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IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
COMMERCIAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13 February 2008

Before:

THE HON. MR JUSTICE TOMLINSON

- -

Between:

STANDARD LIFE ASSURANCE LIMITED	**Claimant/ Part 20 Claimant**
- and -	
OAK DEDICATED LIMITED and others	**Defendants**
- and -	
(1) AON LIMITED **Formerly known as AON GROUP LIMITED**	**Part 20 Defendants**
(2) REYNOLDS PORTER CHAMBERLAIN (a firm)	

- -
- -

George Leggatt QC and Simon Birt
(instructed by **Messrs Ince & Co**) for the **Claimant**
David Railton QC and Tim Lord
(instructed by **Messrs Kennedys**) for the **Insurer Defendants**
Tom Weitzman QC and Peter Ratcliffe
(instructed by **Messrs Holman, Fenwick & Willan**) for the **(1) Defendants**
Derek Holwill (instructed by **Messrs Herbert Smith**) for the **(2) Defendants**

Hearing dates: 19-22, 26-29 November, 3-6 December 2007

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Judgment

The Hon. Mr Justice Tomlinson :

1. In these conjoined actions Standard Life Assurance Limited, formerly the Standard Life Assurance Company, sues its professional indemnity underwriters for the period 1998 to 2001. It also sues its erstwhile brokers Aon Limited, who placed the 1998 to 2001 cover on its behalf.

2. At all relevant times the Standard Life Assurance Company, to which I shall refer hereafter as SLAC, was a mutual society. It has recently demutualised and its business, including its rights of action in these proceedings, has been transferred to Standard Life Assurance Limited, to which I shall refer hereafter as SLAL, pursuant to an insurance business transfer scheme under Part VII of the Financial Services and

Markets Act 2000. A point arises out of that transfer but save in dealing with that discrete point I shall refer to the claimant insured entity as SLAC, as indeed at all times material to the placement of the cover it was.

3. The Defendants in the action against insurers are, with three absentees, the underwriters who subscribed to an insurance policy which provided SLAC with liability cover of £75 million in excess of £25 million for claims made during the period of three years from 15 May 1998 to 14 May 2001. The most notable absentee underwriter not sued is The Independent Insurance Company ("The Independent"). Since July 2001 that company has been in provisional liquidation. As it happens The Independent led the 1998-2001 policy, but its subscription bound no other following underwriters. SLAC has concluded a settlement agreement with The Independent.

4. The background to the claims can be shortly stated. It is what is colloquially known as the mis-selling of mortgage endowment policies which were widely sold in the last 30 years or so of the twentieth century. As is well known these were financial products sold to prospective mortgage borrowers on the basis that their projected maturity value would be sufficient to discharge the mortgagor's outstanding debt to the mortgage lender at the conterminous final repayment date of an interest-only mortgage. As is equally well known many such policies have in the event on maturity realised less than was required for that purpose or are projected to fall short. As a result in large part of regulator driven market-wide enquiry and reassessment, mortgage endowment providers including SLAC have incurred substantial liabilities arising out of what has been determined to be the mis-selling of such policies. The claims underlying these proceedings alone have involved payment to date by SLAC of over £100 million in compensation to over 97,000 investors.

5. On 30 April 2001 SLAC gave notice to the underwriters on the 1998-2001 policy, to which I shall refer hereafter as "the policy", of circumstances which might give rise to claims against it in respect of which SLAC would seek indemnity under the policy. SLAC now claims an indemnity under the policy for the full sum insured. Although the individual claims made by investors in relation to their endowment policies are relatively small, the average payment being well under £10,000, it is SLAC's case that they arise from a single originating cause or source. Summarising, that cause or source is said to be a systemic failure as to the approach on the part of SLAC (and more generally within the financial services industry within the UK) relating to the sale of endowment mortgages, and thus to the sale of mortgage endowment policies. There is said to have been a systemic failure as to the ascertainment and recording of the customer's attitude to risk. The relevance of this is that the policy, as is typical, contains a provision permitting the aggregation of claims arising from or in connection with or attributable to any one originating cause or source. Thus it is that SLAC contends that it may recover from underwriters the full policy limit, since these 97,000 small claims aggregate to produce a total loss of over £100 million, resulting in a claimed recovery of the full £75 million excess of £25 million.

6. Almost every aspect of SLAC's claim is contentious, beginning with the suggestion that notification thereof was late. Underwriters also deny that SLAC has identified or can identify a permissible single aggregating cause or source of the claims. However for present purposes I am concerned with only two of underwriters' defences. Underwriters contend that even if the individual claims arise from a single originating cause or source, a separate excess of £25 million applies to each individual claim

because they were made by different individual claimants. In support of this contention underwriters rely upon the fact that the excess is described in the Schedule to the policy as £25 million "each and every claim and/or claimant". Insurers argue that the words "and/or claimant" in the Schedule have the effect that a separate excess of £25 million is applicable in respect of each one of the 97,000 claimants. Underwriters also put SLAL to proof that the Part VII transfer has been effective to vest in it a cause of action. By the end of the trial this had become a positive averment to the effect that the Part VII transfer had had the unintended consequence that neither SLAC nor SLAL enjoy any relevant rights of action against underwriters.

7. In the separate action against the brokers, Aon, SLAL claims damages from Aon in respect of any sums which SLAL is not able to recover from the underwriters under the policy. It is SLAL's case that, whatever the true construction of the policy, Aon was in breach of duty in arranging insurance cover which did not clearly and indisputably meet its client's requirements and which has provoked this litigation.

8. Aon claims damages in turn from Messrs Reynolds Porter Chamberlain, a firm of solicitors who in November 1999 were asked to review the policy wording and who advised thereon in December of that year. Although I am for present purposes not directly concerned with this further claim, it is only right that I should point out straightaway that it is not suggested that Messrs Reynolds Porter Chamberlain were specifically asked to advise on the wording in the schedule to the policy with the effect of which I am immediately concerned. However the advice of Messrs Reynolds Porter Chamberlain is relied upon indirectly in this action by Aon as being supportive of its contention that it was not itself negligent in the manner alleged.

9. Cresswell J directed that the "Insurer Action" and the "Broker Action" should be managed and tried together, with disclosure and evidence in each to stand as disclosure and evidence in the other and findings to be binding in both actions. He also directed that there should be a staged trial, with certain issues to be tried in Stage 1 and all other issues to be tried as Stage 2 after determination of Stage 1.

10. The Stage 1 issues which remain live and which I must determine are, broadly:

    1) The transfer issue (Issues 1 and 9)

    2) The construction issue, i.e. whether the policy permits aggregation of claims by different claimants against SLAC arising from or in connection with or attributable to any one act, error, omission or originating cause or source (Issue 3)

    3) The liability of Aon, (Issues 11-14, 17 and 18) specifically:

        a) Whether Standard Life required cover against liability for claims which in their nature were individually likely to be well under the policy excess of £25 million but which together exceeded that figure, where such claims arose from or in connection with or were attributable to any one act, error, omission or originating cause;

        b) Whether Aon understood that Standard Life required cover as set out above;

c) The nature and extent of the contractual and tortious duties owed by Aon to Standard Life;

d) Whether Aon was in breach of duty or negligent in and about the placement of the policy;

e) Causation: if Aon had not been in breach of duty, then:

i) Would Standard Life have instructed Aon to obtain cover of the kind it required (that is, without the words "and/or claimant" in item 4(ii) of the schedule to the policy)?

ii) Would Aon have been able to obtain such cover at a premium acceptable to Standard Life?

iii) Would Standard Life have been able to recover under such cover in respect of the sale of endowment policies?

f) Whether such liability as Aon may have to Standard Life is to be reduced by reason of the contributory negligence of Standard Life – (Issue 17);

g) Whether Standard Life's claim is time-barred.

11. When Cresswell J gave this direction there was, very significantly, a further Stage 1 issue which was whether, if the policy on its true construction permitted aggregation of claims by different claimants, SLAC was nonetheless estopped or otherwise precluded from so contending. There was said by underwriters to be an estoppel by convention to that effect arising out of what transpired on the placing of the renewal of the policy in May 2001. It was no doubt in the light thereof that Cresswell J declined Aon's invitation to direct that there should in the first instance be a trial simply of the question of construction. Having decided that the estoppel issue should be tried at Stage 1 also, it was natural further to include in Stage 1 the other issue or issues on which evidence from the brokers seemed potentially relevant, viz the question whether Aon had been in any respect negligent in discharging its duties.

12. The estoppel argument was abandoned very shortly before there took place before me on 9 October 2007 an interlocutory hearing one purpose of which was to seek its striking out. For the reasons I then gave I did not feel able at that stage simply to rule as inadmissible, as I was invited to do, the evidence, other than expert evidence, which the underwriters then intended to adduce at trial. Although I did not then have it in mind, the history of the litigation in *ProForce Rugby Recruit Limited v The Rugby Group Limited* [2006] EWCA Civ 69 and [2006] EWHC 1621 demonstrates that the court is sometimes better placed at trial than on an interlocutory application to rule on questions as to the admissibility of evidence said to be relevant to a disputed question of construction. The hearing before me on 9 October at least achieved the result that the underwriters thought better of their attempt to call ten or twelve witnesses whose main contribution it seemed would be to give to the court the benefit of their understanding of what the contractual words meant. That notwithstanding, as was wryly observed by Mr Tom Weitzman QC for Aon in his closing address, more time was spent at trial in examining the circumstances in which cover was placed in

1995 (and indeed in 1996 and 1997) than in examining the circumstances of the more immediately relevant 1998 placement. This was of course done under the guise of examining the factual background or matrix in the light of which the 1998 policy falls to be construed. At the outset of the trial Mr David Railton QC for the underwriters sought leave to introduce, by way of further amendment, a yet further argument to the effect that there arose out of the 1995 placement a common understanding between the leading underwriter and the placing broker as to the meaning of the "and/or claimant" language in the policy and that this common understanding or assumption was in turn part of the relevant background circumstances in the light of which the 1998 policy falls to be construed. I rejected this application for the reasons which I gave on the second day of the trial. However the circumstances in which the relevant wording was first introduced continued to be prayed in aid as going to the genesis or origin of the words.

13. The upshot is that the court has heard a good deal of evidence which was of at best dubious admissibility on the issue of construction. Whilst that has extended the length of the trial, it has obviated the need for further time-consuming argument on the bare question of admissibility. Furthermore I have in consequence of hearing the evidence been able to form clear conclusions as to its, for the most part, lack of relevance and inability to assist the court in its task of construction. Some of the evidence was relevant to the question on what terms cover was available in the market in 1998, an important issue in the event that I decide that the cover is in fact limited in the manner for which underwriters contend. The question then arises whether and if so on what terms cover not so limited could have been obtained by SLAC. Moreover, some of the evidence also cast clear light upon the role played by Aon. In the event Aon did not dispute that it understood that SLAC required cover against liability for claims which in their nature were individually likely to be well under the policy excess of £25 million, and indeed under the policy excess which obtained before 1998, £2.5 million, but which together might exceed that figure where such claims were capable of aggregation. Aon accepted not just that it never suggested to SLAC that such cover had not been obtained, Aon accepted that it had on many occasions advised SLAC positively to the effect that such cover had been obtained. In the circumstances Aon took the line that the brokers actually involved in placing the cover on SLAC's behalf during the period 1995-1998, principally Mr de Zulueta and Mr Castle, had no evidence of any relevance to give and it did not call them. These gentlemen were in fact no longer employed by Aon but it was not suggested that they were for that reason unavailable to be called. Evidence from the sole Aon witness, Mr Wood, was however to the effect that Mr Castle "did not necessarily leave Aon with a good taste in his mouth". Mr Castle is apparently still in the London market and it is my understanding that Mr de Zulueta is also. Aon's stance was portrayed as, depending upon counsel's viewpoint, either principled or cynical. Mr Railton and Mr George Leggatt QC for the Claimants naturally invited me to infer that Mr de Zulueta and Mr Castle could have given no evidence of assistance to Aon. In fact the advice which they gave to their clients SLAC emerged clearly from the documents. Unless they are to be regarded as having acted in bad faith, which no-one suggested they should be, it is obvious that they must have thought that they had carried out their client's instructions. No doubt Aon would have called them had it thought that they had evidence to give which would arguably be helpful in the contest with underwriters. In the event however no such hostages to fortune were given. This left

some gaps in relation to which at trial both counsel and the court resorted to speculation. I shall refer to these one or two episodes in more detail in due course.

The cover

14. The cover is contained in Policy No. 823/FB9804867. It is described as a Financial Institutions Claims Made Comprehensive Insurance. The insuring clauses provide two broad classes of cover, traditionally designated by the market as professional indemnity and crime insurance, the latter sometimes called "bankers' bond". In the year in question underwriters for their own purposes allocated the premium as being equally divided between the two classes of cover – in earlier years that had not always been so. I do not suggest that this is of any relevance to the construction of the policy. What is however arguably relevant is that the professional indemnity cover is cover in respect of third party loss initially suffered by a third party claimant whereas the "crime" cover is in respect of what is sometimes called first party loss, i.e. loss directly suffered in the first instance by the assured itself. The policy included the following provisions:

> "INSURING CLAUSES
>
> A. LEGAL LIABILITY AND FINANCIAL LOSSES
>
> We the Underwriters agree, subject to the Terms, Exclusions, Limitations and Conditions below, to indemnify the Assured against:
>
> 1. their LEGAL LIABILITY for compensatory damages and costs arising directly from any Claim or Claims first made against the Assured within the Period of Insurance arising by reason of:
>
> a) any negligent act error or omission, breach of contract or any breach of professional duty;
>
> b) any dishonest or fraudulent act or omission;
>
> c) any breach of statutory duty, including but not limited to breaches of Section 5 and Section 62 of the Financial Services Act, or the application of any statutory provision insofar as it gives rise to civil liability;
>
> …
>
> 2. FINANCIAL LOSSES directly incurred by the Assured by reason of any of the following insured events discovered within the Period of Insurance:
>
> a) Costs and expenses incurred by the Assured, with the written consent of Underwriters (such consent not to be unreasonably withheld) in representation at, or in connection with any official investigation examination or proceedings ordered or commissioned by any official

or regulatory body in which the affairs of the assured or of any Director, office, employee or agent of the Assured are the subject of investigation, including liability to comply with a restitutionary order, insofar as it is not within the power of the Assured by proceedings or otherwise to account for or to recover the money or property the subject of such Order;

…

c) The Assured's inability to complete transactions, or other legal liability, by reason of the physical loss, destruction or theft of or damage to Documents, securities and cash or due to the forgery or theft of securities in which the Assured is dealing and/or due to any deception of the Assured as to the identity of any person for the purposes of buying or selling stock;

d) Any dishonest, fraudulent or malicious act or omission by any past or present, officer, employee or agent of the Assured or of their agents or their predecessors in business, including but not limited to theft, abstraction or other improper appropriation of money or any Documents belonging to the Assured, or for which the Assured are legally liable;

…

LIMIT OF INDEMNITY

The total liability of Underwriters under this Policy shall not exceed the Limit of Indemnity specified in item 4(i) of the Schedule in respect of all Claims, Losses, costs and expenses covered under this Policy and any extensions to this Policy subject always to any sub-limits as specified in the Memoranda attached hereto.

REINSTATEMENT OF INDEMNITY

The amount of reduction in the aggregate limit of indemnity by reason of any Claim, Loss, costs or expenses the subject of indemnity hereunder will be reinstated without payment of additional premium, but such reinstatement shall apply only after the whole limit of indemnity of this Policy (but not any policies affording aggregate cover in excess of this Policy) has been exhausted and only in respect of payments which are totally unrelated to the payments which gave rise to such reduction. Furthermore the liability of the Underwriters for any one Claim or Loss shall not exceed the Limit of Indemnity stated in item 4(i) of the Schedule AND the maximum amount

payable hereunder in respect of any one Period of Insurance is limited to twice such limit of liability.

EXCESS

In respect of each and every Claim and/or Loss the amount as specified in item 4(ii) of the schedule which amount shall be inclusive of costs incurred in the investigation, defence or settlement of any Claim or Loss under the Insuring Clauses hereof, shall be borne by the Assured at their own risk or by captive arrangement as the case may be, and Underwriters shall only be liable to indemnify the Assured in excess of such amount.

GENERAL CONDITIONS

1. The Corporate Risk Department of the Assured shall give to Underwriters immediate notice in writing of:

   i) any Claim made against the Assured where the sum claimed is clearly stated to be in excess of sixty per cent of the applicable excess or is likely to exceed that figure in the experience of the Corporate Risk Department of the Assured.

   ii) the discovery of any loss or circumstance or loss which may give rise to a claim, or the receipt by the Corporate Risk Department of the Assured of notice from any person of any intention to make a claim as specified in (i) above.

   'Immediate' in this context shall be deemed to mean as soon as Standard Life Assurance Company Corporate Risk Department become aware of any situation.

2. In the event that anything specified in (i) or (ii) above occurs but that it is not possible to determine the likely amount of the claim or loss, it is understood and agreed that Underwriters hereon grant the assured the authority to investigate such claim or loss.

3. The Corporate Risk Department of the Assured shall notify half yearly all claims, losses or circumstances irrespective of Conditions 1 and 2 above. Failure to notify on such bordereaux will be a breach of policy conditions.

   Provided the Corporate Risk Department of the Assured shall give to Underwriters notice as required herein, any claim subsequently made against the Assured or loss subsequently discovered by the Assured arising out of the circumstance so notified shall for the purposes of this

> policy by deemed to have been made or discovered during the Period of Insurance. …
>
> DEFINITIONS
>
> …
>
> 3. 'Claim' shall mean each Claim or series of Claims (whether by one or more than one Claimant) arising from or in connection with or attributable to any one act, error, omission or originating cause or source or dishonesty of any one person or group of persons acting together and any such series of Claims shall be deemed to be one Claim for all purposes under this Policy.
>
> 4. 'Loss' shall mean each and all loss arising from or in connection with or attributable to one original cause or source or the dishonesty of any one person or group of persons acting together, and all such Loss shall be deemed to be one Loss for all purposes under this Policy.
>
> …
>
> EXCLUDING PENSION TRANSFERS
>
> It is hereby noted and agreed that this policy excludes any claims or losses arising out of advice given or action taken in respect of Pension Transfers and/or Opt Outs from occupational pension schemes prior to the 15th May 1994."

The schedule is a single page in box layout form, the principal function of which has been aptly described by Mr Leggatt as to specify names, addresses, dates, amounts and other details which may change from year to year. Box 4 contains the following:

> "4.(i) Limit of Indemnity: £75 million any one claim and in the aggregate including costs and expenses (plus one direct reinstatement)
>
> (ii) Excess, including Costs and Expenses: £25 million each and every claim and/or claimant including costs and expenses."

15. It is the words "and/or claimant" in Box 4 of the Schedule upon which underwriters rely as importing into the cover a limitation that in order to be recoverable there must be a claim by a single claimant which exceeds the policy excess. Mr Railton accepted that a series of claims made by a single claimant could properly be aggregated, provided of course that the insured is able to identify an appropriate unifying cause or source. However in the context of mass retail claims of the type in respect of which SLAC seek an indemnity, it is virtually inconceivable that a single claimant could have either a single claim of more than £25 million or indeed a series of related claims aggregating to an amount in excess of £25 million. The evidence demonstrated beyond any shadow of doubt that the principal exposure of SLAC to liability which

would potentially rank for indemnity under a professional indemnity policy was in relation to mass retail claims. Naturally it had other exposures, including potentially arising out of its management of company pension schemes and similar activities. There is however no real doubt but that the principal source of risk on the professional indemnity side to a company such as Standard Life would have been identified in 1998 by insurance market professionals as being its exposure to mass retail or consumer claims. Such claims would be in relation to some perceived shortcoming in its financial products or the manner in which they were marketed. That was also SLAC's own perception and was the principal driver in its seeking professional indemnity cover. It follows that if the underwriters' construction of the cover is correct the cover was of very little use to SLAC. That is not in itself a reason for rejecting underwriters' construction. However the fact that on underwriters' construction the policy excludes cover for what insurance market professionals would identify as the insured's principal risk of exposure is certainly a consideration which it is appropriate to bear in mind when approaching the task of construing the cover. Before I approach that task I must first sketch in the remainder of the background material in the light of which the cover falls to be construed.

Background

16. It was naturally common ground that the proper construction of the policy should be discerned from the words used, giving to them the meaning which they 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 making of the contract, and which would have affected the way in which the language of the document would be understood by a reasonable man – see *Investors Compensation Scheme v. West Bromwich Building Society* [1998] 1 WLR 896 per Lord Hoffmann at pages 912 to 913. This includes such factual background knowledge as the parties had at or before the date of the contract, including what can be described as the "genesis" and objectively the "aim" of the transaction – see per Lord Wilberforce in *Prenn v. Simmonds* [1971] 1 WLR 1381 at 1385. Thus the admissible background undoubtedly includes the nature of SLAC's business, which was in any event comprehensively described in the Proposal Form, and the nature of the professional indemnity risks to which the parties could reasonably have anticipated SLAC's business would give rise. That in turn involves at any rate a working understanding of the regulatory regime introduced by the Financial Services Act 1986, to which express reference is made in the relevant insuring clause. The reference there to section 62 is itself significant and relevant. I shall return thereto in the context of the regulatory regime more generally.

17. I must first describe SLAC's business. At the relevant time Standard Life was a mutual society, constituted under the Standard Life Assurance Company Act 1991. Since it was established in 1825, by far the largest part of Standard Life's business has always been, and was in 1998, the provision of life assurance, annuities and pensions. Standard Life also provided health insurance policies, investment management services and some banking services. In the 1998 Proposal Form, the "type of Company" was stated as "Mutual Life Assurance Company" and Standard Life's activities were described as follows:

> "The Group transacts life assurance, annuity and health insurance business. Management services for pension funds

> are provided in the UK by Standard Life Pension Funds Limited and in Canada by Standard Life Portfolio Management Limited. Standard Life Trust Management Limited and Standard Life Fund Management Limited act as managers for a range of authorised unit trusts."

The information in the Proposal Form also demonstrated that most of Standard Life's income derived from its volume consumer business, i.e. the sale of life policies, annuities and pensions. Management services for pension funds and unit trusts accounted in total for only 0.3% of the group's income. Standard Life's annual report for 1997 clearly demonstrates a consumer focussed business. It is right to say therefore that SLAC's business consisted mainly of the sale of retail financial products to consumers. I have already referred to the perception of insurance market professionals that this would be where the principal exposure of a company such as SLAC would lie. It is right to recognise however that there were other professional indemnity risks to SLAC which could give rise to a catastrophic liability. These would include pension fund mismanagement, systemic administrative error involving the two tied agencies, Halifax Building Society and Bank of Scotland, misappropriation of funds, rogue fund transfers and, relevantly for this three year policy placed in 1998, Year 2000 disaster possibilities such as the loss of computerised investment records. Mr Stretton, SLAC's Chief Executive Officer at the relevant time, defined a catastrophe for SLAC as "any event or series of events which could either (a) lead to losses which would cause a step decrease in the rate of bonus addition to our with-profits policies, or (b) result in serious disruption to our services to clients". SLAC was in 1998 a financially strong institution and would have been so perceived in the market. I doubt if the market would have defined what for SLAC would be a catastrophe in quite the focussed way in which Mr Stretton did. However any market professional faced with a financial institution such as SLAC seeking professional indemnity (and crime) cover with an excess pitched at £25 million would readily appreciate that what was sought was perceived by the insured as catastrophe cover.

The Financial Services Act and the regulatory regime

18. The Financial Services Act 1986 brought about a sea change in the environment in which financial institutions such as SLAC operated. Central to that transformation was section 62 of the Act which opened up the prospect of financial institutions attracting liability in the absence of negligence. This led to the development of new professional indemnity policy wordings such as the wording with which I am concerned with its express reference to section 62. The wording is an amended form of the "Sentry" wording developed by specialist brokers, Special Risks Services Limited ("SRS") in the late 1980's with the assistance of Messrs Reynolds Porter Chamberlain. This wording was specially designed to cater for the risks faced by financial institutions.

19. The Financial Services Act introduced regulation of the sale and marketing of investment products, including personal pension policies. Under the regime established, the Securities and Investment Board (the "SIB") was the top layer of regulation, which supervised a number of Self-Regulatory Organisations ("SROs"). The SROs had responsibility for regulating the sale of such products. These included LAUTRO (Life Assurance and Unit Trust Organisation), FIMBRA (Financial

Intermediaries, Managers and Brokers Regulatory Association) and IMRO (Investment Management Regulatory Organisation). In July 1994, the Personal Investment Authority (the "PIA") took over many of the responsibilities of LAUTRO and FIMBRA. The SROs had various disciplinary powers, including the ability to impose fines.

20. Section 62 of the Financial Services Act established a claim for breach of statutory duty for breach of rules or regulations. Sub-section (1) provided that a contravention of (among other things) any rules or regulations made under Chapter 5 of the Act ("Conduct of Investment Business") would be actionable at the suit of a person who suffered loss as a result of the contravention. Sub-section (2) extended this to a contravention of the rules of an SRO by one of its members (in circumstances in respect of which rules or regulations had been or could have been made under Chapter V).

21. Section 62 was confined, by section 62A, to actions brought by a "private investor" save as provided in regulations. The regulations made under this section confined a "private investor" to individuals (but not when in the course of carrying on investment business) or other persons (but not when in the course of carrying on any business). There were limited circumstances under Regulation 3 where an action could be brought by someone who was not a private investor.

22. The regulatory framework imposed on financial institutions obligations not only in respect of the advice given by the representative selling a financial product or otherwise dealing with an investor, but also obligations in respect of the financial institution's own procedures. These included obligations to keep proper records and to have adequate arrangements to ensure that representatives were suitable, properly trained and supervised and had well defined compliance procedures etc.

The Pensions Review

23. An early manifestation of the way in which the environment in which financial institutions operated had changed was the "Pensions Review". This was a review exercise imposed by the regulator SIB in relation to alleged pension mis-selling. Between April 1988 and June 1994 hundreds of thousands of individual investors had received advice in relation to occupational pension schemes. The purpose of the Pensions Review was to determine whether individual investors ought to be compensated for losses as a result of advice that they should:

- transfer deferred benefits from an occupational pension scheme to a personal pension policy (so-called "Transfer Cases"); or
- opt-out of an occupational pension scheme in favour of a personal pension policy (so-called "Opt-Out Cases"); or
- effect a personal pension policy rather than join an occupational pension scheme (so-called "Non-Joiner Cases").

The Pensions Review continued until June 1998. Financial institutions which had made what was regarded as inadequate progress in reviewing their cases were "named and shamed" in Parliament by the Economic Secretary to the Treasury. Typical

redress varied between about £3,000 and £10,000 with the average being just over £5,000. There were perhaps three features of this exercise which are and were of particular significance to the professional indemnity insurance market. Firstly, it involved a financial institution being obliged to investigate all of its relevant transactions and, where appropriate, to advise its own customer of his or her entitlement to redress. An institution could not wait for a complaint to be made. Secondly, the purpose of the review was to ascertain whether in any case the advice given had been compliant with the institution's relevant duties. Those duties were as prescribed by the various regulatory bodies in their rules. The perception in the industry, which was well-understood in the professional indemnity insurance market, was that the criteria by reference to which institutions were required to assess their own compliance were for the most part criteria which had been introduced subsequent to the transactions in question. Market professionals who gave evidence in this trial routinely referred to this as the regulator moving the goalposts. Thirdly there was a particular emphasis placed upon training and documentation. By 1997 most institutions were conceding non-compliance in the substantial majority of cases not because they considered that their advice or pension sale was necessarily non-compliant with the relevant regulatory rules on suitability of advice but because, in most cases, there was insufficient documentary evidence on file to demonstrate compliance. Non-compliance was presumed in such cases.

24. The impact on the insurance market was two-fold. Firstly, it became general practice that the professional indemnity insurance of financial institutions excluded cover for what, by way of shorthand, was referred to as any claims or losses arising out of any advice given or action taken in respect of Pension Transfers and/or Opt-Outs from occupational schemes. This was certainly general practice by 1998 – the evidence in fact demonstrates that it became general practice much earlier. The wording to achieve this exclusion obviously varied. The wording set out above in SLAC's 1998 policy in fact appeared in their 1994/95 policy placed on 13 May 1994, which as it happens was the first occasion on which SLAC purchased professional indemnity cover. Sometimes policies specifically identified the review of transfers and opt-outs from occupational pension schemes conducted by the SIB and/or PIA and/or LAUTRO and/or FIMBRA and/or IMRO. Secondly, the Pensions Review obviously indicated both to the financial institutions and equally to the professional indemnity insurance market that other products could be subject to a similar regulatory review, with the potential for another regulator-driven claims process. The best articulated manifestation of this concern, at any rate in the evidence deployed at this trial, is to be found in a Technical Services Bulletin issued by Sun Alliance on 14 October 1996. That said, the evidence demonstrated that Sun Alliance was not at about this time a prominent participant in the Financial Institutions market and certainly not a leader in the field. I do not suggest that the approach advocated by first Sun Alliance and then by the Royal and Sun Alliance was typical, although the problem which they identified is of course that which confronted all participants in the market, whether leading or otherwise. Sun Alliance participated in the SLAC cover in 1994/95 and 1995/96. In 1996/97 they were dropped from the primary cover (and the lineslip pursuant to which it was written) on account of their insistence, made known some months before circulation of this Bulletin, on an excess written on an each and every claimant basis across the board. For this stance they were castigated by SLAC's then broker Mr de Zulueta as being "a blasted nuisance". This irony is of no relevance to the construction of the policy. It is of more, although ultimately little relevance to the

claim against Aon, and it should perhaps be borne in mind when attempting to reconstruct what may have happened in earlier placements, insofar as that is of any relevance. The Sun Alliance Technical Services Bulletin was entitled "Professional Indemnity Insurance 'Low-Cost' Endowment Mortgages". There was then a Management Summary in these terms:

> - "The potential for claims arising from the underperformance of investments supporting 'low-cost' endowment mortgages is becoming increasingly apparent, with considerable press comment and the prospect of intervention by regulatory bodies.
>
> - We need to take pre-emptive action to protect our account against the possibility of a high volume of claims from this source.
>
> - The professions affected are those which provide 'low-cost' endowment mortgages or give advice on them; they include accountants, surveyors, financial advisers and building societies.
>
> - The action to be taken includes the application of aggregate inner limits and increased excesses on those risks, whether New or Existing Business, where there has been an involvement in 'low-cost' endowments during the last ten years."

Apart from directing supplementary questionnaires to be issued to life assurance companies together with their renewal documentation, the Bulletin discussed the need to protect the account by the possible imposition on Building Society insureds of an overall excess of between £10,000 and £25,000 per claimant. A follow-up issued on 21 January 1997 by the then Royal and Sun Alliance was in these terms:

> "RE PROFESSIONAL INDEMNITY – 'LOW-COST' ENDOWMENT MORTGAGES
>
> Portfolio Assurance Bulletin No. PA/13/96 introduced guidelines on the action to be taken on risks with an exposure to claims arising from the provision of, or advice in connection with 'low-cost' endowment mortgages.
>
> Where advice in connection with 'low-cost' endowment mortgages has been provided and we have obtained a completed Supplementary questionnaire, we need to include an endorsement on the Policy which applies
>
> - an inner Limit of Indemnity on an aggregate basis
>
> - a per claimant Insured's contribution

> so that we all maintain a consistent approach to the application of this restricted cover, the following endorsement should be used, using the SACS freeform facility:
>
> Restricted Low Cost Endowment Mortgage Cover
>
> In respect of any claim or claims arising out of the provision of or advice in connection with 'low-cost' endowment mortgages
>
> A) the liability of the Company for damages and claimant's costs and expenses arising out of all claims notified during any period of Insurance shall not exceed £…
>
> B) the Insured's contribution is £… each and every claimant.
>
> The amount of the inner Limit of Indemnity and Insured's Contribution will be determined on a case by case basis by National Portfolio with due regard to
>
> - specific regulations applying, for example in respect of the maximum permitted Insured's Contribution
>
> - degree of exposure (the number and value of endowment mortgages)
>
> - size of firm."

It is to be noted that this approach does not appear to contemplate the total exclusion from cover of all such claims but rather is an approach geared to the circumstances of the particular insured. Furthermore the evidence demonstrated that by 1998 the concerns which undoubtedly there were in relation to mortgage endowments had not reached a level at which either possible claims were notified or specific exclusions were sought to be introduced as had been done in relation to the occupational pension scheme issue.

25. In the early 1990's the financial institutions market and the professional indemnity market were relatively distinct, but as the decade progressed the boundaries became less distinct. This was no doubt due in large measure to the soft, and softening, market conditions which prevailed between 1993 and 1998. These conditions persisted for another two or three years after that, with only modest signs of recovery in 2001. During this period there was massive overcapacity in both the financial institutions and the professional indemnity markets. There was competition both at Lloyd's and in the companies market for these risks, which were often heavily oversubscribed. It was a buyer's market, with rates falling and the breadth and limits of available cover increasing. The fact that in 1998 SLAC secured a three year deal was itself symptomatic of the extremely soft market, although it should be recognised that multi-year deals were at this time also popular in view of the fact that their wording would not it seems generally reflect (by exclusion) the Year 2000 implications about which there was of course some concern. Aon was in 1998 one of the major brokers in both the financial institutions and the professional indemnity markets. Any underwriter in this field would be keen to be shown their business. The

ability of a broker of Aon's size and influence to take advantage of a soft and still softening market is obvious and was acknowledged in the evidence. Furthermore not only was competition cut-throat in these markets but also The Independent through its financial institutions and professional indemnity underwriter Mr Terence Kerrison was aggressively seeking to establish itself as a leader in this class of business. It was Mr Kerrison who led the 1998 policy. Although Mr Kerrison bound no-one else, it is usually the case in a soft market that the following market will accept the leader's terms.

26. So far my description of the relevant market conditions in 1998 has I think been non-controversial. I must however resolve a dispute about the nature of the cover generally available in 1998 to financial institutions in respect of which there was a perceived exposure to mass retail claims. This is not intended to be pre-emptive of my conclusion as to the proper construction of the policy. In his first report the underwriters' expert witness, Mr Anthony Millard, said this:

> "My impression and recollection of the market at the time is that, for relevant clients with exposure to the effects of the pensions review and similar mass retail claims, if there was the absence of the word 'claimant' from the excess definition of a policy it is likely to have been an inadvertent omission on the part of underwriters rather than a deliberate conscious desire to include such mass retail claims coverage in their contracts."

In the experts' joint memorandum prepared after discussion with his opposite number the point as to cover available in the relevant period i.e. after 1994 and in 1998 was put succinctly in this way:

> "It is Mr Millard's opinion that coverage without a 'claimant' deductible was not available where a mass retail claims issue was perceived or observed."

This view was unsustainable and in fairness to Mr Millard he qualified it after there was produced by Aon on an anonymised basis all the financial institutions covers placed by them in the relevant period. However he continued to maintain that for the period in question coverage without a 'claimant' deductible or other limiting factor was not commonly available where a mass retail claim issue was perceived or observed. He also suggested that cover which permitted the aggregation of mass retail claims would attract a premium of in the order of 10-15% of the sum insured. Mr Millard's evidence was in my view advanced with rather greater confidence than was justified by his experience, which in the relevant field was limited. He had been a financial risks underwriter for only four years between 1994 and 1998 and has essentially since that time been pursuing wider interests.

27. The material disclosed by Aon of itself demonstrated that even Mr Millard's modified views were unsustainable. That material was to some extent unsatisfactory because it did not include all placement materials and there may well have been factors not referred to in the documents disclosed which in some way mitigated the effect of cover being granted on a per claim basis. I should clarify that although anonymity was preserved in the public forum of the court, I was supplied as were counsel and the witnesses with versions of the documents which revealed the identity of the insured.

It was therefore possible to evaluate to what extent one was dealing with institutions comparable to SLAC. These policies showed that other financial institutions, including comparable institutions with a similar risk profile so far as concerns mass retail claims, were able to purchase cover with per claim excesses. There was no example of the unequivocal imposition of a per claimant deductible applicable to the whole cover so as to prevent aggregation generally. There was however a standard form wording, the so-called PIA Ombudsman extension, which imposed a per award excess. This wording was incorporated into some but by no means all of the policies placed by Aon. The level at which the excess was pitched varied, but since the maximum award which could be made by an Ombudsman was for £50,000, and the provision envisaged that there would be indemnity in respect of awards, it is obvious that the deductible would be at a relatively low level. One example was £1,000 or £2,500 depending on the type of activity involved and the identity of the assured within a larger group – another was £5,000. An excess of £5,000 would have been effective to exclude many mass retail claims, but of course not all such claims are pursued through the medium of the PIA Ombudsman. One Building Society cover had a per claimant excess which applied only to claims in excess of £10,000 which then aggregated to go to erode an annual aggregate of £250,000 upon exhaustion of which the underwriters would not be liable for the first £10,000 of any further claim by any one claimant. Thus if there were no claims over £10,000 the annual aggregate would never erode and the per claimant deductible would never become applicable. On the assumption that this policy permitted aggregation of related claims (the full wording was unfortunately not produced) such claims would be recoverable in excess of the £250,000 deductible. In two cases of striking comparability with SLAC cover was placed with a deductible on a per claim basis. Aggregation of related claims was permitted. In the first example the excess was £10 million. In the second it was £100,000, although in that case there was also a PIA Ombudsman Endorsement the terms of which I have not seen. In no case shown to the court was the premium anywhere approaching 10 to 15% of the sum insured. In every case the premium was orders of magnitude removed from such a sum.

28. It follows that I cannot accept as reliable or accurate Mr Millard's recollection and reconstruction as to the market's response to the perceived risk of further regulator driven mass retail claims in fields other than pension mis-selling, where the risk had of course already manifested itself. I also heard evidence from Mr Malcolm Warrington for SLAC. He worked full time in the London insurance market from 1962 to 2003 and still has a consultancy and advisory role. For very many years he was principally concerned with the writing of cover for financial institutions or with the reinsurance thereof. His evidence commanded respect. It confirmed that at the relevant time coverage without a per claimant deductible was readily available. Insurers' concern was not so much with the total exclusion of an obvious risk to which their insureds were exposed but rather with the possibility that an attempt might be made to aggregate such claims in reliance on, as they saw it, spurious connecting factors. Such factors would have their roots in regulatory compliance failures rather than focussing on the extent to which there could be identified some more traditional common cause or origin such as a clear single event or a repeated mistake. It was not he thought the desire of underwriters, who were after all in the business of accepting risk, to exclude their obligation to indemnify in circumstances where they recognised that related claims could properly be aggregated. The adoption of a straight across the board per claimant deductible is a blunt instrument which

would if pitched at a level in excess of tens of thousands of pounds effectively exclude all claims by customers to whom products were sold, including those claims which insurers recognised as in principle an appropriate subject matter of insurance. Mr Warrington's evidence was powerfully corroborated by the evidence of Mr Mark Wood. He is now Chairman of Aon's Financial Services Group and Professional Services Group. In 1998 he had been a Managing Director (there was apparently more than one) of Aon's Financial Institutions and Professional Risks Division. Although not called as an expert witness he was well qualified to give evidence as to the basis upon which at the relevant time business was in his experience written. Whilst Mr Railton did not cross-examine Mr Wood at the length or in precisely the same manner as he cross-examined Mr Warrington he was not in reality inhibited in putting his case to Mr Wood by reason of his status as a witness of fact. It would be unrealistic to ignore the evidence of so well qualified a witness as Mr Wood, particularly where he gave his evidence with conspicuous clarity and depth of understanding, and moreover in an important respect in a manner adverse to the interests of his employer Aon who called him.

29. My conclusion based on the evidence of Mr Warrington, on which I regard Mr Wood's evidence as at the least a useful cross-check, is that at the relevant time there was simply no common market approach or market practice so far as concerned financial institutions with an obvious exposure to mass retail claims, and in particular no common approach which involved adoption of a per claimant deductible in order effectively to exclude all such claims from the scope of insurance cover granted. Some underwriters may have attempted to introduce such a deductible and for that purpose, but in general they did not succeed. Their lack of success can be attributed to at least two factors. One is the exceptionally weak market. The other is the fact that a straight across the board per claimant deductible, pitched at a relatively high level, *a fortiori* at £25 million, is an inappropriately blunt instrument with which to effect a targeted limitation of liability, which can be more appropriately accomplished with suitably specific exclusionary wording.

The history of the cover

30. I propose next to deal with the history of the cover. The parties were most helpfully able to agree a short history of the placement of the cover which I have largely reproduced in the next 31 paragraphs. I have made certain additions in what are now paragraphs 31, 37, 38, 47 and 61. The Schedule to the Agreed History, which sets out the premium for each policy to which reference is made, should be regarded as an annex to this judgment.

31. The relevant cover was first placed on behalf of SLAC in May 1994 by brokers, Special Risks Services limited ("SRS"). It was then renewed by the SRS broking team in May 1995, 1996 and 1997. In about September 1995, SRS was acquired by Minet Limited, a member of the Minet group of companies. Following this acquisition SRS became a division of Minet Limited. In about May 1997, the Minet group of companies (including Minet Limited) was acquired by the Aon Group. The SRS team moved to and became employees of Aon in January 1998 and in that capacity placed the Policy in May 1998. However as I record in paragraph 88, Mr Castle who led the team in 1998 had not been involved in the 1995 placement. Furthermore the involvement of Mr de Zulueta in the 1998 placement seems to have been limited.

32. The successive covers were placed, in part, under brokers' lineslips – in particular the SRS Revolver lineslip as renewed annually between 1994 and 1997, and the Aon "Jumbo" Lineslip which commenced on 31 August 1997 and was renewed in amended form on 1 March 1999. Each of the covers, other than the 2001/04 Cover (which was placed entirely under the Aon "Jumbo" Lineslip), were also partly placed on the open market.

1994 – 1995

33. In May 1994 SRS effected financial institution and professional comprehensive risks excess of loss cover on behalf of SLAC for the period from 15 May 1994 to 14 May 1995 (which was subsequently extended by 30 days to run to 14 June 1995) ("the 1994/95 Cover").

34. The member of the SRS team with overall responsibility for the SLAC account at the time when the 1994/95 cover was effected (and at all times thereafter until about 14 March 1996) was Francis de Zulueta. Mr de Zulueta was assisted in the servicing of the SLAC Account by Kelvin Curran (from 1994 to about October 1995), Kevin Bayes (from about November 1994 to about October 1995) and Nigel Primmer (from about late 1995 to early 1996).

35. The 1994/95 Cover comprised a primary layer of £5 million excess of £2.5 million, a first excess layer of £20 million excess of £5 million, and a second excess layer of £25 million excess of £25 million. The premium charged for the 1994/95 Cover is set out in the schedule.

36. In the usual way, the 1994/95 Cover was originally placed by means of a series of slips, which were followed in due course by policies. The slip for the primary layer of the 1994/95 Cover described the £2.5 million excess as applying to "*each and every claim*", while paragraph 4(ii) of the Schedule to the policy stated that the amount of the excess was £2.5 million, without more.

37. The policy wording for the primary layer of the 1994/95 Cover, which was agreed by the leading underwriter Mr Loucaides of Syndicate 702 on 16 August 1994 included the following provisions:

> "EXCESS
>
> In respect of each and every Claim and/or Loss the amount as specified in item 4(ii) of the Schedule which amount shall be inclusive of costs incurred in the investigation, defence or settlement of any Claim or Loss under the Insuring Clauses hereof, shall be borne by the Assured at their own risk or by captive arrangement as the case may be, and Underwriters shall only be liable to indemnify the Assured in excess of such amount.
>
> DEFINITIONS
>
> …

> 3. 'Claim' shall mean each Claim or series of Claims (whether by one or more than one Claimant) arising from or in connection with or attributable to any one act, error, omission, or originating cause or source or the dishonesty of any one person or group of persons acting together and any such series of Claims shall be deemed to be one claim for all purposes under this Policy."

38. By letter to SRS dated 6 November 1994, SLAC gave notice under the 1994/95 Cover of various potential compliance breaches by one of its appointed representatives for the sale of endowment policies, Halifax Building Society and/or Halifax plc (together "Halifax"), which breaches were then being investigated by a project team consisting of SLAC and Halifax staff ("the Halifax Notification Letter"). Aon says that, on about 16 November 1994, SRS showed the Halifax Notification Letter to the lead insurers subscribing to the 1994/95 Cover. The potential compliance breaches had all occurred at one office of the Halifax in Liverpool.

1995 – 1996

39. In around May-June 1995, SRS arranged the renewal of the cover on behalf of SLAC for the period from 15 June 1995 to 14 May 1996 ("the 1995/96 Cover"). The 1995/96 Cover also comprised a primary layer of £5 million excess of £2.5 million, and first and second excess layers of £20 million excess £5 million and £25 million excess £25 million respectively.

40. The 1995 renewal of the primary layer was effected as follows:

    1) Lloyd's Syndicate 702 was the lead underwriter on the primary layer of the 1995/96 Cover and one of the binding underwriters on the SRS Revolver lineslip for 1995.

    2) On 5 June 1995 Mr Loucaides, who was then the underwriter of Syndicate 702, scratched a quotation slip setting out the terms on which he was willing to provide cover. The quotation slip described the applicable excess as "£2,500,000 each and every claim including costs and expenses". Mr Loucaides endorsed the reverse of the slip with the words "Definition of eec [each and every claim] after claim insert '<u>claimant</u>' 95/96", although he cannot now recall when he did so.

    3) At some stage during the renewal process (although he does not recall when) Mr Loucaides also endorsed a copy of page 11 from the policy for the primary layer of the 1994/95 Cover with the words "and/or claimant 95/96" (so that it read " 'Claim' shall mean each Claim and/or claimant or series of Claims (whether by one or more than one Claimant) arising from …").

    4) On 7 June 1995, Mr de Zulueta of SRS sent a fax to Mr Mike McConnell of SLAC. In that fax Mr de Zulueta referred to the quotations offered by underwriters for the 1995/96 Cover and stated as follows:

> "Underwriters have also tried to restrict the wording but we have resisted (as we have on further price increases). The only change is to clarify the definition 3 as below:
>
> > 'Claim' shall mean each Claim and/or claimant or series of Claims (whether by one or more than on Claimant) arising from or in connection with or attributable to any one act, error, omission or originating cause or source or the dishonesty of any one person or group of persons acting together and any such series of Claims shall be deemed to be one Claim for all purposes under this Policy."

5) Aon's case is that on 9 June 1995 Mr McConnell orally instructed Mr de Zulueta to proceed to effect cover on SLAC's behalf in accordance with the quotation given by Mr Loucaides.

6) On about 13 June 1995 Aon approached Mr Loucaides to effect cover. Mr Loucaides scratched the slip for the primary layer of the 1995/96 Cover with the abbreviation "FON" (Firm Order Noted"), indicating the agreement of Syndicate 702 to participate on that layer on the terms previously quoted. Mr Loucaides added in manuscript the words "and/or claimant" to the description of the excess in the slip, so that it read "£2,500,000 each and every claim and/or claimant including costs and expenses". Mr Loucaides says that he made this amendment because he noticed that the amendments which he had proposed (referred to above) had not been included on the slip presented to him.

7) Thereafter the other insurers subscribing to the primary layer of the 1995/96 Cover either themselves subscribed to this slip or became bound thereto.

41. So far as the parties are aware, no policy wordings were ever issued in respect of the 1995/96 Cover. The premium charged for the 1995/96 Cover is set out in the Schedule.

1996 – 1997

42. On about 14 March 1996 Mr John Castle, then of Minet's SRS Division, took over primary responsibility for the day-to-day servicing of the SLAC account (although Mr de Zulueta continued to have some involvement in the account until about mid-1998 – see paragraph 88 below).

43. In May 1996, Minet's SRS Division effected a further renewal of the cover on behalf of SLAC for the period from 15 May 1996 to 14 May 1997 ("the 1996/97 Cover"). As in previous years, the 1996/97 Cover comprised a primary layer of £5 million excess of £2.5 million, a first excess layer of £20 million excess of £5 million and second excess lay of £25 million excess of £25 million.

44. In both the slip and paragraph 4(ii) of the Schedule to the policy for the primary layer of the 1996/97 Cover, the excess was described as "£2,500,000 each and every claim and/or claimant". Mr Kerrison of The Independent (the leading underwriter for the primary layers of the 1996/97 Cover) added the words "each and every claim and/or

claimant" to the Schedule to the policy, before he agreed the wording of the policy in about November 1996, in order, he says, to reflect the wording of the slip. The policy for the primary layer of the 1996/97 cover included the same wording in respect of "Excess" and the definition of "Claim" as set out above in the 1994/95 Cover wording. The premium charged for the 1996/97 cover is set out in the Schedule.

45. The words "and/or claimant" were added in manuscript to the slip for the first excess layer of the 1996/97 Cover by a person unknown. The words "and/or claimant" were added in manuscript to the slip for the second excess layer of the 1996/97 Cover by Mr James Weatherstone, the underwriter for Syndicates 861 and 1209.

1997 – 1998

46. In 1997, Minet's SRS Division renewed the cover on behalf of SLAC for the period from 15 May 1997 to 14 May 1998 ("the 1997/98 Cover"). Again, the 1997/98 Cover consisted of a primary layer of £5 million excess of £2.5 million, a first excess layer of £20 million excess of £5 million and a second excess layer of £25 million excess £25 million. Once again, the slip and paragraph 4(ii) of the Schedule to the policy for the primary layer of the 1997/98 Cover described the excess as "£2,500,000 each and every claim and/or claimant". The policy for the primary layer of the 1997/98 Cover included the same wording in respect of "Excess" and the definition of "Claim" as set out above in the 1994/95 Cover wording. The premium charged for the 1997/98 Cover is set out in the Schedule.

47. The words "and/or claimant" were added in manuscript to the slip for the second excess layer of the 1997/98 Cover by Ms Jane Bennett, the underwriter for Syndicate 1212. No such words were added to the slip for the first excess layer.

1998 – 2001

48. It is Aon's case, which SLAL does not admit, that at a pre-renewal meeting in Edinburgh on 28 April 1998 between Mr McConnell and Lindsay Easton of SLAC's Risk Management Department and Mr Castle of Aon, Mr McConnell informed Mr Castle that he was being asked by SLAC to reduce its overall insurance spend.

49. In a renewal report dated 8 May 1998 presented by Aon to SLAC, Aon set out various quotations which it had obtained from The Independent (as lead underwriter) for the renewal of cover. These quotations were based on an excess of £2.5 million. The renewal report stated that "to limit the deductible to an annual aggregate amount of £7.5 million would result in an additional premium of 25% of the primary premium".

50. On a date unknown but between 8 and 19 May 1998, SLAC instructed Aon to renew the cover with an excess of £25 million. SLAL's case (which Aon admits) is that SLAC continued to require cover which responded to claims by different claimants where such claims arose from or in connection with or were attributable to a single act, error or omission or originating cause or source and exceeded £25 million.

51. Aon then effected the policy on behalf of SLAC for the period from 15 May 1998 to 14 May 2001, with The Independent as lead underwriter. The policy provided cover by way of a single layer of £75 million excess of £25 million. Both the slip for the 1998/2001 cover and paragraph 4(ii) of the Schedule to the policy described the

excess of £25 million as applying to "each and every claim and/or claimant". The policy included the same wording in respect of "Excess" and the definition of "Claim" as set out above in respect of the 1994/95 Cover wording. The premium charged for the policy is set out in the Schedule.

52. In November 1998, Aon arranged professional indemnity/crime insurance "infill" cover for Standard Life Bank Limited and Standard Life Investment Limited (two of SLAC's subsidiary companies) for the period from 15 November 1998 to 14 May 2001. This cover operated as a layer of cover (£24.5 million excess of £500,000) below the cover provided by the policy for those two companies. The applicable excess was described in the relevant slips as "£500,000 each and every claim and/or claimant including costs and expenses Excess Aggregated to £1.5m" and was described in paragraph 4(ii) of the Schedules to the relevant wordings as "£500,000 each and every claim and/or claimant including costs and expenses capped at £1,500,000 in the aggregate". Details of the premium charged in respect of these infill policies are given in the Schedule.

53. In November 1999 Mr Castle of Aon, acting on behalf of SLAC, sent Reynolds Porter Chamberlain, "RPC", a copy of the policy and asked RPC to conduct a review. There is a dispute between Aon and RPC as to the scope of the review which RPC was asked to carry out. By a letter dated 9 December 1999 from Jonathan Davies of RPC to Mr Castle, RPC provided advice setting out the results of RPC's review. This advice is the subject of Aon's Part 20 Claim against RPC in the present proceedings.

2001 – 2004

54. In about January 2000, a Mr Mark Pearce of Aon became account executive for the SLAC account and, as such, took over primary responsibility for the day-to-day servicing of the SLAC account from Mr Castle.

55. By a letter dated 19 April 2001 to Aon, SLAC purported to give notice pursuant to General Condition 1 of the policy of circumstances which might give rise to claims against SLAC in respect of the sale of contracts for Free Standing Additional Voluntary Contributions ("the FSAVC Notification Letter"). Aon showed the FSAVC Notification Letter to The Independent on 23 April 2001.

56. By a further letter to Aon, dated 30 April 2001, SLAC purported to give notice pursuant to General Condition 1 of the policy of circumstances which might give rise to claims against SLAC in respect of the sale of endowment policies ("the Endowment Notification Letter").

57. On 8 May 2001 Mr Pearce and a Mr Chris Root of Aon met John Munro of The Independent (as lead underwriter on the cover) to discuss the renewal of cover from 15 May 2001. Aon and Insurers agree that in the course of this meeting Mr Munro indicated that he would be willing, as part of such renewal, to agree to a number of changes to the terms of the policy proposed by Aon, including the deletion of the words "and/or claimant" from the description of the excess.

58. Aon says that it showed the Endowment Notification Letter to Vicky Evans of The Independent on 9 May 2001 and that she endorsed the letter with an instruction to Aon to pass the papers on to Messrs Barlow Lyde & Gilbert for their urgent (in view

of the imminent renewal of the cover) advice on coverage and the timing of the notification. Aon says that, in accordance with Ms Evans' instructions, it then forwarded the Endowment Notification Letter to Barlow Lyde & Gilbert with instructions to advise insurers on coverage and notification.

59. On 18 May 2001 Mr John Munro of The Independent (as lead underwriter), scratched and stamped Aon's slip, agreeing to the renewal of the cover for the period from 15 May 2001 to 14 May 2004 ("the 2001/04 Cover"). He added against his scratch the words "Subject to … Exclusion of prior notified claims circumstances, i.r.o. endowments and FSAVC's as per Insured's letters dated 30th and 19th April respectively."

60. The 2001/04 Cover provided cover of £75 million excess of £25 million. The slip and paragraph 4(ii) of the Schedule to the policy both described the excess of £25 million as applying to "each and every claim".

61. On 28 August 2001, John Kopczynski (a claims handler on behalf of Syndicate 839, the Lloyd's lead) had a meeting with Aon at which Aon showed him a copy of a letter dated 1 August 2001 from Barlow, Lyde & Gilbert to Nicholas Wylie of Aon referring to the April 2001 notifications to the Policy. Mr Kopczynski made various manuscript annotations on the letter. SLAL and underwriters say that these annotations included the following: "Endowments only. ROR (Reservation of rights). Late advice but given £25M per claimant pol XS [policy excess] U/W's [underwriters] will not have any involvement in this matter." Aon does not admit the contents of the annotation on the grounds that it is not fully legible. It is in fact perfectly legible. The letter was disclosed by Aon from its claims files. Aon accepts that neither a copy of the annotation nor its gist was passed on to SLAC.

Inferences to be drawn and other elements of the history

62. The foregoing largely agreed history is necessarily incomplete and begs some questions. Underwriters place some reliance on this history as showing the genesis of the words whose proper construction I must determine. The extent to which the history is relevant or admissible is obviously contentious. It is contentious even whether I may properly look at the 1998 slip as an aid to construction of the policy wording and indeed as to whether, if I may, I can derive any assistance therefrom.

63. I heard evidence from Mr Loucaides, Mr Kerrison, Mr Adams, Mr Curran and Mr Weatherstone regarding the role played by each in the events which are briefly summarised above. None professed to have any recollection whatsoever of these events. That is unsurprising. Their evidence was therefore recent reconstruction. Furthermore it was reconstruction in the knowledge of the dispute and of the stances being adopted by the respective parties thereto. What is more, each of Mr Loucaides, Mr Kerrison and Mr Adams is currently associated with some or other of the Defendant underwriters. Mr Loucaides and Mr Kerrison are employed by Catlin Insurance Company Limited which manages four Lloyds syndicates which are respectively the Second, Third, Fifteenth and Thirty-Fifth Defendants and Mr Adams is employed by Novae Syndicates Limited, which as I understand it has a similar role in relation to Novae Syndicates numbers 1007, 1203, 1212 and 1115 which are the Sixth, Tenth, Twentieth and Thirtieth Defendants respectively. It would be surprising if their reconstruction of their earlier thought processes was not influenced by

consideration of what they would like to think they may have done consistent with the interests of those with whom currently they are associated. That is not intended as a criticism but rather as a recognition of reality and human nature. In such circumstances I was little assisted by the oral evidence as to the history of the placement and I have regard rather to the contemporary documents and to the inherent probabilities as they emerge therefrom.

64. I can however state my conclusions as to the history of the cover very shortly. I leave out of account for the moment the 1998 slip as to which special considerations apply, and to which I must return. Since each policy apart from the first was in turn a renewal of the previous policy, it must be proper and appropriate to look at the prior contract as part of the background against which the later contract is made – see per Rix LJ in *HIH Casualty and General Reinsurance Limited v New Hampshire Insurance Company* [2001] 1 Lloyds IR Rep 596 at 619. Further than that, mere negotiations and expressions of subjective intent uttered in the course of those negotiations are classically inadmissible as an aid to construction even where they relate to the contract the proper construction of which is under consideration. See generally per Lord Hoffmann in the *Investors' Compensation* case and per Lord Wilberforce in *Prenn v. Simmonds* in the passages to which I have already referred. The course of negotiations leading to an earlier contract is an *a fortiori* case. In fact the evidence here was in any event simply inconclusive and unhelpful on the construction issue. It supported the contention of no party. It supported the position of no party because it is apparent that insufficient attention was given to the effect of amendment to the original wording agreed in 1994, or to the introduction of wording which was not in standard form. I cannot conclude that the language in the contractual documents was used advisedly. I cannot conclude that either underwriters or the brokers considered with any care whether the language used in the contractual documents achieved their objectives. The evidence is for that reason of some relevance to the question whether Aon was negligent and perhaps to the issue of contributory negligence, although in the light of Aon's realistic approach to the nature of their instructions and as to the manner in which they reported back to their clients their compliance therewith, the issues remaining here are narrow. The evidence, or some of it, was however in my view of some considerable importance in my evaluation of the extent to which cover written on a deductible per claim basis would have been available to SLAC in 1998 in the event that I find that the cover actually written in that year was in fact on a deductible per claimant basis. I should however make some observations about what struck me as significant features of the placement history. I begin with the 1995 placement.

The 1995 placement

65. As I have already recorded Mr de Zulueta was not called to give evidence in relation to the role played by him. I draw no inference adverse to Aon on account of this. It is quite possible that, like Mr Loucaides, Mr de Zulueta at this distance in time has no recollection of what at the time no doubt seemed an unremarkable transaction typical of many that Mr de Zulueta would conduct in the course of a busy schedule. Even if he did have some recollection, Aon should not be criticised for failing to deploy evidence which is irrelevant to and inadmissible on the question of construction. By the time of the critical 1998 placement Mr de Zulueta no longer played a leading role.

66. When presented with the 1995 quote slip Mr Loucaides in fact made two endorsements on the back thereof. The one already noted above was preceded by the note:

> "Definition of Legal Liability should be limited only to Om – [Ombudsman] Awards as per PIA word[ing] only."

Depending of course on how that was followed through the incorporation of the PIA wording could have had a serious impact on the width of the cover, bearing in mind that no award could be in an amount greater than £50,000 and that the standard PIA Ombudsman Extension clause applies the policy excess to each and every award. However that may be Mr Loucaides obviously did not succeed in this endeavour since this endorsement was at some stage struck through. It is possible that it is to this aspect that Mr de Zulueta was referring when he spoke in his fax of 7 June of underwriters trying to restrict the wording and he having resisted. It is I think equally possible that Mr de Zulueta was referring to both endorsements. The fact that in his second endorsement Mr Loucaides referred to the definition of "each and every claim" leads me to conclude that it is likely that what he had in mind when making it was the excess provision in the slip, which uses that language. The "each and every claim" language is not present in the definition of claim in the policy wording. It is true that Mr Loucaides again used the word "definition" which might be taken to be a reference to the definitions section in the wording in which definitions of both "claim" and "legal liability" are to be found. On the other hand Mr Loucaides is most unlikely to have had a copy of the wording to hand. Whilst he had approved it in August 1994 and whilst he may frequently have contracted on similar terms, it would perhaps be surprising if he had recall of the detailed provisions without prompting. The reference to the definition of legal liability could have been simply a reference to the words "legal liability" which appear in the "Interest" provision in the slip, just as I think the reference to "each and every claim" is probably a reference to the excess provision which appears in the slip almost immediately below the "Interest" provision. Whatever the truth of the matter, which it is now impossible to reconstruct, I agree with the submission of Mr Leggatt that it should not be supposed that the discussion between Mr Loucaides and Mr de Zulueta took place at a high level of analytical detail. Mr Loucaides acknowledged at trial that an alteration to the definition of claim as he subsequently noted on a copy page of the wording would not be effective either to prevent the aggregation of related claims by more than one claimant or to impose a per claimant excess. Whether he would necessarily have thought the point through and reached that conclusion at the time is I think open to question. Mr Loucaides speculated that his emendation of the wording was perhaps more in the nature of an aide memoire than an attempted re-draft of the wording on which it was written. That is I think a little unlikely, although the fact that such a suggestion is made again lends weight to my belief that this is unlikely to have received careful analysis or to have been the subject of detailed discussion at the time. I would also not rule out that it may have been Mr de Zulueta who suggested to Mr Loucaides that whatever was the object intended by the second endorsement on the back of the quote slip was achieved by alteration of the policy wording in this manner. It is possible that Mr de Zulueta realised that what Mr Loucaides really wanted to achieve was a per claimant excess so as, effectively, to remove the risk of having to indemnify in respect of aggregated mass retail claims, but thought that he had succeeded in resisting this attempt by persuading Mr Loucaides to settle for the

anodyne alteration to the wording which he referred to as "clarification". In a weak market and acting for a prestigious client Mr de Zulueta had the upper hand in these negotiations. By overt and sustained insistence on a per claimant excess Mr Loucaides risked losing the business which in that market he would have been loathe to do.

67. There remains the fact that Mr Loucaides did on either 13 or 16 June add to the signing slip in manuscript the words "and/or claimant" in the description of the excess. It would not be normal practice for an underwriter to attempt at this stage to alter the basis upon which the earlier quotation had been given and accepted. Thus the objective interpretation of this action in the market would be that it was simply intended to give effect to the earlier quotation. That reinforces my belief that it may all along have been the intention of Mr Loucaides to effect an amendment to the excess provision in the slip rather than to the definition of claim in the wording. On the other hand I find it difficult to conclude that Mr Loucaides can either have thought that he had unequivocally achieved his aim or have thought that Mr de Zulueta had accepted a limitation on the cover of that sort. It was common ground at trial that an excess provision written in that way is not standard market wording. Its meaning is not immediately obvious, as this litigation demonstrates. It may be that the alteration was made by Mr Loucaides in that form and tolerated unremarked by Mr de Zulueta precisely because it was equivocal.

68. It is possible that when Mr Kerrison scratched the signing slip on 15 June the excess provision remained unamended. Mr Kerrison will have seen the endorsements made by Mr Loucaides on the back of the quote sheet and he very probably will also have seen his initialled amendment to the wording. Whatever else these various notations achieve they plainly did not involve at that stage writing additional words into the excess provision. If that had initially been intended attention had diverted to the definition of claim in the wording. Furthermore Mr Kerrison was content to scratch the first and second excess layer slips, neither of which contained the words "and/or claimant" in the description of the underlying excess. That would tend to suggest either that the primary layer slip was similarly unamended when he scratched it or that, if it had been amended, he perceived no discrepancy. This lends weight to my belief that the successful exclusion of liability to indemnify in respect of mass retail claims by imposition of a per claimant deductible was not a consideration uppermost in underwriters' minds when they subscribed to the 1995 cover.

69. On 15 June 1995 Mr Bayes of SRS confirmed to Standard Life that the "limit of indemnity of £50 million in the aggregate (plus one 'around the clock' reinstatement) is paid when SLAC pays the first £2.5 million each and every claim including costs and expenses". From this it is clear that there can have been no understanding within the responsible team at SRS that the cover was subject to the significant limitation that the excess operated on a per claimant basis. Cover Notes were sent on 25 July 1995, under cover of a letter from Mr Adams. The Cover Note for the primary layer referred to the excess as being £2.5 million each and every claim and/or claimant including costs and expenses. The Cover Notes for the two excess layers describe the underlying excess in the primary layer as being £2.5 million each and every claim. This correctly reflected the wording of the three slips by reference to which Yvonne Collins would have prepared the Cover Notes. Mr Adams and Mr Bayes initialled each page of each Cover Note. It is plain that either they failed to notice the

discrepancy or regarded it as of no moment. At the very least this is to my mind conclusive that Mr de Zulueta cannot have thought that the scope of the cover had been restricted by the imposition of a per claimant deductible. Had he thought that that had occurred he would have been bound both to have discussed it with his colleagues and, either himself or through one of his colleagues, reported back to Standard Life. Neither Mr de Zulueta nor anyone else at SRS can have had any reason whatever to mislead SLAC. Quite apart from the fact that there is no reason to believe that anyone involved at SRS was anything other than honest, all of those who dealt with clients would have realised the immense folly of misleading a client on the extent to which cover had been secured. If cover was unavailable on the required terms or only available at enhanced cost there would have been no reason whatever to withhold that information. I reject Mr Adams' "guesswork" that Mr de Zulueta may have reported a perceived limitation in the cover to SLAC by a telephone call of which there is no record. Such a report would have generated at SLAC both paperwork and consternation. Mr Adams cannot have thought at the time that a per claimant excess had been achieved and that that was something of which Mr de Zulueta had orally advised SLAC. Had he thought this he would have highlighted the point in his letter covering the dispatch of the Cover Notes. It is plain that Mr Adams cannot at the time have thought that the wording in the primary layer Cover Note introduced a significant restriction on the cover which SLAC had enjoyed in the expiring year.

70. As already noted no wording was issued in respect of the 1995/96 policies. It appears that this was caused by a delay in finalising a complaints handling procedure and it is of no significance.

71. On 21 August 1995 SRS sent to Standard Life a "resume" of the professional indemnity insurance cover, which started by explaining that the professional indemnity policy which SRS had arranged essentially covered "claims brought by unhappy clients who believe that they have had a financial loss due to Standard Life's mistakes". The contents of the resume clearly had in mind retail claims of the sort that individually would be small and could not possibly be covered by the insurance unless they could be aggregated.

72. A telling incident occurred at the end of 1995. Towards the end of 1994 Standard Life had at the suggestion of SRS commissioned Professional Liability Surveys ("PLS") to undertake a risk audit. As well as raising awareness within Standard Life of the risks faced by its business, this report was intended to provide the insurers with further information about the risks they were covering. The PLS report was published in March 1995 and, among other things, emphasised the risk that a number of individually small claims could accumulate to catastrophe level, including claims arising from consumer or regulatory pressures. The report was shown to insurers. By a note dated 2 May 1995 underwriters required Standard Life to respond to the particular points raised in the report. A copy of the report with Standard Life's comments interleaved was left with Mr Loucaides on 16 October 1995. Mr Loucaides noted thereon a query which related to SLAC's potential liability to consumer purchasers of its financial products where those products were bought through an intermediary independent financial adviser. The request for further information was passed on to SLAC by SRS at a meeting on 1 February 1996. The request was quite focussed. It asked for a copy of the disclaimer used by SLAC to seek to avoid such

liability and for SLAC's views as to the efficacy thereof in the light of the Unfair Contract Terms Act. In my judgment Mr Loucaides' attention to these matters is likely to have reflected his belief that underwriters were at risk in respect of the aggregation of a series of small claims arising out of the sale of products by independent financial advisers. Mr Loucaides suggested that this merely reflected a concern that an insured should not unduly expose itself but I do not regard this as entirely convincing.

The 1996 placement

73. At the 1996 renewal Mr Loucaides was again approached to lead the risk but it seems that on this occasion he wished to introduce "some fifteen or so additional exclusions, which he refers to as business risks, and a £7,500 additional premium" refundable after successful implementation of the PLS recommendations. The quotation is from the report to SLAC by Mr Castle of SRS who had by now assumed primary responsibility for the placement from Mr de Zulueta. This was regarded by SRS as an "inflexible attitude to coverage and terms" but there is no suggestion that any of the exclusions sought had any bearing on SLAC's ability to aggregate related consumer claims. Mr Kerrison took over as leader. In the subsequent "Stewardship Report" The Independent was described as having "shown a flexible and helpful approach to the risk".

74. I have already recorded above the form taken by the slips. The 1995/96 primary slip, with Mr Loucaides' addition of the words "and/or claimant" to the excess provision in manuscript in turquoise ink was used as the quote sheet. The primary layer signing slip was prepared by SRS and as presented to underwriters had typed in the words "and/or claimant" in the excess provision.

75. After the placement Mr Kerrison was asked to agree the 1996 wording. This was dealt with at a series of meetings. The following account I have taken very largely from Mr Weitzman's written closing submissions:

    1) On 2 October 1996 there was a meeting at SLAC's offices in Edinburgh attended by Mr Kerrison, Mr McConnell of SLAC and Mr Castle of Minet, which had by this date acquired SRS. Mr Kerrison had been provided with and had the opportunity to read a draft amended wording prior to this meeting. It appears that the proposed changes were agreed save in three respects: (a) the deletion of the word "indirectly" from the exclusions; (b) the "New Companies Acquisition" clause; and (c) the provisions of General Condition 1 dealing with the reporting of claims.

    2) On 3 October 1996 Mr Castle faxed both Mr Kerrison and Mr McConnell attaching suggested revised wordings addressing the second and third outstanding matters identified above i.e. the New Companies Acquisition clause and General Condition 1. The copy of General Condition 1 sent to Mr McConnell had various manuscript amendments which seem to have been made by Mr Castle. It is unclear when these amendments were made.

    3) On 5 November 1996 Mr Castle sent a fax to Mr McConnell attaching a copy of the "original draft wording". It seems likely that the draft attached was that which had been discussed on 2 October 1996. In particular, the provisions of

the New Companies Acquisition clause and General Condition 1 do not include the revisions shown in the attachments to Mr Castle's faxes of 3 October 1996.

4) On 7 November 1996 there was a further meeting in London between Mr Castle, Mr McConnell and, for the last part of the meeting only, Mr Kerrison. Agreement was reached as to all outstanding matters in relation to the wording and it was agreed that Mr Castle should now produce a final version for issue by Insurers.

5) Subsequently, on a date unknown, Mr Kerrison was provided by Mr Castle with a version of the wording. Mr Kerrison's evidence was that the wording would have been presented to him by either Mr Castle or another broker. He made two manuscript amendments to the document, deleting part of the No Claims Bonus clause and adding the words "and/or claimant" to paragraph 4(ii) of the Schedule. He then scratched and stamped the document.

6) Some time later Minet arranged for the formal issue of the 1996 wording by LIRMA. In this version the words "and/or claimant" appear in type in paragraph 4(ii) of the schedule. Mr Kerrison's evidence was that this would have been done by Minet who would have arranged for LIRMA formally to issue the 1996 wording without going back to him.

76. A number of points emerge from this. The draft policy wording that was the subject of discussion and negotiation at these meetings did not contain the words "and/or claimant" in the Schedule. The excess clause and the definition of claim in the wording plainly envisaged and had the effect that the excess would be on a per claim basis and that a series of small claims by different claimants could be aggregated if related. If Mr Kerrison had thought that the cover had been placed on a per claimant basis, precisely so as to avoid this consequence, it is I think highly likely that he would have raised so significant a point in discussion and suggested alterations to the wording to reflect his understanding of the cover he had given. In fact the discussion proceeded on a basis consistent only with a per claim excess and Mr Kerrison initialled and stamped the pages of the wording on which the excess and the claim definitions having this effect were set out.

77. It was Mr Kerrison himself who, after this series of meetings, added the words "and/or claimant" to paragraph 4(ii) of the Schedule. It was his evidence that in so doing his intention was simply to reflect what appeared in the slip. That must of course be reconstruction rather than genuine recollection but it is plausible. It is plain that neither Mr Kerrison nor the brokers can have attached any very great significance to this amendment to the Schedule. Had either party thought that the words had the effect of introducing a per claimant deductible, it seems highly likely that this would have provoked both discussion and, necessarily, negotiation. In the light of this I find it difficult to conclude that Mr Kerrison can have thought that the slip provided for a per claimant excess. As I have already indicated had he done so this would by now have been reflected in discussion of the draft wording.

78. Standard Life was not told about the addition of the words "and/or claimant". On the contrary in early November 1996 Minet produced a "Stewardship Report". This informed Standard Life that the insurance had been "continuously reviewed and

improved since [1994] both in terms of coverage provided, competitive pricing and security of insurers". It also referred to the wording review earlier in 1996, which Minet had commissioned "with a view to representing the widest cover available to meet the needs of SLAC. To this end a number of changes have been made to the 1995/96 wording. None of these is fundamental but the changes have improved its clarity…".

79. There is one further point arising out of the discussions of the wording in 1996. The provisions of General Condition 1 were one of the three matters which were not resolved at the meeting on 2 October 1996, in respect of which Mr Castle produced revised wordings on 3 October and which were finally agreed at the meeting on 7 November. The sequence of these negotiations can be deduced from comparing the original proposed draft, Mr Castle's revised draft and the final draft initialled and stamped by Mr Kerrison. One of the issues the subject of negotiation was whether SLAC should be required only to notify insurers of claims which were likely to exceed 60% of the excess of £2.5 million, or losses or circumstances which were likely to result in such claims, or whether rather they should be required to report all claims, losses and circumstances irrespective of the amount involved. What was eventually agreed was that all losses, claims and circumstances were to be notified on a half-yearly basis, whatever the amount involved. If the cover was subject to a "per claimant" excess which had the effect of excluding all small consumer claims this would have been a pointless exercise. Naturally Mr Kerrison was asked about this in cross-examination. Mr Kerrison did not give a very good account of himself in the witness box. This may have been due in part to the fact that he was plainly in some physical discomfort throughout in consequence of some obviously debilitating condition which affected his ability freely to move his neck. On the day in question his evidence had to be interrupted because he was feeling unwell. I must plainly make due allowance for the fact that Mr Kerrison was not at his best. Even so, his explanation of why underwriters required notification of claims below 60% of the excess was not convincing. The incidence of such claims had no bearing on the question whether any single claim would be likely to exceed 60% of £2.5 million.

The 1997 placement

80. Little emerged from the 1997 placement, save that the absence of the words "and/or claimant" in the description given in the first excess layer slip of the excess in the primary layer did not deter underwriters from subscribing to that layer. One such underwriter to whom I must return was Mr Weatherstone of the Brockbank Syndicates numbers 861 and 1209. He had added those words to the second excess layer slip in 1996 but said in evidence that in 1997 he "missed it". There were eleven other underwriters subscribing to the first excess layer in 1997 including Mr Kerrison.

The 1998 placement

81. I come finally to the 1998 placement. It is I think an oversimplification to suggest that SLAC was seeking to reduce its expenditure on insurance. The management was undoubtedly very cost conscious. It was also very sensitive to the possibility that the very financial strength of SLAC might be perceived as a reason for attempting to overcharge it, and the management was keenly averse to being overcharged. Memorably, Mr Ross, at the relevant time Head of Group Audit and Compliance, described Standard Life as an institution with deep pockets but short arms. The

management also saw the possibility of using the financial strength of SLAC to its advantage by increasing its retention and insuring only at a high level which was unlikely to be reached, save in the event of a catastrophe of a high order.

82. In March and/or April 1998 Mr Kerrison was asked to provide quotations for various different levels of cover. The options for which he was asked to quote included an "aggregate stop on self insured retention". Mr Kerrison wrote out his quotations on various bases dating the document 8 May 1998. All of the quotations presupposed that there would be an excess of £2.5 million, with quotations at higher levels being on that basis, for example, a first excess layer of £25 million excess of £27.5 million. One unresolved mystery is how in the end the cover came to be agreed at £75 million excess of £25 million for the premium which Mr Kerrison had in fact quoted for cover of £75 million excess of £27.5 million. However this does not on any view matter.

83. Two points are however of significance. The first is that the quotations demonstrated the extreme softness of the market. In 1997/98 the premium for cover of £50 million excess of £2.5 million had been £528,500. The quotation for the same cover for twelve months as at May 1998 was £390,000, a reduction of 26% to which Aon not unnaturally made express reference when reporting to Standard Life. Cover of £100 million excess of £2.5 million was offered for £525,000, as Aon pointed out an additional £50 million of cover at no additional premium – in fact at marginally less cost than the previous year's cover. It is perhaps worth recording that the Aon Renewal Report in which this information was conveyed as its headline described the cover offered as being £50 million over a deductible of £2.5 million each and every claim. This notwithstanding later in the document under the rubric "Programme Coverage Summary" there was reproduced what was in effect a draft slip which repeated and incorporated the language of the previous year's primary layer excess provision, i.e., £2.5 million each and every claim and/or claimant.

84. The Renewal Report went on to set out Mr Kerrison's quotations for three year policies on various different bases, including a variation between a single aggregate "stretched" over three years or an annual aggregate deductible. The Report then records:

> "To limit the deductible to an annual aggregate amount of £7.5 million would result in an additional premium of 25% of the primary premium. These are lead indications with Independent taking 25%."

85. Mr Kerrison said that he had no recollection of giving a quotation for an annual aggregate deductible. He said that he had never been a fan of such deductibles since once they are exhausted the insured has no further incentive in the field of risk management and claims handling. The force of that point of course depends on the level at which the limit of indemnity is set. It is right to point out that the documents which have survived, been located and in turn disclosed do not include any note in Mr Kerrison's handwriting of such a quotation. However the same is true of two other features of the quotations reported by Aon to SLAC on 8 May. One is a special deductible of £500,000 for the Standard Life banking operation. The second is the no claims discount of 10%. Mr Kerrison said in evidence that he had a recollection of giving a quotation for the bank with a £500,000 excess but that he had no recollection of offering a 10% no claims discount. The inference is irresistible that it was Mr

Kerrison who gave the quotation for the annual aggregate deductible. The Aon report said that the quotations were lead indications identifying The Independent as the leader and the quotation for the annual aggregate deductible could in fact have come from nowhere else.

86. There was some debate at trial as to how the annual aggregate deductible would work. Mr Kerrison's evidence on this point was not easy to understand. He seemed to suggest that it would work in conjunction with the deductible of £2.5 million. The cap could therefore be eroded either by a single qualifying loss event in excess of £7.5 million or by three separate qualifying loss events each of £2.5 million, which could include three series of related claims. It seems to me that an annual aggregate which worked on that basis would be of very little benefit to an insured. After exhaustion of the annual aggregate deductible the insured would recover all claims and losses from the ground up, but the insured would need to be singularly unfortunate to breach the cap at all. Furthermore if the cap were breached by a single loss the insured's cover for that loss would potentially be £5 million less than without the annual aggregate. I might add that this approach to the annual aggregate deductible would in any event make no sense if the underlying cover were written on a per claimant basis. It is more likely in my opinion that what was intended was an aggregate which would be eroded by all claims or losses, whether related or not. The significance of the quotation for the annual aggregate deductible is that it demonstrates that, however it was intended to work, the basic underlying cover for which Mr Kerrison was at the same time quoting simply cannot have been regarded by him as having been structured with a per claimant excess. If the existing cover was on a per claimant basis, insurers were simply not on risk for small claims because those claims would be made by separate claimants. The effect of the annual aggregate deductible would be to expose insurers to all small claims, whether related or not, once the aggregate deductible had been breached. It would transform the nature of the cover, bringing back in that which is said to have been excluded by the per claimant excess. Had Mr Kerrison thought that his underlying quotation was given on a per claimant basis, so that small claims were excluded from cover even if related, it seems most unlikely that he would have thought it appropriate to offer this huge extension to the cover at only a 25% enhancement to the premium.

Mr Weatherstone

87. I turn finally to Mr Weatherstone, who gave evidence at the trial. He was an obviously intelligent and articulate witness. He had written contemporary notes recording the nature of the risks accepted by him, a practice which was I think most unusual amongst underwriters in the period under discussion. In 1994/95 Syndicate 861 became bound to the primary layer by virtue of their adherence to the lineslip. The syndicate also took a line on the first excess layer although Mr Weatherstone was not then involved. In 1995 Syndicate 861 had no involvement in the primary layer but Mr Weatherstone bound it to the first excess layer slip on 8 June 1995. Mr Weatherstone confirmed in evidence that he had been happy to renew the excess layer on the basis that the underlying excess was on a per claim basis. His underwriting notes stated that there had been "no significant changes from last renewal". It was in 1996 that Mr Weatherstone added the words "and/or claimant" to the slip for the second excess layer. On this occasion he noted in his underwriting notes that:

> "Coverage excludes claims arising out of pension transfer/opt-outs prior to 15.5.94 but E.E. (each and every) claimant deductible will keep us away from future problems from this area."

This speaks for itself as to his then understanding of the nature of the cover. 1997 was the year when, as I have already recorded, Mr Weatherstone "missed" the omission from the slip he scratched for the first excess layer of the words "and/or claimant" in the description of the excess in the primary layer. His underwriting note for that year reads, in part:

> "Standard Life are not one of the 'bad boys' of the pension transfer and opt-out fiasco. Refer last year's entry for additional information."

In 1998 Mr Weatherstone wrote the risk for both Syndicates 961 and 1209. In his notes he recorded that the programme had been restructured from the previous SRS placement. He described the cover as "£75 million stretched aggregate 36 months excess £25 million E.E.L." i.e. each and every loss which is he confirmed in evidence for present purposes synonymous with each and every claim. His note made no mention of a per claimant deductible although it did record "very much minimum premium for catastrophe programme". Of course it is right to say that the slip to which Mr Weatherstone subscribed had the "and/or claimant" wording in the excess provision. The inference I derive however is that, with the excess point now at £25 million, the question whether it operated on either a per claim or a per claimant basis was not uppermost in Mr Weatherstone's mind. That is unsurprising. £25 million was an enormous excess at the time. Mr Wood thought that a deductible of that size could readily have been converted to an aggregate deductible, i.e. one which would permit the aggregation of claims without a common cause or source. Although obviously Mr Weatherstone had been alive to the point in 1996, in the light of his having written the cover in 1995 on an explicitly per claim basis and in the light of what occurred in 1997, I find it difficult to conclude that the consideration whether the cover was written on a per claim or a per claimant basis was ever a determinant factor in Mr Weatherstone's decision whether or not to subscribe to the risk. Mr Weatherstone himself pointed out that many factors are in play when an insurer is considering a renewal. These include not just underwriting criteria but all sorts of other criteria including the reinsurance programme, the cost of capital and the pressure to underwrite renewal business. There are, he said, "a lot of moving pieces when you are renewing a piece of business".

88. It follows from what I have already said that I do not regard Mr Weatherstone's evidence as relevant to the question of construction. The same is true of most if not all of my findings in relation to the history of the placement. I have made those findings out of deference to the arguments which I heard on the matter and in case it should be argued hereafter that my approach to the matters relevant to construction is unduly restricted. I would however observe for completeness that, technical though it may seem, Aon as a corporate entity had not broked the earlier placements. Moreover Mr Castle was not involved with the 1995 placement. Mr de Zulueta was in the background during the 1996 and 1997 placements, although he did not himself broke the risk to underwriters. Mr de Zulueta was also involved in the background in the run up to the 1998 placement – his presence at Aon and participation is shown in

documents dated 5 and 22 May. Whether he was still at Aon by the time of the placement I do not know. It was actually the evidence of Mr Wood that Mr de Zulueta, unlike Mr Castle, had not come to Aon on the takeover. I infer therefore that his presence, on whatever basis, was short-lived. Whilst there was obviously considerable continuity on the underwriting side, by no means all those who subscribed in 1998 participated in earlier years. The underwriters would have had no records of the course of earlier placements and I know of no relevant principle of attribution which would fix them with knowledge of what had gone before nor no principle which would require them to make enquiry as to what had transpired on earlier placements.

Construction of the policy

89. Where, as in this case, a contract of insurance is initially contained in summary form in a slip which is later followed by the agreement of a full policy wording, it is established orthodoxy that the parties' contract is to be found exclusively in the later contract which the parties intend to supersede their earlier contract. See generally the analysis of Rix LJ in the *HIH v New Hampshire* case to which I have already referred above, at paragraphs 69 to 81 of his judgment. However there remains the question whether, to use the formulation of Rix LJ at paragraph 91 of his judgment, construction of the policy may be educated by a consideration of the slip. I do not propose to embark upon an analysis of the authorities since that task has been undertaken by Rix LJ in his judgment at paragraphs 69 to 92. This part of the judgment of Rix LJ was, as he expressly noted, unnecessary for the determination of the appeal. Naturally however I attach great weight to his observations made after full argument. In any event, I respectfully agree with what I take to be his conclusion that on the narrow question of the extent to which consideration of the slip may properly inform construction of the policy authority does not dictate and common sense militates against any dogmatic assertion one way or the other. In many cases reference to the slip will be simply unhelpful for the reasons given by Rix LJ. Certainly a slip could not be used to alter or to contradict the construction of a policy which has superseded it, as Rix LJ pointed out. However as he also pointed out it is always admissible to look at a prior contract as part of the matrix or surrounding circumstances of a later contract.

90. This point is or may be of some significance in the present case because the argument deployed by Mr Leggatt is that the substantive words as to the operation of the excess, the meaning of claim and the availability of aggregation are to be found in the corresponding provisions of the policy wording itself rather than in the Schedule. Mr Leggatt also submitted that reference to the slip would simply take matters no further forward. The slip recites that the Form is to be J(A) plus wording as expiring or to be agreed slip Leading Underwriter only. The expiring wording was identical to the 1998 wording, with the exception that there were obvious consequential amendments in the 1998 Schedule and there had been added to item 4(ii) thereof the words "including costs and expenses". These words in fact appeared in the excess provision of both the 1997 slip and the 1998 slip. As it happens there is no evidence that Mr Kerrison was ever invited to agree the wording of either the 1997 or the 1998 policies. There had of course been the extensive exercise in 1996 culminating in Mr Kerrison scratching each page. The evidence suggests that in both 1997 and 1998 the wording was simply prepared by the brokers and submitted to, in 1997, LIRMA (London

Insurance and Reinsurance Market Association) and in 1998 its successor the IUA (International Underwriting Association of London) for agreement, signing and issue. There was of course also a Lloyd's Co-insurance Policy and indeed a Companies Collective Co-insurance Policy which simply incorporated the IUA policy. It appears that Mr Kerrison played no part in the issue of either the 1997 or the 1998 wording. It was the broker who added the words "including costs and expenses" by way of faithful reproduction of the words in the excess provision in the slip. None of this detracts from the status of the policy wordings since the relevant market associations had authority to act on underwriters' behalf.

91. Since "the wording as expiring" is materially identical to the issued 1998 wording, it can in one sense be said that reference to the slip carries one no further forward since the slip simply incorporates the very same wording which it is the task of the court to construe. However I do consider that in this case reference to the slip is of some assistance. At the very least reference to the slip demonstrates that the slip was thought to be consistent or capable of being read together with the expiring wording. I regard that as helpful when the critical words appear in a position of prominence in the slip but are relegated to the Schedule in the policy. It is counter-intuitive to regard words which appear in the excess provision on the face of the slip as not being part of the substantive words descriptive of underwriters' obligations. In my judgment to ignore the slip in this case is to deprive oneself of a valuable aid to the proper approach to construction of the policy. That will not always be so, but it is here. The slip, in my judgment, as part of the surrounding circumstances in the context of which the policy should be construed, indicates that the words "and/or claimant" are likely to have been regarded by the parties as of relevance to the extent of the substantive obligations undertaken by underwriters. I therefore reject Mr Leggatt's approach to the effect that the Schedule is not a part of the policy where one finds the substantive rights and obligations of the parties which are, by contrast, to be found in the main body of the policy wording. The words in the Schedule must be read with those in the main body of the policy wording which they may qualify. I do not accept that the words in item 4(ii) of the Schedule should be regarded simply as a highly abbreviated summary of the substantive provisions in the policy and I am assisted to that conclusion by reference to the slip. The words "and/or claimant" which figure prominently in the slip should when carried through to the policy be given a meaning, if that is possible. Their appearance in the slip suggests that they are intended to have some function. This is in my view more than simply an application of the presumption against surplusage, which presumption may however be of a little more weight in relation to slips, which traditionally employ an economy of language, than in relation to some other longer form commercial documents which may be ill-considered accretions of hallowed clauses without undue regard to how they sit together.

92. I might add that I regard my approach as in this case reflecting the reality of the situation. When they put down their lines all of the subscribing underwriters will, by definition, have had the slip in front of them but not I suspect the expiring wording. Some of the following market may never have seen the wording. When Standard Life were advised subsequently of the successful placing of the cover, the Cover Note by which that was done set out the wording of the slip. The slip plays a pivotal role in the making of a contract of insurance such as this, and it would in this case be a

triumph of form over substance if the court were to be denied such assistance as it may give in elucidating the terms of the bargain struck.

93. I turn therefore to the rival contentions. Mr Leggatt suggested that if it is appropriate to construe the words in the Schedule item as altering the effect of the substantive provisions of the policy, or, as I would prefer to put it, as having substantive effect, then the only construction which makes coherent sense of those words is Aon's construction. Mr Weitzman for Aon suggested that the natural ordinary meaning of the phrase "each and every claim and/or claimant" is one that encompasses three possibilities, namely that the excess can be satisfied:

1) on an each and every claim basis. The excess can be satisfied either by a single claim or by a series of related claims whether made by one or more than one claimant. This is what the parties referred to throughout the trial as a "per claim" excess;

2) on an each and every claim and claimant basis. The excess can be satisfied by a single claim or a series of related claims by the same claimant. This is what the witnesses and the parties referred to at trial as a "per claimant" excess although Mr Weitzman suggested that this term is something of a misnomer in that it fails to recognise that on this basis the excess cannot be satisfied by a series of unrelated claims by the same claimant;

3) on an each and every claimant basis. The excess can be satisfied by either a single claim or a series of claims by the same claimant, whether related or not.

Mr Weitzman accepted that the second suggested manner in which the excess can be satisfied adds nothing to the other two. If the excess is satisfied on an each and every claim and claimant basis, then it will inevitably also have been satisfied on an each and every claim or an each and every claimant basis.

94. Mr Weitzman also accepted that if the words "each and every claim and claimant" had been used then their effect would have been to impose a per claimant excess of the kind contended for by insurers. However those words were not used. Insurers' construction, he suggested, fails to give effect to the use of the phrase "and/or", the effect of which is to allow all possible permutations of the matters identified. The effect of Aon's construction is thus that SLAC is required to bear the first £25 million of an insured loss, but that this requirement can be satisfied in the various ways identified.

95. The difficulty I feel about this construction is threefold. Firstly, this construction introduces, I think, an imbalance between the excess as it applies to the Legal Liability cover under insuring clause A1 and the Financial Losses cover under insuring clause A2. The basic scheme of the policy is that both claims falling for indemnity under clause A1 and losses falling for indemnity under clause A2 may be aggregated where they are related. I use the word "related" as a shorthand for the aggregating provisions to be found in the definitions of "claim" and "loss" at paragraphs 3 and 4 of the "definitions" section of the policy wording. If Aon's construction is right, the effect of the "and/or claimant" wording is to permit aggregation of unrelated claims by virtue solely of the coincidence that they are made by a single claimant, whereas there is no corresponding possibility of aggregation of

unrelated losses. This seems to me capricious. Secondly, Aon's construction involves that the "and/or claimant" wording effects an extension to the basic aggregation provision, viz, the ability to aggregate unrelated claims by virtue of the coincidence that they are made by a single claimant. I do not consider that appropriately informed market professionals would have identified any desire or any need for such cover. I also think that they would conclude that if aggregation of either claims or losses having no common originating cause or source was to be permitted, it would be likely to be achieved by the well-understood mechanism of an aggregate deductible. Thirdly, I think that Mr Railton is correct to draw attention to the excess provision in the policy wording. The insured has agreed to bear the amount as specified in item 4(ii) of the Schedule. If the effect of the words in the Schedule is that the specified amount may be reached in different ways, it is the more natural construction of the excess provision that the insured must be in a position to satisfy each method cumulatively, rather than permitted to select the method of aggregation most favourable to it.

96. Whether one is looking at the words "each and every claim and/or claimant" in the slip or in the Schedule, they have to do duty in relation both to the liability to indemnify in respect of claims under insuring clause A1 and to the liability to indemnify in respect of losses under insuring clause A2. There can be no doubt that "claimant" would be understood to refer, and to refer only, to a third party claimant whose claim involved the insured's legal liability so as to rank for indemnity under insuring clause A1. In such circumstances Mr Railton for the insurers submits that the word claim must accordingly have been intended to apply to both limbs of the policy. If it does not there is no amount specified as being the excess applicable in respect of each and every loss recoverable under insuring clause A2. Thus each and every claim read alone must be intended to refer to each and all loss as it is defined in Definition 4 and is the subject matter of insuring clause A2. A claim may be either a first party claim or a third party claim. When it is a first party claim, the excess is applied disjunctively, without need to consider the obviously inapplicable alternative "or claimant". Where however it is a third party claim the conjunctive "and claimant" comes into play, since claimant is obviously referable to third party claims. In other words, the excess must be established both by reference to the underlying claim and by reference to the underlying claimant. There must be a claim, in the extended sense which might include a series of claims, by a single claimant which exceeds the excess. In this way, submits Mr Railton, weight is given to each word in the excess provision.

97. There are difficulties about Mr Railton's construction too. The first is that it attributes to the word "claim" two different meanings. I am not however too troubled about that. The word "claim" is a word frequently used by insurance market professionals but not always to mean precisely the same thing. The word takes its meaning and its colour from its context. Whilst I attach little weight to the use of a capital or lower case for the initial letter I do not think that it can be assumed that the word claim when used in the slip and in the Schedule necessarily bears the extended meaning set out in Definition 3. One obvious example where it does not is in the phrase "No Claims Bonus". Furthermore the policy wording itself is not consistent. The word claim when first used in General Condition 1(ii) must obviously mean both a first and a third party claim. The more fundamental difficulty as it seems to me is that Mr Railton's construction emasculates the aggregation provision in Definition 3 of the policy wording. There are two aspects to this. First, as a matter of construction, it

involves the conclusion that the words in the slip and in the Schedule negate the effect of the bracketed words in Definition 3 "whether by one or more than one Claimant". Second, the vast bulk of Standard Life's business was known by insurers to be the provision of financial products to consumers. An objective observer would reasonably conclude that the principal reason why a company in Standard Life's position required professional indemnity cover at a catastrophe level was to protect against the risk of a series of such claims from a common cause or source which in combination exceed £25 million.

98. I agree with Mr Leggatt that a commercial contract ought not to be construed in a manner repugnant to its purpose. I also agree with him that in the present context it does not greatly assist underwriters to point out, as they do, that their construction does not leave the contract devoid of all possible application. It is also right to point out that a deductible pitched at a level of £25 million does not wear the air of a per claimant deductible – no claim or even series of claims by a single claimant was realistically likely to reach this sort of level. If the intention had been to exclude from the scope of cover a particular category of claims, such as those arising from endowment policies or even from consumer products more generally, it would have been normal practice and relatively straightforward to devise a suitable form of words, as was done in relation to occupational pension transfers and opt-outs. No properly informed market professional would have regarded it as appropriate to introduce a per claimant deductible which applied across the board, as opposed to one targeted at a specific category of claim, as an underwriting measure designed to exclude that specific category of risk from cover. All these reasons militate strongly against an intention to impose an across the board per claimant excess.

99. I am however left with the words used in the Schedule and, as I think, more tellingly in the slip. No witness at trial could recall ever seeing this form of wording before, let alone in a financial institutions cover. No witness at trial could think of any plausible purpose for the inclusion of the words "and/or claimant" in the excess provision in the slip other than the attempted achievement of a per claimant excess. That evidence is I think admissible because it demonstrates that there is in the relevant market a common understanding that the introduction into an excess provision of the word "claimant", qualified by the words "each and every", is likely to be associated with an attempt to procure that the excess operates by reference to each and every claimant. Even if the evidence is not admissible, it is the conclusion to which I would myself come. That is not conclusive of the question whether the attempt has succeeded, but it is in my judgment a factor to which the court must give considerable weight when the court is giving to the words used the meaning which it is to be presumed the parties intended them to have.

100. Had the words used been "each and every claim and claimant" it is acknowledged, at any rate by Mr Weitzman, that it would have been clear that, notwithstanding the words in Definition 3 "whether by one or more than one claimant", what was intended was a per claimant excess and furthermore it is accepted by Mr Weitzman at any rate that that intention would have been achieved. I am left therefore to ask myself whether on account of the addition of "/or" there should be attributed to the parties a different intention, or, if it is a separate enquiry, whether I am driven to the conclusion that they have simply failed to achieve their object. In my judgment the answer to

these questions is no. I conclude that the policy does not permit the aggregation of related claims made by separate claimants.

Was Aon negligent in placing the 1998-2001 cover?

101. This question would have arisen even had I concluded that the cover on its true construction responded on a per claim rather than a per claimant basis because SLAC wishes in any event to pursue a claim against Aon in respect of such loss as it can demonstrate flows from Aon's failure to arrange cover which clearly and indisputably met SLAC's requirements. As it is, in the light of my conclusion on construction, the claim which SLAC will pursue at Stage 2 of the trial will be on the much broader basis of such loss as SLAC can demonstrate flows from the failure of Aon to arrange cover which responded on a per claim rather than a per claimant basis.

102. There is no dispute as to the nature of the duties owed by Aon to SLAC. Aon accepted as accurate a report on market practice in this regard prepared for the trial by Mr Graham McKean, who has long and relevant experience as a result of his working life spent in the London market. From his evidence the following uncontroversial propositions emerge:

1) It is the duty of a broker to identify and advise the client about the type and scope of cover which the client needs and, in doing so, to match as precisely as possible the risk exposures which have been identified within the client's business with the coverage available.

2) Having identified what cover the client needs, it is the broker's duty to arrange insurance cover which clearly meets those requirements.

I should add that on this point there is also some authority, in the shape most recently of the decision of the Court of Appeal in *FNCB v Barnet Devanney* [1999] Lloyds Rep IR 459 at 468 and of Cooke J in *Talbot Underwriting v Nausch Hogan & Murray* [2006] 2 Lloyds Rep 195 at 218, whose conclusions in this regard were not challenged on the appeal which was subsequently brought, unsuccessfully, against other aspects of his decision. This body of authority establishes that it is the duty of a broker to obtain, so far as is possible, insurance coverage which clearly meets his client's requirements. Coverage is only clear in so far as it leaves no room for significant debate. The coverage will be unclear, and the broker in breach of duty, if the form thereof exposes the client insured to an unnecessary risk of litigation. Of course the risk of litigation can never be wholly avoided and the broker is not in breach of duty in consequence alone of insurers putting forward a spurious construction of the cover. The present however is not a case in which it is necessary to explore the nature of the duty at its limits. The cover placed in this case was on no showing clear. It left room for significant debate.

3) If the cover which is needed by the client is not available, the broker must take care to ensure that the precise nature of what is and is not covered is made entirely clear to the client.

4) In relation to the preparation of the policy, the broker must be careful to ensure that the policy language clearly encompasses the needs of the client.

5) The duties of the broker on the renewal of an existing policy are no different from on the initial placement, and at each renewal the broker must ensure that the cover arranged clearly meets the client's needs in the most appropriate manner.

103. There are no doubt several ways in which the relevant test can be formulated, the expression of which depends not least on whether the test is formulated in a positive or a negative manner. It is I believe sufficient for present purposes to pose the question as "would a reasonably competent broker in Aon's position reasonably have concluded that the words 'each and every claim and/or claimant' used to describe the excess in the slip and wording were sufficiently clear to meet SLAC's requirements without exposing SLAC to an unnecessary risk that insurers might argue that the cover granted was on a per claimant basis only". In answering the question one must of course guard against hindsight, although in that regard it is not without significance that when circumstances which might give rise to a claim were first notified to the Lloyd's lead underwriter on 28 August 2001 the immediate response of the claims handler for the syndicate was "given £25M per claimant pol XS (policy excess) underwriters will not have any involvement in this matter".

104. There can in my judgment be only one answer to the question which I have posed. No reasonably competent broker could reasonably have come to the view that SLAC's requirements were clearly met. The ability to aggregate claims by different claimants arising from a common cause or source was, as Aon knew, of critical importance to SLAC in the context of the professional indemnity cover which it sought, the need for which had incidentally been identified by Aon's predecessors. The wording proffered by Aon in the slip to which it invited underwriters to subscribe contained the "each and every claim and/or claimant" wording which has no recognised market meaning. As I have already recorded none of the market professionals who gave evidence in this case had come across this wording before, its use in the Standard Life cover is apparently unique. The inclusion in a description of an excess of the wording "each and every … claimant" gives rise to the obvious inference that what is sought to be achieved is the application of the excess separately to each individual claimant. In the event I have concluded that that is what was in fact achieved, although my conclusion as to Aon's breach of duty would have been precisely the same had I thought that either of the suggested constructions of the cover put forward by SLAC and Aon was correct. Even in such circumstances, the wording used was insufficiently clear to achieve that result without exposing SLAC to an unnecessary risk that insurers might contend to the contrary, as has in fact occurred and which has given rise to what can only properly be described as significant debate.

105. Aon suggested that a useful corrective against adoption of hindsight was to have regard to the advice of two firms of solicitors, experienced in insurance work, when asked in the one case to review the policy wording in late 1999 and in the other to advise The Independent in the light of SLAC's notification of possible claims in 2001. I derive little or no assistance from either episode.

1) Reynolds Porter Chamberlain (RPC)

At the outset I should stress that nothing I say here is intended to pre-judge the outcome of Aon's separate claim against RPC. I have heard neither evidence nor argument in relation to that matter.

In the course of a telephone conversation on 1 November 1999 between Mr Castle of Aon and Mr Jonathan Davies, a partner in RPC, there was a discussion as to a possible review to be conducted by the latter of the current Standard Life wording. Under cover of an e-mail dated 10 November 1999 Mr Castle supplied Mr Davies with a copy of the 1998 wording including the Schedule. So far as I am currently aware RPC were not supplied with, and did not ask for, a copy of the slip. In the e-mail of 10 November Mr Castle asked for confirmation of "the fee and timescales for a review which should inter alia look at" five particular issues none of which had anything to do with the basis on which claims might or might not be aggregated. Mr Davies replied on 15 November:

> "I have had a quick glance at the policy.
>
> As I understand it, you require a review of the policy wording and a letter of advice rather than any very substantial re-draft. I anticipate the cost of this should not exceed £1,000 plus VAT, and I hope this can be completed within about a fortnight."

Mr Davies was told in response that his understanding was correct and that he should go ahead on that basis. RPC subsequently provided Aon with a letter of advice dated 9 December 1999. That letter identified various possible problems with the wording but did not suggest that the description of the excess in item 4(ii) of the Schedule gave rise to any problems.

Subject to the caveat which I have already expressed I do not regard this as providing support for Aon's case. So far as appears from the materials currently before me, RPC was not specifically asked to advise on the policy excess and indeed RPC has asserted that its instructions were properly to be understood as limited to providing advice as to a standard wording and did not include giving advice as to the specific terms negotiated on behalf of SLAC. Aon says that this is incorrect but of course if RPC did understand their instructions in an incorrect or limited manner the fact that they did not advise more widely can have no relevance to the immediate question which I have to decide. RPC also asserts that Mr Davies would have had no reason to look at the Schedule and that he now has no recollection of either reading item 4(ii) or considering its effect. Since I cannot, at this stage at any rate, be certain whether Mr Davies ever saw item 4(ii) of the Schedule, I cannot regard his lack of advice thereon as casting any light on the standard reasonably to be expected of Aon. As I have already pointed out the relevant wording is far more prominent in the slip than in the policy wording produced thereafter. Finally, RPC did not of course have Aon's detailed background knowledge of the nature of SLAC's business and the scope of the indemnity insurance cover which it required and which it had instructed Aon to place.

2) Barlow Lyde & Gilbert (BLG)

I have already described the circumstances in which Messrs BLG became involved – see paragraphs 58 and 61 above. In accordance with The Independent's instructions Aon forwarded the Endowment Notification Letter

to Mr Warren-Smith at BLG under cover of a letter dated 9 May 2001 which stated as follows:

> "Please accept this letter as formal notification of the leading Underwriter's instruction (Vicky Evans Independent Insurance Company) that you represent Underwriter's interests in these matters. Copies of the slip, file and policy wording are attached.
>
> Given the each and every claim excess of GBP25Million it would appear highly unlikely there shall be any claim arising from either of these matters. Nevertheless the lead has asked that you provide a (brief) report on policy coverage and the timing of the notification, in view of the imminent renewal of the policy due to take place on 15th May 2001."

Thereafter BLG proceeded to investigate Standard Life's claim. BLG appears initially to have done so on behalf of all insurers subscribing to the policy. However in about mid 2004 the defendant underwriters instructed RPC to represent their interests and thereafter BLG acted for The Independent alone.

It is to be noted that the thrust of the instructions to BLG was that there was unlikely to be any claim, having regard to the excess, and BLG clearly understood their instructions as in the first instance relating to the question whether the notifications should be accepted under the 1998-2001 policy and whether or not they had been given in a timely fashion or were late – see their letter of 1 August 2001 to which I have already referred at paragraph 61 above. The material showing what thereafter BLG (and precisely who at BLG) thought and understood is scant. The Independent is not party to this action so there is available only such correspondence or material as was sent to or shown to other underwriters and/or the brokers. On 11 November 2003 BLG wrote to SLAC:

> "…
>
> It would be helpful to know the criteria that you are applying in determining whether or not compensation is due. Assuming that different causes of loss apply in different cases, it would be helpful to have some indication as to the approximate percentage of the overall liability that is attributable to each operative cause of loss."

BLG had been told on 1 October 2003 that the average compensation payment was at that stage approximately £2,000. It seems that it was in response to BLG's letter of 11 November 2003 that SLAC consulted Messrs Ince & Co. I suspect that it may have been Messrs Ince who pointed out what SLAC then described to Aon as a "contradiction" between Definition 3 of the policy and item 4(ii) of the Schedule.

It is certainly right to record that, so far as it appears, BLG did not at any time assert that the policy was subject to a per claimant excess. Ironically on 27

July 2004 RPC, by now acting for the Lloyd's lead on the 1998 cover, Syndicate 239, did put forward just that assertion. At a meeting with Ince on 12 January 2006 a Mr Stephen Whinder of BLG described the Schedule wording, i.e. item 4(ii) thereof, as "a bit of an enigma" on which he did not seek to rely. Whilst it is also right to record that from the outset BLG had also had a copy of the slip, the paucity of the material available concerning BLG's long involvement on behalf of The Independent is such that it would be unsafe to draw any conclusions either as to what was thought at any particular time or by whom that was thought and what experience should be attributed to that person. In so far as I do know what Mr Whinder said to Ince at the meeting on 12 January 2006, his reference to the Schedule wording as being "a bit of an enigma" could itself be characterised as somewhat enigmatic. The note of that remark is preceded by this:

> "SW conceded that the aggregation clause was very wide and that the claims ought to aggregate."

For my part, as is apparent from my earlier conclusions, I do not consider that wording which enjoyed such prominence in an important part of the slip can be cast aside or ignored without further consideration. Of course Mr Whinder's remark may not be fully reported – I have only Ince's attendance note which whilst likely to be broadly accurate does not set out to be an exhaustive account. Furthermore Mr Whinder may not have wished to share his full thought processes with his opponents. In any event one of the issues which has to be determined at Stage 2 of the trial is whether the settlement between The Independent and SLAC incorporates a discount to reflect the possible success of underwriters' argument in reliance on the "and/or claimant" wording and, if so, whether the amount of the discount is recoverable from Aon. In this regard I do not know what advice Mr Whinder gave to his clients. He may well have advised that the argument based on the "and/or claimant" wording had some prospect of success. I would be surprised if he advised that it had no prospect of success. In my view no solicitor could reasonably have so advised. I simply do not know what considered advice BLG gave to their clients. Again, there is here scant support for the proposition that Aon could reasonably have concluded that the wording to which they invited underwriters to agree clearly met SLAC's requirements.

106. At the end of the day I am of course concerned with an evaluation of the standard of care required of an insurance broker. Aon appreciated that the ability to aggregate related claims brought by many individual claimants was critical to the cover which its client required it to place. In such circumstances to proffer for acceptance the wording which appeared in the slip was in my view courting disaster. The question of the policy wording does not arise in isolation but again it should in my view have been obvious to Aon that the inclusion in item 4(ii) of the Schedule of the wording which there appears at the very least detracted from the necessary clarity of the cover which it was Aon's duty to procure. Nothing in what I know of the involvement thereafter of Messrs RPC and BLG persuades me to regard those conclusions as influenced by hindsight. Aon was in my judgment clearly negligent in placing the 1998-2001 cover.

Causation – could cover have been procured with a straightforward per claim deductible and, if so, at what cost?

107. It was the evidence of Aon's own witness, Mr Wood, in agreement with SLAC's expert witness Mr Warrington, that such cover could readily have been procured. Indeed as I have already recorded Mr Wood thought that a deductible of £25 million could readily have been converted into an aggregate deductible. It was Mr Warrington's view that if Aon had sought to place the SLAC cover in 1998 without the words "and/or claimant" appearing in the description of the excess in the slip, or in the policy schedule, the cover could probably have been placed without any other alteration in its terms and in particular therefore at the same premium. The factual evidence at trial strongly bears out this opinion. I do not consider that Mr Kerrison thought that he was quoting for cover placed on the basis of a £25 million per claimant excess. I do not consider that at any stage in the history the inclusion of the words "and/or claimant" in the description of the excess made any material difference to Mr Kerrison's perception of the risk, his willingness to write it or the manner in which he rated it. I think it unlikely that Mr Weatherstone's underwriting decision would in 1998 have been any different had the words "and/or claimant" been absent. In the previous year 1997 twelve underwriters including both Mr Kerrison and Mr Weatherstone were content to subscribe to a first excess layer slip which did not contain these words. The same had happened on the two excess layers in 1995. The market in 1998 was exceptionally weak, with over-capacity and competition as I have already described. Aon's share of the market was such that its business was highly prized by underwriters. SLAC would have been perceived as a blue-chip insured – a first rate risk. Moreover SLAC was willing to bear an immense deductible. I am left in no doubt whatever that Aon could have placed cover for SLAC in 1998 with a straightforward per claim deductible on terms which were otherwise no different from those actually achieved.

108. I reach that conclusion without regard to what happened in 2001. There was that year an exclusion of claims arising out of the circumstances of which notice had been given, or purportedly given, by the letter of 30 April 2001 to which I have already referred. I therefore approach the comparison with caution. Even so a financial institution such as SLAC could face other mass retail claims. The cover was renewed for three years on the same terms as expiring save for the removal of the "and/or claimant" wording. The increase in premium was consistent with no more than the improvement in the market and there was no evidence to suggest that the rating of the risk was altered to take account of the removal of the "and/or claimant" wording. This is at least supportive of my clear conclusion as to what would have happened in 1998 had cover been sought on this basis.

Contributory negligence

109. This defence was memorably described by Mr Railton at an early stage of the trial as "limp". Mr Railton was not of course involved in this particular argument between Aon and SLAC, but his evaluation was in my view not uncharitable. To be fair to Mr Weitzman it was not an argument which he pursued with any more enthusiasm than his professional duty required, and with characteristic frankness he recognised that Aon would if this point were reached have to bear the greater part of the responsibility. He contended for only a modest reduction in SLAC's recovery. In my view no reduction is appropriate.

110. Although an insurer, SLAC is not in the business of providing professional indemnity insurance cover and in fact before taking out this cover in 1994 had no experience of it. From the beginning and throughout the history SLAC was reassured by its brokers that the cover which had been placed met its requirements. It was specifically and repeatedly reassured that it had cover in respect of its liability for claims which in their nature were individually likely to be well under the policy excess but which together might exceed that figure where such claims were properly capable of aggregation because arising from a common cause or source. As I set out in paragraph 69 above, in 1995 SLAC received from the brokers three cover notes, containing two different descriptions of the primary layer excess without any suggestion that there was any distinction between the different formulations. In early 1996 SLAC was told that there had been conducted a review of the wording which had confirmed that the cover was extremely relevant to SLAC's activities. Later in 1996, as I have recorded in paragraphs 75-79, SLAC was extensively involved with brokers and underwriters in discussion of the wording. The draft policy wording under discussion did not include the words "and/or claimant" in the Schedule and SLAC was not told that Mr Kerrison later added those words. SLAC did not of course see the slips generated each year. It is true that the cover note for 1998 reproduced the language of the slip and invited SLAC to check whether the coverage provided conformed with its instructions. It is also true that I have recorded my own view that the language of the slip courted disaster. However that is a view reached after consideration of the evidence in the case and moreover with the benefit of long familiarity with excess and aggregation provisions in liability policies. In reality SLAC was being asked to check dates and figures, not the efficacy of contractual wording which had long been the subject of separate advice. In the light of all that had gone before SLAC in my judgment acted reasonably in relying upon the advice given by its specialist professional advisers to the effect that the wording agreed with underwriters met its requirements. SLAC is certainly not in such circumstances to be regarded as having been at fault. SLAC did not in my judgment share in the responsibility for the failure to obtain insurance cover on the required terms.

Limitation

111. It is accepted that there is no limitation defence in tort. It is therefore unnecessary to consider the position in contract. In case for any reason it does become necessary to consider it I will state my conclusion very shortly. The question is whether the breach occurred before or after 13 May 1998. The activity surrounding the placement straddled that date. The actual renewal date was 15 May. However it was not until 13 May at the earliest that SLAC communicated to Aon its preferred option out of those presented. It was on that day that Mr Stretton gave his agreement to the high level deductible. In my judgment the relevant breach occurred when Aon actually concluded the contract or contracts of insurance on SLAC's behalf. That cannot have been before 13 May because until that time they had no instructions so to do. Traditionally underwriters become bound when they scratch the slip. The earliest scratch is that of Mr Kerrison on 11 June. However Mr Kerrison had on 8 May given his binding quotation on the various different bases open for 30 days. The Independent and no doubt all other underwriters plainly became bound earlier than 11 June, but there cannot have been a contract with The Independent until the brokers informed Mr Kerrison of the option selected by the insured. That cannot have occurred before 13 May. Tellingly it was only on 19 May that Aon reported to SLAC

that cover had been effected as per its instructions. Aon cannot in my judgment establish that the claim in contract is time-barred.

The Part VII transfer

112. Initially underwriters merely put SLAC to proof as to the efficacy of the transfer to vest in SLAL rights of action which once belonged to SLAC. As Mr Railton warmed to his theme there emerged a positive allegation to the effect that it had not been effective. There is a similar transfer in relation to rights of action against Aon. Mr Weitzman adopted Mr Railton's argument. Both underwriters and brokers had of course to have an eye on what might be said by those from whom they themselves might in due course be seeking an indemnity.

113. The point turns on the true construction of two orders made by the Court of Session on 4 September 2007. However those orders need first to be put in context. I shall not over-burden this judgment with citation from the considerable documentation generated by the Part VII Transfer, which was sanctioned by the Court of Session on 9 June 2006 and which became effective on 10 July 2006. In order to become effective the scheme required, amongst other things, a resolution of the board of SLAC. The scheme also envisaged that SLAC and SLAL could agree to withhold from immediate transfer assets which were described as "residual assets". The transfer date, if any, in respect of those assets would be such as was agreed upon by SLAC and SLAL. In respect of assets the subject of immediate transfer, they vested at and with effect from the effective date. Nothing in the scheme is suggestive that any transfer, when it took place, would be retrospective in effect.

114. By letter dated 7 July 2006 SLAC and SLAL agreed to hold back, as residual assets:

1) the contracts to which SLAC and Aon are or were parties, including the retainer between SLAC and Aon around January 1998 and May 2004 as SLAC's insurance brokers for the purposes of Standard Life's Professional Indemnity and other insurance policies, together with the "Standstill Agreement" between SLAC and Aon dated 9 September 2004 in respect of claims against Aon in relation to the contract of insurance which claims were the subject of proceedings which SLAC raised against Aon in the High Court in May 2004 and May 2006 respectively;

2) the financial institutions insurance contracts with which this action is concerned; and

3) in each case, all SLAC's rights of action in relation to such retained contracts.

115. Thereafter SLAC sought the consent of underwriters and Aon to the transfer to SLAL of all SLAC's rights and obligations under the insurance contracts, in each case whether accrued, future or contingent. Some underwriters consented, some did not and so SLAC and SLAL had to return to court for a further order. An application was made on 25 June 2007. In a Note to the Court of 9 August 2007 it was spelled out that the combined effect of the existing scheme and court order was that, with effect from whatever became the Subsequent Transfer Date, the relevant contracts would become assets of SLAL. It was further spelled out that, were the order which was then sought made, it would not prejudice any legitimate interest of underwriters

because the rights which would be transferred by the order were rights which already existed, either as accrued rights under the policy or, to the extent that the limit of recovery under the policy had not been exceeded, rights to recover in respect of claims still to be settled.

116. By letter of 17 August 2007 SLAC and SLAL agreed that the effective date of transfer of both the consenting contracts and the non-consenting contracts should be the date on which the further court orders became effective. Included amongst the non-consenting contracts were all of SLAC's rights and liabilities under and in relation to the Aon retainer.

117. It was against that background that the court made the orders of 4 September 2007. That which concerns the policies provides, *inter alia*, as follows:

> "The Lord Ordinary, having heard Counsel on the Note, No. 144 of Process:
>
> 1. Pronounces an Order under section 112(1)(a) and section 112(1)(d) of the Financial Services and Markets Act 2000 ('FSMA') transferring to and vesting in or, as the case may be, imposing upon Standard Life Assurance Limited ('SLAL'), under the scheme between The Standard Life Assurance Company 2006 (formerly The Standard Life Assurance Company) ('SLAC'), SLAL and Standard Life plc, which was sanctioned by Order of this Court pronounced on 9 June 2006 (notwithstanding that SLAC would not otherwise have had the capacity to transfer the rights and liabilities in question) all rights, benefits and advantages conferred on or vested in SLAC, together with all liabilities imposed upon SLAC, under the contracts and insurance policies contained in or evidenced by the Financial Institutions Claims Made Comprehensive Insurance Policy Number 823/FB9804867 ('the Policy') between SLAC as the assured and those underwriters or companies which subscribed to the Policy and (1) for which Counsel appeared; or (2) upon which either (a) service of the Note number 144 of Process was effected pursuant to the Order of Lord Reed dated 27 June 2007 or (b) service of the amended Notes numbers 159 and 160 of Process was effected pursuant to the Order of Lord Reed dated 20 August 2007 (all as listed in the Schedule appended to this Order), such Policy to take effect in relation to those underwriters and companies for all purposes as if SLAL were substituted for SLAC as a party thereto and to the effect that the underwriters and companies shall have no greater liability to SLAL arising under the Policy than they would have had if the transfer had not taken effect, and to the effect that the underwriters and companies which subscribed to the Policy shall be entitled to assert against SLAL all rights, defences, equities, benefits and advantages whatsoever, whether

accrued or contingent, arising in whatsoever manner out of or in relation to the Policy, which they could have asserted against SLAC if the rights, benefits, advantages and liabilities hereinbefore transferred to SLAL had not been so transferred;

2. Pronounces an Order under section 112(1)(c) and section 112(1)(d) of FSMA for the continuation by SLAL in the place of and to the exclusion of SLAC, from the date of the Order, of the proceedings raised by SLAC in the High Court of Justice of England and Wales under Claim Number 2006, Folio 863, on 31 August 2006 (the 'Policy Proceedings') and those proceedings raised by SLAC in the High Court of England and Wales under Claim Number 2007, Folio 1105, on 6 July 2007 (the 'Further Proceedings') and to the effect that the underwriters and companies which subscribed to the Policy shall be entitled to assert against SLAL all rights, defences, equities, benefits and advantages whatsoever, whether accrued or contingent, arising in whatsoever manner out of, or in relation to, the Policy and/or the Policy Proceedings and/or the Further Proceedings which they could have asserted against SLAC if the Policy Proceedings and/or the Further Proceedings had not been so continued; …"

The order which concerns Aon provides:

"The Lord Ordinary, having heard Counsel on the Note, No. 141 of Process:

1. On the motion of the Noters, allows the Note, No. 141 of Process, to be amended in terms of the Noters' Minute of Amendment, No. 157 of Process, and to be further amended at the Bar; and Dispenses with re-service thereof;

2. Pronounces an Order under section 112(1)(d) of the Financial Services and Markets Act 2000 ('FSMA') transferring to and vesting in or, as the case may be, imposing upon Standard Life Assurance Limited ('SLAL'), under the scheme between The Standard Life Assurance Company 2006 (formerly called The Standard Life Assurance Company) ('SLAC'), SLAL and Standard Life plc which was sanctioned by Order of this Court pronounced on 9 June 2006 (and notwithstanding that SLAC would not otherwise have had the capacity to transfer the rights and liabilities in question), all rights, benefits and advantages conferred on or vested in SLAC, together with all liabilities imposed upon SLAC (whether present, future, actual or contingent) under the following:

> (a) the retainer in terms of which, between January 1998 and May 2004, Aon Limited ('Aon') agreed to act as broker in connection with the negotiation and placement on behalf of SLAC of various professional indemnity and other policies, including Policy Reference Number 823/FB9804867 ('the Retainer'); and
>
> (b) the 'Standstill Agreement' dated 9 September 2004 in terms of which proceedings ('the Proceedings') issued by SLAC against Aon in the High Court of England and Wales on 13 May 2004 (Claim Number 2004 Folio 400) were allowed to lapse but suspending the operation of all and any limitation periods applicable to the claims in respect of which the Proceedings were raised with effect from that date,
>
> such Retainer and Standstill Agreement to take effect for all purposes as if SLAL were substituted for SLAC as a party thereto and to the effect that Aon shall have no greater liability to SLAL arising under the Retainer and/or the Standstill Agreement than they would have had if the transfer had not taken effect, and to the effect that Aon shall be entitled to assert against SLAL all rights, defences, equities, benefits and advantages whatsoever, whether accrued or contingent, arising in whatsoever manner out of or in relation to the Retainer and/or the Standstill Agreement which they would have asserted against SLAC if the rights, benefits, advantages and liabilities hereinbefore transferred to SLAL had not been so transferred, which Order shall not become effective until all rights and liabilities (whether present, future, actual or contingent) under and in connection with the contract of insurance (Policy Reference Number 823/FB9804867) ('the Policy') entered into between SLAC as the assured and various underwriters and companies who subscribed to the Policy are transferred from SLAC to SLAL either (a) with the consent of those underwriters and companies or (b) by the further Order pronounced by this Court on 4 September 2007 in the application of the Noters (No. 144 of Process) under section 112(1)(a) and section 112(1)(d) of FSMA; …"

118. Mr Railton contended that the first order set out above had the effect that whereas under the second paragraph SLAC's cause of action against underwriters had apparently been transferred with effect from the date of the order, the policy itself including all rights, benefits, advantages and liabilities had pursuant to the first paragraph been transferred to SLAL *ab initio*, that being the effect of the words "for all purposes". That being so, contended Mr Railton, since SLAC had never been a party to the contract of insurance, it had no cause of action to transfer to SLAL in

respect of those claims in relation to which it had, prior to this order, paid compensation. SLAL could only recover to the extent to which it had paid compensation or might in the future do so.

119. I reject this argument. I start with the presumption that instruments are not to be presumed to have retrospective effect unless they contain explicit language to that effect. The words "for all purposes" do not have any necessary temporal connotation. In the context of all that had gone before, the Scheme, the consents sought from underwriters and the Note to the Court, it is quite unnecessary to construe those words as achieving something unheralded, moreover a result not achieved in respect of all assets other than the residual assets. Furthermore paragraph 1 of the order read as a whole makes it clear that this result is not intended. The opening part of the first paragraph presupposes that SLAC has accrued rights under the policy which are to be transferred. If however the benefit of the policy is to be transferred *ab initio* to SLAL, there are no such rights. Furthermore, paragraph 2 makes no sense whatsoever if the policy is to be regarded as having only ever afforded cover to SLAL rather than to SLAC. The words "for all purposes" in my judgment do no more than to emphasise that SLAL is to be in no better position vis a vis underwriters than would have been SLAC. Under a Part VII Transfer that would of course always be the case, but it appears that this is a point which was exercising underwriters – it is expressly referred to in the Note to the Court to which I have already referred. It would be astonishing and obviously unintended if this order had the effect that SLAC had divested both itself and SLAL of the opportunity of recovering from underwriters in respect of the matters the subject of the proceedings which were ongoing in this court and in relation to which SLAC had already made substantial payments by way of compensation to the third party claimants. In my judgment the language used when read and understood in its context neither suggests nor compels that result. Precisely the same is true of the second order, concerning the Aon retainer, and I do not need to address it separately.

120. I would not wish to part with this stage of the litigation without acknowledging with gratitude the enormous assistance which I was given by counsel and their instructing solicitors.