

RISK AND CLAIMS MANAGEMENT

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INTRODUCTION

For some reason the term “risk management” seems to convey an impression that some particular skill is required in the managing of an organisation’s exposure to risk whether this be in relation to the prevention of claims in the first instance or the handling of those claims when they have arisen.

We did think about beginning this presentation with the words “common sense” for that is basically all that risk management is, but that phrase does not of course sound anywhere near as sophisticated. Unfortunately whether one uses the term risk management or common sense neither is likely to enthuse senior management within an organisation. This is because managing risk is generally seen as a non profitable activity as a result of which it is often difficult to persuade management to devote adequate resources to trying to ensure that appropriate safeguards are in place with a view to trying to minimise the number of potentially costly problems that occur.

In this regard the brochure that was produced for the conference is of course slightly inaccurate in that it suggests that we will be stating how to prevent claims occurring whereas in fact all that we can do is to advise on how one might try and prevent claims occurring. This is because no matter how good an organisation’s internal controls are, it is now an inevitable fact of life that whatever precautions are taken someone somewhere is likely to be dissatisfied with the outcome of a case at some point in time, and in today’s increasingly litigious climate will look to blame somebody else for failing to achieve the desired result.

Whilst Insurers are by nature risk takers they are not prepared to do so at any cost. They inevitably wish to try and ensure that they have understood the nature of the risk that is being presented to them. Also, they wish to have a certain comfort level that the party that is trying to lay off the risk is doing so in a responsible manner and is trying to ensure that its staff adhere to best practice (in all likelihood, a written set of formal internal controls).

SOURCES OF CLAIM

Before considering what “Risk Management” involves on a practical level, it is useful to give some attention to how claims arise generally, as opposed to specific acts of negligence.

For an Insured to have an effective Risk Management strategy in place, a clear understanding of how claims arise is paramount. Insurers will have a better understanding of this and Insureds can benefit from this knowledge.

However, the current reality is that high level management time continues to be solely focussed on “profit making” activities with not enough time being spent considering areas of risk, and what to do about it.

Before looking at the main sources of claim, there is one area that probably can never be eliminated entirely and that is the “genuine mistake”.

A good recent example of this is where a client company instructed an Insured to pay over a cheque in settlement of a debt.

The Insured forgot to make the payment and the creditor obtained a winding up order against the client company. Following this, the cheque was immediately paid over and the winding up order was set aside. The Insured also wrote an open letter to “anyone concerned” explaining how the winding up order had arisen as a result of their negligence.

However, this did not prevent a claim arising and the sums claimed were staggering when compared to the “error”. The client company alleged that as a result of the winding up order being made:

- *It lost the opportunity to secure planned investment from a large construction company;*
- *It lost a number of existing construction contracts that had been tendered for;*
- *It lost the ability to obtain credit from suppliers, and as a consequence the ability to develop its business.*

The amount claimed was £2.5 million, and the noteworthy aspects of this example are that not only did the claim arise from a simple error, but also that the work being carried out by the Insured was low risk work from an Insurer’s point of view.

There are a number of areas of claim that are capable of being “risk managed”, thereby reducing the number of actual claims, and a few of these are:

- Being out of your depth
- Lack of supervision
- Inability to support the truth
- Conflict of interest
- Failure to identify the client
- E-mail

Being out of your depth

It is common amongst professional firms for the phrase “sink or swim” to be uttered by managers to their employees. Indeed, it is probably common in any business.

This reflects the attitude of some people at the top, but from an Insurer’s point of view it can only mean that risk is increased in that particular organisation.

This is because increased and unnecessary pressures are placed on younger and less experienced employees to take on high workloads. Also, the culture that develops does not encourage the employees to raise their concerns, and a dog eat dog mentality is quickly established.

People getting out of their depth arises in other ways, and it is probably worth remembering that even the most experienced of people can find themselves out of their depth.

This can commonly arise in smaller practices where a long-standing client starts to develop a need for wider professional support. The professional does not want to lose the client and as a consequence takes on more than his actual experience permits. The result is usually bad news for Insurers.

By way of a footnote, a practical problem with such claims is that more often than not the individual concerned will not admit that he was in fact out of his depth. This can be detrimental to the claims handling process in a number of ways, not least as a result of the time and costs that are spent dealing with the issue.

Lack of supervision

The term “supervision” means a lot of things to a lot of different people, and the level of supervision is always being balanced with:

- *Financial considerations; and*
- *The need to allow individuals space to develop.*

However, Insurers can be confident in the fact that if all their Insureds operated a mandatory system whereby each individual’s work was reviewed by a senior colleague at the more important stages, claims would be reduced to a more than acceptable level.

The main obstacle to high level supervision is a financial one. Clients will not pay for this level of supervision and Insureds will not implement it without being paid for it. There continues to be a reluctance amongst many professionals to sacrifice profit for quality.

Given this, firms with identical practice areas can have staggeringly different approaches to supervision.

The larger accountancy firms are a possible exception to this, and they tend to have in place more rigorous structures for supervision. However, experience has shown that even strict “partner supervision” regimes can sometimes amount to only a cursory signing off of reports without any real input or objective analysis.

Therefore, it remains a truism to say that the general trend to reduce (rather than increase) the number of Chiefs still exists in professional firms, whilst at the same time there are internal pressures to increase the number of Indians.

The other problem alluded to already is the balancing act that needs to be performed by employers so that employees are given the space to develop and enjoy their career without having “Big Brother” on their shoulder.

This can be a very real problem for Insureds, particularly given the direct and hidden costs involved in recruiting new staff. If supervision levels are too high the first problem that an Insured is likely to face is a desertion by its more experienced Indians.

Inability to support the truth

The most frustrating aspect of claims handling has to be:

- *A lack of file notes recording what work has been carried out on a file;*
- *A lack of file notes recording telephone conversations;*
- *A lack of file notes recording what was discussed at a meeting, and whether the meeting took place at all;*
- *A lack of detailed letters of advice, either advising the client generally, or recording advice given previously;*

This remains the most common problem despite all the efforts made by all professions to implement Risk Management.

The reasons for this have remained constant from the time that the term “Risk Management” was first uttered by Underwriters, and they are:

- *Lack of time;*
- *Lack of training;*
- *Lack of insistence by employers;*
- *Lack of incentive to Insureds, or at least a lack of understanding by Insureds of the financial rewards that can follow.*

There can be no excuse for failing to make file notes. By doing so claims, can sometimes be eliminated completely, or at the very least settlement negotiations are assisted.

On that rare occasion where a claim does end up in Court, the evidence of a credible Claimant will almost always be preferred where there is no documentary evidence to counter it. With a file note, Insurers have a potent weapon which can often turn a case.

The importance of this area of risk management is highlighted by the absurd interpretation by the Court of Appeal of Section 32 of the Limitation Act 1980. Until the decision is overturned (fingers crossed for *Cave v Robinson Jarvis & Rolf*), or the limitation laws are revised by statute, claims against professionals will be made long after the actual event and this makes the need for documentary evidence even more acute.

This is because the problem faced by Insurers will no longer be an Insured's failing (or in most cases failed) memory but the fact that the key witnesses will have long since disappeared or passed away.

The fact that this simple aspect of Risk Management remains a problem, means that Risk Management remains as important as ever.

Whilst in almost every case a file note would offer some assistance to the defence of a claim, an eye must be kept open for the "after the event" file note which conflicts with other pieces of evidence. This is where an Insured has decided that it would be helpful to have a note of what happened, even though the note was written some time after the alleged act.

Conflict of interest

This source of claim is close to being inexcusable, and is often closely linked with someone being out of their depth and/or a lack of adequate supervision.

Conflicts can arise all the time in the course of a retainer and it must be one of the many issues that is reviewed on a regular basis.

After a claim has been made against an Insured, and after Insurers have carried out an investigation, it is surprising how often the conflict of interest is immediately apparent, putting to one side the benefit of hindsight.

A common example is where a solicitor, who has acted for a local family for years, accepts instructions to act for the entire family on a re-mortgage.

The mother and father instruct the solicitor that they have decided to re-mortgage their house (having spent 25 years paying it off) to enable the equity to be used by their daughter who is starting up a new business. The daughter is to be a party to the new mortgage.

Given the "happy family" relationship at the time, hard advice is shied away from (or not considered) and the solicitor agrees to act for all three parties. Inevitably, the entire family later falls out, and the daughter's business fails. The parents then want their money back.

The Insured solicitor is left with no defence to allegations of breach of duty, and is immediately on the back foot having to argue causation. Even if the causation defence is strong, the existence of the conflict will always favour the Claimant if a Court is in any doubt as to which way a case should be decided. The lack of judgment by the professional will more often than not enable a Court to justify its decision.

The more oblique problems of independence and confidentiality were highlighted and tested in the case of *Prince Jefri and KPMG* and the simple message to take away is that courts will not give the professional any slack in such instances.

The relevant facts of *Jefri* are that KPMG acted for the Brunei Investment Agency (“BIA”) and undertook annual audits of its core funds. From those core funds, certain payments had been made which the board confirmed had been made for the benefit of the Brunei Government. At the time, Prince Jefri was the BIA Chairman.

KPMG were then retained by one of Prince Jefri’s companies between 1996 and 1998 and carried out extensive litigation support investigations. In so acting, KPMG obtained extensive confidential information concerning Prince Jefri’s assets and financial affairs.

Following this, the Government of Brunei instructed KPMG to investigate the activities of the BIA. KPMG had concerns over accepting these instructions and took steps to protect the confidentiality of information concerning Prince Jefri that was in KPMG’s possession, and they sought to build a “Chinese Wall”.

Prince Jefri sought an injunction preventing KPMG from acting and the matter ended up before the House of Lords. The House of Lords held that:

- Relief should not be granted where there is no risk of the disclosure or misuse of confidential information;
- The evidential burden fell on KPMG to show that there was “no risk”;
- KPMG were unable to demonstrate that they could provide the protection to which Prince Jefri was entitled in order to ensure that there was no risk that confidential information which KPMG had acquired from him would be disclosed.

Failure to identify the client

Surprisingly, this is a common source of claim and the number of times that Insureds fail to identify who their client is must be a cause for concern.

Engagement letters are designed to deal with this at the outset, as well as determining precisely what an Insured’s instructions are.

A recent example of this is where a solicitor receives instructions from the two main shareholders in a Company to apply to remove one of the Joint Supervisors. The petition to remove one of the Joint Supervisors is issued in the name of the Company and in the name of one of the Directors.

The Company and the Director later bring a claim against the solicitor alleging that they were unduly exposed to a significant costs risk (the application failed) without receiving any advice on the matter.

The Insured had proceeded on the basis that the Shareholders were acting on the Company's authority and, further, on the basis that the Director was being kept fully informed of the developments.

Whilst it is probably true to say that the Shareholders were effectively running the Company, and also that the Director would have agreed to the course of action taken had he been fully appraised of matters, proving this becomes an extremely difficult, expensive and risky task.

Engagement letters are designed to alleviate this problem but despite Professional Codes of Conduct requiring such letters, it remains the case that they continue to be absent from many files.

E-mail

The use of e-mail in business has increased dramatically over the last two years. Most firms allow employees direct access to the internet and most clients now insist on communication by e-mail wherever possible.

The issue of "Supervision" comes to the forefront here, given the fact that clients are entering into day to day e-mails with the person who has day to day conduct of that client's matter. The client wants (and gets used to) an immediate response.

The person with the day to day conduct of the matter gets into a comfortable pattern of replying to the client instantly wherever possible. A few pitfalls of this method of communication are:

- *Informality– at best the e-mail is ambiguous, and at worst the client is offended;*
- *The advice given is not thought through;*
- *The advice given is not supervised.*

There are solutions to this but they are cumbersome and defeat the whole object of e-mail! Whilst the use of e-mail has increased massively, risk management of its use has not.

The same amount of effort that is being put into developing computer security and avoiding computer bugs needs to be put into developing proper supervision of e-mail use.

An Afterthought

Whilst the areas that Risk Management seeks to address are unlikely to alter significantly year on year, the framework for doing so will, and a good example of this is the Law Society's Lexcel Practice Management Certification Scheme.

The Scheme requires firms to have procedures in place to deal with some of the issues that have been mentioned, including:

- Identifying conflicts of interest;
- Monitoring workloads;
- Compliance with Rule 15 Engagement Letters;
- File audits.

The RICS Standards of Practice Department confirmed recently that they do not have an overall document which formally set out standards of practice to reduce risk. However they have produced two leaflets following advice from Counsel dealing with:

- retention of old files; and
- use of locums in periods of absence from the firm.

They do not have a certification scheme and are unaware of plans to introduce one. However there is a requirement that all members are committed to continuing professional development (CPD). Whilst some of these courses would deal with standards of professional practice, attendance is not compulsory.

The Institute of Chartered Accountants confirmed recently that they do not have publications dealing with risk reduction and no publications are planned. All they have is their Members Handbook, which contains a Statement of Practice but does not specifically address risk management.

The Royal Institute of British Architects confirmed that they do not have any risk management publications or certification schemes in place. However the new President of the Institute has taken a real interest in risk management and has undertaken an investigation into the increase in negligence claims. He is seeking to combine a risk management policy with a policy of ongoing architectural education.

In addition, the RIBA Journal does have regular articles on risk management issues.

Regardless of whether or not certification schemes exist, a Risk Management policy will only work if a company is truly committed to it.

This is possibly the most important issue to tackle in the future, and the message that still needs to be taken on board by Insureds is that there are tangible benefits in them having an effective Risk Management procedure in place. By having effective procedures in place, lower premiums would follow and, also, Insureds would begin to feel more comfortable increasing the level of their deductibles.

HOW TO TRY AND PREVENT CLAIMS OCCURRING – READING THE SURVEY

It has been said that Insurers are realistic and appreciate that mistakes do happen. It is equally true however that Insurers now require more of a proactive role by their Insureds to try and prevent claims occurring in the first instance.

It is becoming more frequent for insurers to require that a risk management survey is to be undertaken in relation to prospective Insureds prior to acceptance of a risk. This part of the presentation focuses on the areas that such a survey should cover and the points that Insurers should have particular regard to.

Such surveys will generally conform to a set pattern beginning, as with all good presentations, with a section setting out what is to be done, a further section stating what has been seen by way of documentation and who by way of personnel have been interviewed, a description of what has been related to the writer of the report and finally a conclusion and recommendations section.

As the legal profession has found to its cost over the years just as a taxing master seems to feel that it is part of the reason for his existence that he must tax off at least part of any bill that appears before him so the writer of a risk management survey will feel compelled to end with some recommendations as to how the system can be improved, no matter how good the internal controls appear to be. As will be mentioned later, the survey is the easy part of the equation.

The difficult part of the process is implementation and care needs to be taken to ensure that those in senior positions within the organisation are ready to “lead from the front” rather than merely paying lip service to the concept of risk management as that is simply a waste of the time of everybody concerned within the organisation.

What should one expect to see covered in a survey?

1 General background setting out when the organisation was established and who has control of the equity interest.

In general terms the longer that the organisation has been in existence the better from an insurance perspective as the organisation is likely to have an established claims history which should assist with the rating of the risk.

- 2 **Reference should be made to the spread of the equity interest.** In general terms the wider the spread of the equity interest the better as this would suggest that the organisation is not subject to the “whim” of one person.
- 3 **The organisation’s current attitude to risk management.** For example, does it have a professional standards group monitoring who within the organisation does what, where and when and to ensure that the appropriate systems are in place which both manage the policing process and standardise jobs which are done on a frequent basis to try and ensure maximum efficiency and accuracy.
- 4 **Identify who has been assigned responsibility for risk management within the organisation.** The more senior person with this responsibility the better. Is there an awareness of the directors/partners of the annual cost of claims to the business? Is the premium for the professional indemnity insurance closely monitored to ensure that any increases raise alarm bells?
- 5 **Rate of staff turnover.** If the rate of turnover is high then investigation should be made as to the reason for this. The higher the rate of turnover the greater the risk there may be of claims arising as it is likely that staff do not feel particularly motivated or loyal to the organisation and may take less care in dealing with their work in the knowledge that they intend to move on within a relatively short period of time.
- 6 **Level of excess and therefore potential involvement of the Insured.** The higher the level of excess the greater the involvement of the Insured in both trying to prevent claims and managing them when they arise. The difficulty that is likely to be experienced in this regard is that the smaller the organisation the less likely they are to be able to afford what is regarded as a reasonable excess whereas, in general terms, these potential Insureds might be regarded as a higher risk as they are thought less likely to be able to devote adequate time to risk management.
- 7 **Do the insured have a “blame culture”?** This is the situation where, if a claim is successful a financial penalty is imposed upon a particular person or group from whom the claim emanated. This is wholly contrary to fostering an environment where employees are encouraged to report matters whilst they are still circumstances as opposed to claims.

It is almost inevitably going to be the case that a matter will be disposed of more cheaply whilst it remains a circumstance than if matters have developed to the stage where a formal claim is pursued. Employment conditions should not penalise individuals in any way for the reporting of circumstances and/or claims.

- 8 **Rate of growth of the organisation.** As with the rate of staff turnover the faster the rate of growth of an organisation the greater the likelihood there is of claims occurring. This can arise as a result of expansion of the business without adequate training of the additional staff required. Regular staff reviews/performance reviews should identify any poorly performing or problem staff at an early stage. Care should be taken to ensure that work is not undertaken by people who do not have sufficient expertise.

- 9 **Management structure.** Regard should be had to the reporting structure within the organisation to ascertain the level to which claims are reported.

The higher up the management chain that such claims are reported the greater the likelihood that management treat such matters seriously and, hopefully, will wish to reduce the incidence of such matters occurring by adopting a proactive approach to risk management and ascertaining why such problems are occurring.

- 10 **File management.** Whilst in theory this is one of the most straightforward matters to attend to, it is one of the most important issues that should be addressed. Of all the steps that an organisation can take to try and reduce the risk of either a claim arising or of putting itself in the best position to successfully defend a claim, this is the most important step and is also one of the most basic steps.

This step is simply the making of notes of what was said at meetings and in telephone conversations. Other steps such as the logging and date stamping of post and printing off and filing of e-mails and facsimiles are in their way as equally as important but in so many cases disputes arise over what the representative of an organisation said or did not say at any particular point in time. In particular, does the organisation make notes of conversations, meetings etc.?

Whilst we are still awaiting the arrival of the totally paperless office consideration should be given to whether the organisation logs and/or date stamps post and whether e-mails are printed off and put on the relevant file before being deleted from the screens.

When the paperless office has arrived care will need to be taken to ensure that the documents received by computer are transferred to the correct file. Is post logged and/or date stamped and are e-mails printed off and filed?

- 11 **Does the organisation have engagement letters?** This is another basic step which can help reduce the incidence of claims arising. Many professional bodies now require their members to issue such letters in which they set out the scope of their instructions and therefore, hopefully, their duty. Despite these requirements, however, a number of organisations still fail to issue such letters.

In many cases, the concern relates to fees and the fact that the people concerned do not like seeing written down in black and white the basis of the fee structure. The problem for the organisation when a claim arises is satisfying a court that their obligations were as limited as they subsequently tried to maintain.

Whilst a party can always assume additional duties which are not contained in the contract a Claimant may find it more difficult to persuade a court that those additional duties have been assumed in the absence of a written document confirming this to be the case.

- 12 **What is the training policy?** This again is a question of investment and the more that an organisation is prepared to invest in training its staff the more likely it is that it appreciates that this assists in the reduction of claims being pursued. This training should not simply relate to the professional aspects of the business but also the steps that can be taken to reduce the risk of claims occurring.

This presentation has focused upon the risk management survey as a tool that might be used by Insurers to try and improve their understanding of the quality of the risk that they are being asked to accept. One way in which Insurers may try and enforce the message that they expect the Insured to adopt a continuous approach to risk management is to incorporate a condition in the policy that the insured shall take all reasonable steps to enforce the risk management policy that they have in place.

It will doubtless come as no surprise to Insurers, however, to read that the enforcing of such a clause is far easier said than done. Where those protections may help however is in identifying at an earlier stage than might otherwise be the case who might be regarded as a poor risk from a claims perspective.

As indicated in the introduction to this paper there is no particular “magic” to approaching the subject of risk management. Much of what has been written above is common sense but regardless of any of the advice that has been given it won't matter what protections an organisation has in place if the people there fail to implement those systems.

CLAIMS HANDLING

It is all too easy to lose sight of the basics of handling professional indemnity claims amid the hype of mediation and pre-action protocols, and the changes introduced by the Civil Procedure Rules. However, the fundamentals of claims handling remain as important as they always have been.

The writer therefore makes no apology for stating that basics such as reading the policy wording, speed of response, and the development of an agreed case strategy remain the cornerstones of effective claims handling. However, it is the CPR and its supporting practice directions which have been the drivers of change in the way professional indemnity claims (and indeed all litigation) should be handled. It is not the aim of this paper to analyse in detail the impact of the CPR, merely to highlight those areas which have been confronted over the last year or so.

Pre-action protocols

As is well known, compliance with pre-action protocols is now of serious importance. The CPR sets out a summary of the aims of pre-action protocols, and also provides that a less than conscientious approach to compliance with the protocols may result in prejudicial costs or procedural penalties against offending parties. Of the aims of the protocols, the desire to put the parties in a position where they may be able to settle cases fairly and early without litigation appears to be particularly significant. This should also be seen in the context of the Court's encouragement to parties to consider alternative dispute resolution.

It should perhaps be noted that the Court will expect to see reasonable pre-action behaviour applied in all cases regardless of the existence of a specific protocol. This is particularly important in cases where a draft protocol is in existence, although this view is not universally held by Claimants' solicitors.

As outlined above, the CPR enables the Court to take account of the parties' compliance with protocols when giving directions for the conduct of proceedings or as to costs. The Court has power to order that costs be paid on an indemnity basis, or deprive/reduce the Claimant's entitlement to interest. Conversely a Court can award a higher rate of interest if it is the Defendant who is at fault. One should resist the temptation of paying lip service to the requirements of the pre-action protocols; going through the motions without, for example, providing a full response or proper disclosure will be penalised.

After what was in part a slow start, the use of protocols has now generally been accepted by most litigants and advisers in professional indemnity claims and this has undoubtedly led to the early and cost effective settlement of claims which would otherwise have taken the traditional route through the Courts. It is comforting to note that the Courts are showing an increasing tendency to stay claims to enable the parties to adopt a protocol.

Alternative dispute resolution

Alternative dispute resolution (ADR) should now be regarded not as an alternative but as a central part of the development of any claim. It should be taken into account before proceedings commence and throughout the proceedings, to ensure compliance with the CPR.

There are of course various forms of ADR including mediation, adjudication and early neutral evaluation, but mediation through commercial mediators or judicial appraisal are most commonly used.

It has been argued that professional negligence actions are not suitable for resolution by ADR. This may in part be because the Claimant feels that he will not recover the damages he would obtain at trial, but there remains an element of Claimants still wanting their day in Court.

Conversely Defendant professionals remain concerned that settlement at mediation, which is reliant on compromise, unfairly impacts upon their business both as to reputation and on their premiums for professional indemnity insurance. A further genuine area of concern arises where a defence may depend upon the detailed analysis of the Claimant's claim or documents. In these circumstances mediation can be inappropriate; by its very nature it does not lend itself to a detailed analysis of legal and factual disputes.

It may be trite to comment but it would be naïve to go into a mediation expecting to reach a settlement which does not involve a payment, save perhaps in a multi-party mediation.

Other less prominent forums of ADR are the mini-trial, expert appraisal and judicial appraisal.

Expert and judicial appraisal can be of particular assistance in professional negligence cases either because the issue at stake is purely technical or legal, or where the opportunity to obtain a senior legal opinion on the likely outcome of the case would be of assistance and where there are issues which militate against mediation.

The importance of technical issues in professional negligence claims and the significance of legal points which usually arise will probably indicate that the parties will feel more comfortable accepting an independent legal opinion. It is envisaged that the expert/judicial appraiser could either be a QC or retired Judge. These alternative fora for dispute resolution should, where the issues lend themselves, provide an opportunity for a swift and cheaper resolution to claims, particularly where the parties have adopted polarised positions on the points of legal analysis/principle.

Funding arrangements

An increasingly important element in formulating the strategy for the defence of a claim is a consideration of the Claimants' funding arrangements. Claimants are now increasingly bringing claims either with the benefit of assistance from the Legal Services Commission, or more widely having obtained insurance against the liability for costs.

The assessment of the risks of proceeding to a trial needs to take account of the Claimant's funding, particularly if it is provided by non-standard means, as Insurers may have to face taking enforcement action from those funders. This paper does not deal in detail with the various funding arrangements which are now available, but as is well known these include conditional fee arrangements (either with or without enhanced fees), insurance backed policies, and pursuit policies.

The essential terms of a "pursuit policy" are that it provides unlimited cover for the other side's costs and ensures that the majority of the "Insured's" costs and disbursements will be paid. It does not however, cover any "success fee" payable to the opponent's legal team.

The unique element of a pursuit policy is that a premium is not payable up front; the premium only becomes payable if the insured is successful, and which is then recoverable from the other side.

In addition to taking into account the Claimant's funding arrangements, Insurers and defence teams should at all times take steps to avoid the possibility of an Order for costs against them in the event the Claimant succeeds and the policy limits are exceeded.

In the leading (and well known to all) case of *T G A Chapman Ltd and Another –v- Christopher and Another*, a costs Order was made against an Insurer who had been held to have fought a claim exclusively for its own interest. Defendants facing professional negligence claims will almost invariably be insured under a professional indemnity policy or other scheme providing cover.

Cover, of course, extends in the majority of cases to the costs of defending the claim, and assuming that the indemnity limit and the costs provisions contained in the policy wording are adequate, the Defendant will not feel at risk. However, in some cases the limit may be lower than the claim plus costs, or the policy wording may provide for restrictions on underwriters' liability to meet defence costs, in which case the Defendant and potentially Insurers remain at risk.

Funding has also shown itself to be a fertile ground for unease between Insurers and Insured. Even where the Defendant is adequately insured and is ultimately successful he may yet suffer after the event. Insureds naturally become concerned where a claim is successfully resisted at trial, but owing to the funding arrangements of the Claimant recovery of defence costs is impracticable if not, impossible.

Insurers will/may, however, revise premium rates/deductibles or other policy terms, having funded the defence. Tension is created between Insurers and Insured; at such times Insureds may need reminding (or preferably educated at the time of taking the policy) that like themselves, Insurers are commercial organisations operating for profit in a competitive market.

Front loaded litigation

Finally, one of the undoubted impacts of the reforms introduced by the Civil Procedure Rules is that litigation is now, more than it has previously been, front loaded in terms of preparation and costs. This is an inevitable consequence of the CPR and is a point which has been taken on board by Insurers and defence lawyers.

Aside from the costs consequences for Insurers (and the desirability of settling claims early if liability is likely to attach) this underlines the need for the defence team to gear up quickly, and as a team develop a case strategy designed to defeat/restrict the claim. Otherwise, the defence team/Insurers will be playing catch up to the benefit of the Claimant.