this analysis, an insurer's promise is that the insured damage will not occur, meaning its primary obligation is breached the moment the damage occurs. The measure of recovery is governed by

general contractual law principles, meaning that the objective is to place the insured in the same position as if the breach had not occurred, subject to express policy terms to the contrary. The result of this approach was that the insurers were required to indemnify Sky and Mace for loss and damage arising from an insured event occurring during the period of insurance, including for loss caused after the period of insurance by reason of deterioration of damage that first occurred during the period of insurance.

2. Any deviation from this general principle would require clear wording in the policy. This was consistent with the policy wording indemnifying Sky and Mace for the full cost of repairing, reinstating or replacing property, which included deterioration and damage arising from the insured event occurring during the period of insurance.
3. An occurrence-based policy indemnifies an insured for perils occurring during the period of insurance. If the loss first occurred during the period of insurance, all continuing damage is treated as occurring during the period of insurance.

4. The insurers' construction of the CAR policy in this regard was uncommercial.

In making its findings, the Court of Appeal referred to the "death blow" principle. Developed in the context of marine insurance, the principle is that an insured can recover for damage developing after the period of insurance so long as the damage developed from damage sustained during the period of insurance. It was therefore possible to distinguish *Wasa*, where the damage was continuously occurring separately within each calendar year by way of fresh disposal of leakage or waste, as opposed to the ongoing effects of leakage or waste occurring during the period of insurance.

### Meaning of "damage" in the policy

The insurers contended that, in order to constitute damage, the timbers of the cassettes must have deteriorated to a point requiring "immediate replacement or repair".

The Court of Appeal agreed with the Commercial Court that this argument was untenable. It held that damage is any change to the physical nature of tangible property impairing its value or usefulness.

As such, the Commercial Court was correct to conclude that damage had occurred prior to the expiry of the period of insurance through water ingress, even though the full extent of the damage did not crystallise until later.

### Cover for investigation costs

The Court of Appeal overturned the Commercial Court's finding that only investigation costs revealing damage occurring during the period of insurance would be covered because such a finding would be inconsistent with the Court of Appeal's findings about the scope of cover under the policy. The Court of Appeal determined that, where insured damage has occurred for which damages are recoverable under the policy, the costs of investigating the extent and nature of the damage, including any development and deterioration damage, are recoverable if they are reasonably incurred in order to determine how to remediate it. That is because they are part of the loss caused by the insured damage having happened in the first place.

## Court of Appeal (England and Wales) provides clarity in construction policy coverage



### Our view

The Court of Appeal's decision provides welcome clarity on the meaning of "damage" and the scope of an indemnity under an occurrence-based policy.

Commerciality is central to the Court of Appeal's reasoning. Without clear contractual terms to the contrary, an insured can reasonably expect to be indemnified for damage arising from an insured event during the period of insurance. Additionally, the Commercial Court's interpretation would have resulted in deterioration and damage occurring after the period of insurance essentially uninsurable, including under subsequent cover. Insureds would be placed in the unenviable position of having to choose between undertaking a reasonable but time-consuming investigation at the risk of suffering financial loss from uninsured deterioration damage, or avoiding

uninsured deterioration damage by adopting expensive and urgent solutions that insurers may later contend amount to failure to reasonably mitigate.

The Court of Appeal was careful to make clear that the deterioration damage was a continuation of damage arising from the insured event during the period of insurance. It is therefore distinguishable from cases like *Wasa* where the damage after the period of insurance resulted from separate and continuous occurrences.

The Court of Appeal's decision reaffirms the requirement for insurers to use clear policy wording. Where cover for losses is to be excluded from the scope of the insuring clause, clear wording must be used through the use of exclusions or sub-limits.

The United Kingdom Supreme Court has granted the insurers' application to appeal the Court of Appeal's findings. We await the outcome of any further appeal.

# Brokers find it hard to strike out weak negligence claims

*Norman Hay plc (in Members' Voluntary Liquidation) v Marsh Ltd* [2025] EWCA Civ 58

Authored by Hannah Jaques

The Court of Appeal of England and Wales recently upheld a decision refusing an application by Marsh to strike out a customer's claims alleging a failure to arrange appropriate insurance.

## Background

Norman Hay retained Marsh as broker for various chemical, sealant, and surface coating companies in its group. These companies were located in different jurisdictions and their employees frequently travelled for business.

Norman Hay complained that Marsh failed to arrange worldwide (including United States) non-owned auto cover under the group's travel insurance policy. As a result, one of Norman Hay's subsidiaries had no insurance to indemnify it against liability for a car accident in Ohio involving one of its employees in a hired car. The accident occurred when the employee drove on the wrong side of the road and was tragically killed. Another motorist, who was seriously injured in the accident, brought proceedings against the subsidiary, Norman Hay and others. The claim was settled for USD5.5 million.

Norman Hay had entered into an agreement to divest its subsidiaries, which required it to indemnify the purchaser for the subsidiary's liability to the injured motorist. The settlement sum was deducted from the purchase price for Norman Hay's businesses and paid out of an escrow which had been established under the sale agreement.

Norman Hay then brought a claim against Marsh, alleging that it had been negligent in failing to arrange cover indemnifying Norman Hay and its subsidiaries from liabilities arising from employees' use of hired cars in the United States. It alleged that, had Marsh not been negligent, it would have obtained cover responding to the events or would have acted differently by requiring its employees to take out insurance at the point of hire. Relevantly, Norman Hay's claim did not assert that it was liable to the injured motorist; a pre-requisite to cover under a liability policy.



## Key takeaways from the decision:

In assessing whether a broker's negligence caused loss, the chances of an insurer paying out in the circumstances was not wholly dependent on whether there would have been a valid claim under the policy.

- A court would still need to consider the likelihood of whether the insurer would have paid out in the circumstances, including for commercial reasons – that requires a loss of chance assessment.
- We expect that more claims will be settled due to the greater uncertainty introduced by the loss of chance approach.
- Because of their intensely factual nature, such claims will rarely be appropriate for strike-out or other summary dismissal procedures.
- New Zealand courts are likely to be more hesitant to apply loss of chance principles in light of appellate authority. New Zealand, although the relevant cases have not been decided in the context of a claim for breach of broker's duties.

## Case study:

### Brokers find it hard to strike out weak negligence claims

Marsh denied liability, emphasising Norman Hay's responsibility to provide Marsh with all relevant information at placement and renewal. Marsh also said that worldwide non-owned auto cover is not a feature of standard United Kingdom cover, so it was under no obligation to arrange or advise upon such cover.

Marsh applied to strike out Norman Hay's claim on two grounds. The key ground was that any loss suffered by Norman Hay was not caused by Marsh's alleged breach of duty, because a conventional liability insurance policy would only have responded if Norman Hay or the subsidiary was liable to the injured motorist, which Norman Hay did not allege in its claim against Marsh. Norman Hay could not rely on its settlement with the injured motorist as evidence of that liability. Therefore, the putative insurance policy would not have responded. This was the key issue in both the High Court and Court of Appeal.

Marsh's application failed in the High Court. The Judge held that there was a distinction between what the insured must prove in a claim against its insurer under a liability policy and a claim against its broker for negligence. For the latter, it was not necessary for Norman Hay to prove on the balance of probabilities that it was

liable to the injured motorist and thus that the putative policy would have responded. Instead, the correct enquiry was what would have happened had Marsh not been negligent and Norman Hay had presented its claim to its insurer.

The High Court found that a broader enquiry must be undertaken on a loss of chance basis to allow the Court to ask itself whether, realistically, the putative insurer would have engaged with Norman Hay in dealing with the claim and provided an indemnity of some sort.

#### Appeal dismissed

The Court of Appeal also rejected Marsh's application for strike-out. It approved the High Court's analysis that Norman Hay did not need to establish its liability to the injured motorist. That would just be one factor in the hypothetical counterfactual matrix to be assessed on a loss of chance basis.

#### Inadequate pleadings

The Court of Appeal was critical of Norman Hay's failure to provide all the necessary detail of its claim against Marsh. Because Norman Hay had not pleaded in detail the terms of the policy which it claimed Marsh should have obtained, the Court was not in a position to assess the level of cover the

policy would have provided, nor dismiss Norman Hay's claim summarily on the basis that no cover would have been available.

The Court of Appeal accepted Marsh's submission that a conventional liability policy in the United Kingdom will only respond if the insured is actually liable to the third party. It was not willing to assume in this case that the cover Marsh ought to have placed for Norman Hay was a conventional liability policy, but did address the issues on that basis.

#### Causation to be assessed based on loss of a chance principles

In the context of the claim against Marsh, the question for the Court was not whether the putative insurer would have been required to pay the insured, but instead whether they would be likely to do so in the counterfactual where the insured is able to establish a breach of duty by the broker.

The Court held it was a factual question to be assessed on a "loss of chance" basis. Whilst a strong claim against the hypothetical insurer would be sufficient to prove the insurer's likelihood to make the payment, a weak claim against the hypothetical insurer was not on its own sufficient to prove the opposite. Other relevant considerations for an insurer of

high-standing might (for example) include market perception, or the value of its contract with the insured.

Therefore, even assuming that Norman Hay would not have been entitled to insurance cover for the settlement payment, the Court of Appeal was not willing to find that this necessarily prevented it from proving Marsh's alleged negligence caused it to suffer loss.

The application of loss of chance principles took damages from an "all or nothing" assessment to one based on the degree of uncertainty of recovery from the putative insurer.

#### Different causation tests where there is an extant policy rather than no policy

In reaching its decision, the Court of Appeal distinguished existing United Kingdom authority: *Dalamd Ltd v Butterworth Spengler Commercial Ltd*.<sup>1</sup> In that case the insured sued its broker for negligence without first suing its insurer under an existing policy or reaching a settlement.

<sup>1</sup> *Dalamd Ltd v Butterworth Spengler Commercial Ltd* [2018] EWHC 2558 (Comm), [2019] PNLR 6.

## Case study: Brokers find it hard to strike out weak negligence claims

The court held that the insured had to establish on the balance of probabilities that cover was not available under the policy put in place by the broker because of the broker's negligence. It was not sufficient to show that the insurer would have a reasonably arguable defence to a claim under the policy.

Consequently, a different causation burden will apply in the United Kingdom depending on whether the broker's negligence resulted in no policy being put in place or an inferior or inappropriate policy. A claimant in the United Kingdom will have a lower causation burden (loss of chance) if the broker's negligence led to it failing to place any insurance cover for the relevant risk, but a higher causation burden (balance of probabilities) where cover was placed but was inadequate in some respect.

A claimant need only establish that on the evidence there is a real and distinct, rather than merely negligible, prospect of indemnity from an insurer where the loss of a chance approach applies. By comparison, a claimant must show that it is

more likely than not that the insurer would have accepted the claim or otherwise indemnified the claimant under an existing policy.

The Court of Appeal was clear that it was relying on existing loss of chance principles in other professional negligence contexts, such as unsuccessful litigation as a result of a solicitor's negligence. Those authorities provide that, where the issue is what would have happened but for the professional negligence, the claimant should not be required to establish on the balance of probabilities what third parties would have done.

### New Zealand approach

The New Zealand courts may take a different approach to the causation burden, at least at first instance. The application of the loss of a chance approach is narrower in New Zealand than the United Kingdom. In *Strack v Grey* the New Zealand Court of Appeal took the view that loss of a chance should only apply where the third party's decision is unknowable, so that the outcome cannot be determined. That is, it is incapable of proof given unlimited time, resources and evidence. How a putative insurer would have responded to a claim under a hypothetical policy is not incapable of proof. Evidence can be called from insurers in the market to establish what they would have done.

The New Zealand courts will likely still be willing to consider how a putative insurer would have responded to a claim under a hypothetical policy outside of the insurers' pure contractual rights, but on the balance of probabilities.

Despite the possible divergence in approaches here, it seems clear that it will be difficult for brokers to succeed in a strike out in these circumstances.



# Bear-faced cheek

Authored by Andrew Horne



Insurers must guard against fraudulent claims in many forms. Few, however, reach the heights of audacity achieved by a group of people in the United States early last year.

The claim, on its face, seemed straightforward. The unfortunate insured had left their car parked in the driveway of their house at Lake Arrowhead, California, when, late one night, a passing bear entered the car and wrecked the interior. This was not unprecedented. Last year, in the Ontario township of Larder Lake, bears developed a taste for the foam in car seats and wrecked a number of vehicles. But this claim had some unusual features, and when investigators took a closer look, it became clear that it was very odd indeed.

The claimants provided security camera footage which they said clearly showed the bear entering the car and crawling around, damaging the upholstery. The bear showed good taste; the car was a Rolls Royce Ghost. The video did indeed show a large, furry creature entering the car and moving around, clawing at the seats. They also provided photos evidencing scratch marks to the seats and door panels of the cars.

The claim seemed valid.

But the insurer smelled a rat. Something about the video footage looked odd. The insurer instructed investigators to examine the video footage. The investigators had a wildlife biologist review it, who concluded that the footage was not consistent with typical bear movements and that the offending animal was “clearly a human in a bear suit”.

Insurers informed the California Department of Insurance (CDI). “Operation Bear Claw” was initiated. The CDI discovered that two additional claims had been made for damage to cars caused by a bear in the same location, on the same date, 28 January 2024. All of the claims had been supported by video footage from the same security camera. The other two cars were a Mercedes G63 AMG and a near new Mercedes E350. The insurance companies had accepted the claims and paid a total of USD141,000.

On 13 November 2024, the CDI’s Fraud Division executed search warrants at the address. The evidence seized included a bear suit and a set of meat claws that

matched the damage in the car interiors. The evidence was circumstantial, but compelling. Four suspects were arrested and charged with insurance fraud and conspiracy.

What lessons for the insurance industry? Perhaps only that there is no limit to human ingenuity, so we should keep an open mind and be ready to entertain even the most unlikely of possibilities. And perhaps that a Department of Insurance with a well-resourced Fraud Division might be useful.

The video is, of course, available [online](#).

# Speak to our experts



**Andrew Horne**  
Partner

P +64 9 353 9903  
M +64 21 245 1545  
[andrew.horne@minterellison.co.nz](mailto:andrew.horne@minterellison.co.nz)



**Nick Frith**  
Partner

P +64 9 353 9718  
M +64 21 920 292  
[nick.frith@minterellison.co.nz](mailto:nick.frith@minterellison.co.nz)



**Jane Standage**  
Partner

P +64 9 353 9754  
M +64 21 411 728  
[jane.standage@minterellison.co.nz](mailto:jane.standage@minterellison.co.nz)



**Lloyd Kavanagh**  
Partner

P +64 9 353 9976  
M +64 21 786 172  
[lloyd.kavanagh@minterellison.co.nz](mailto:lloyd.kavanagh@minterellison.co.nz)



**Jeremy Muir**  
Partner

P +64 9 353 9819  
M +64 21 625 319  
[jeremy.muir@minterellison.co.nz](mailto:jeremy.muir@minterellison.co.nz)



**Olivia de Pont**  
Senior Associate

P +64 9 353 9738  
M +64 27 202 1400  
[olivia.depont@minterellison.co.nz](mailto:olivia.depont@minterellison.co.nz)



**Hannah Jaques**  
Senior Associate

P +64 9 353 9956  
M +64 21 177 6340  
[hannah.jaques@minterellison.co.nz](mailto:hannah.jaques@minterellison.co.nz)



**Siobhan Pike**  
Solicitor

P +64 9 353 9859  
[siobhan.pike@minterellison.co.nz](mailto:siobhan.pike@minterellison.co.nz)

ANALYSE



PREPARE

PROTECT