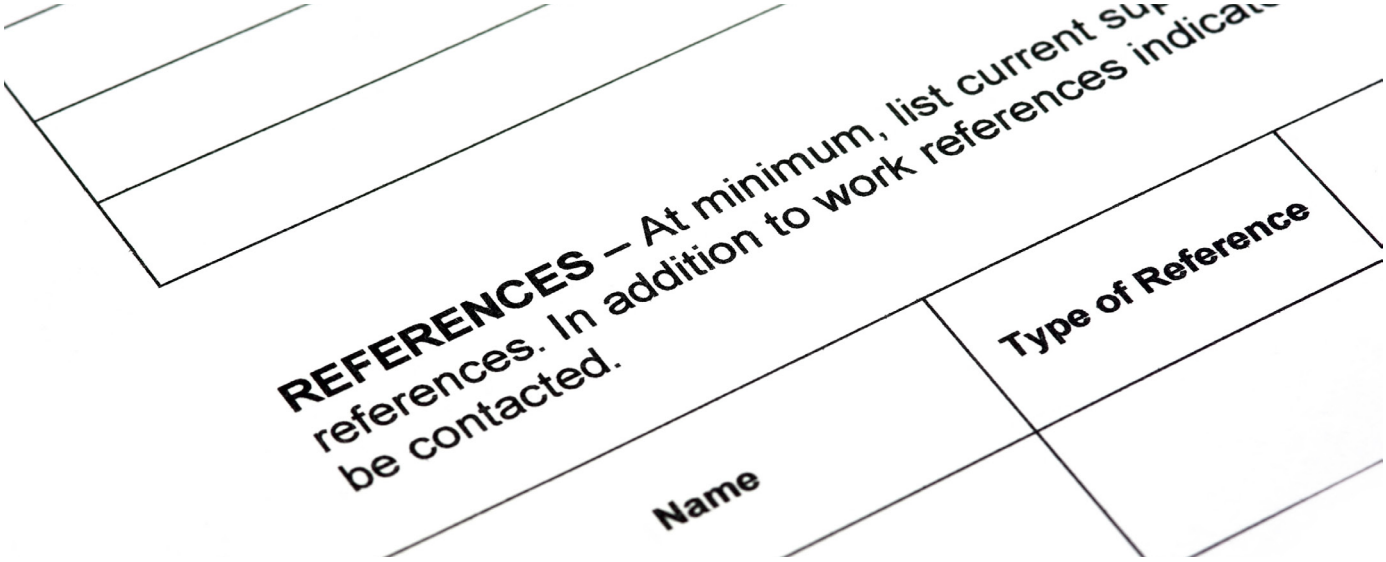
QBE European Operations

UK casualty claims

Case studies | October 2014

In your defence



Accidents happen and in liability insurance the frequency and cost of claims are on the increase. It is only when you receive a claim that you discover the value of your insurance company.

We are equally committed to paying valid claims promptly and maintaining a robust defence where appropriate. Our philosophy reduces the cost of claims against you and protects your reputation. Here are some recent examples evidencing our claims handling approach in practice:

Trial Win – Court of Appeal

Our insured commenced disciplinary proceedings for gross misconduct against an employee who they alleged had provided false references for a former colleague. A disciplinary hearing took place before an independent assessor who dismissed the allegations stating the claimant was "guilty of stupidity and naivety", but not complicity. The claimant went off work sick with stress and following the dismissal of allegations, she left the insured's employment. Thereafter, the claimant initiated a claim against the insured alleging that they were in breach of contract and/or negligent in commencing disciplinary proceedings against her. She claimed that they had led to her developing a psychiatric injury.

The Judge at first instance found that if thorough enquiries had been undertaken, there would have been no proper basis for a charge of gross misconduct and the disciplinary proceedings would not have been instigated.

At trial, the parties were agreed as to the correct test to apply to the facts in order to determine whether breach of duty was established; for the instigation of disciplinary proceedings to be "unreasonable", it had to be outside the range of reasonable decisions open to an employer in the circumstances.

In reviewing the Judge's findings, the Court of Appeal indicated that the test required an objective assessment. The circumstances included both the evidence available to the insured at the time and any further evidence that would have become available as a result of a non-negligently conducted investigation.

The Judge in the first instance had accepted that reasonable people could reach different judgments on the same question and it was possible to be wrong both about the method by which the investigation should proceed and the claimant's culpability as to being complicit in the production of a false reference on behalf of her colleague (without being negligent).

The insured contended that in the circumstances of the case, a reasonable employer could have concluded that there was a disciplinary case for the claimant to answer on a charge of gross misconduct.

Ultimately, the Court of Appeal agreed that the recommendation for a serious disciplinary charge "was entirely reasonable, indeed almost inevitable" and the District Judge was "plainly wrong" to conclude otherwise.

Whilst it had been open to the insured to accept the claimant's denial of complicity in the false reference, it was not unreasonable to reject it in the circumstances.

The District Judge was correct in setting out the appropriate test for the determination of liability. However, he did not apply it and instead made an assessment of the overall merits, influenced by the claimant's account in her evidence at trial, rather than considering whether it was reasonable to instigate disciplinary proceedings in the first place.

"... He elided the question whether the allegations made in the disciplinary proceedings were true with whether there were reasonable grounds to suspect that they were; and ended up substituting his own judgment for that of the university"

The fact that there was evidence, which the District Judge took to support the claimant's account, did not mean it was unreasonable or negligent for the insured to instigate proceedings against her.

It was a very pleasing result and was the culmination of more than four years' hard work and preparation.

Discontinuance five days prior to Trial - Costs to be recovered

The claimant was employed as a production engineer with our insured from 1978 onwards. He alleged that due to working in close proximity to large high speed forging machines he developed Noise Induced Hearing Loss (NIIHL) and tinnitus.

Investigations revealed hearing protection was only supplied from 1990 onward and noise surveys were not conducted until recently. The claimant would have been subjected to eight hours of excessive noise per day until 1990. A breach of duty of care was admitted subject to medical causation.

The claimant's medical evidence advised of a gradual deterioration over the last six years. In December 2006, he noticed a high-pitched whistling noise in both ears, which was diagnosed as moderate tinnitus. Our own medical evidence suggested a cut off date of 1993 was appropriate given audiogram findings from that year, with any hearing loss thereafter being age-related. A conference with our medical expert and Counsel confirmed that this was a case to defend to trial, because the claimant was not suffering from any material disability. Even if it were to be found that the claimant had been exposed to excessive levels of noise, he was not disabled over and above that expected for age.

The claimant put forward Part 36 offers decreasing in value, followed by a costs inclusive offer then a drop hands offer. All were rejected.

Discontinuance on the usual terms was filed five days prior to trial. The matter had been live for just over four years. We are negotiating the recovery of our outlay.

Discontinuance - Costs recovered in full

The claimant brought a significant claim for damages alleging that she had developed fibromyalgia as a consequence of carrying out her work duties. She alleged an unsafe system of work and a breach in Manual Handling Regulations 1992. Her duties involved walking up and down a single flight of stairs whilst carrying garments.

A provisional Schedule of Loss with proceedings totalling £815,416 plus interest was served. She alleged the fibromyalgia had a catastrophic effect on daily living and ability to work. A claim for loss of earnings until retirement was submitted. The Claimant's medical evidence supported her claim on causation. She was 29 at the time of the incident.

Investigations revealed the claimant had complained about issues with her knee. Upon notification of the issue, the insured put her on light duties restricting her to ground floor work only.

A robust denial was maintained throughout and an Application was made for the claim to be struck out following a repeated failure by the claimant to comply with directions. Her schedule of loss and documents were supplied one month after the directions date. Repeatedly she refused to attend our medical expert for examination despite offers for home visits and ambulances for transportation. Prior to the Application Hearing, the claimant offered to accept a vastly reduced sum of £25,000 for damages, plus costs. We rejected the offer and insisted the claimant should discontinue her claim.

The claimant agreed and paid 100% of our costs incurred in defending the claim, which totalled £25,000.

Significant recovery obtained

The claimant was employed by our insured as a rider. Whilst exercising a racehorse, the claimant fell sustaining a spinal injury rendering her tetraplegic. There was evidence that the saddle was defective.

Strict liability was established against the insured under PUWER with no grounds to allege contributory negligence. The claim was pleaded at £11m. Settlement was agreed at £6.1m.

A Contribution Act claim was commenced by QBE against the saddle supplier. The saddle was imported from South America. We initially sought a contribution from both the supplier of the saddle and the saddler, who modified the saddle through the fitting of stirrup bars. It transpired that the saddler was an uninsured sole trader with no assets, and so we concentrated our efforts on obtaining a contribution from the saddle supplier.

The supplier contested liability and produced dynamic testing results that conflicted with our own evidence. Despite their strong repudiation, they eventually agreed to contribute £1m towards Damages and £100,000 to Costs. Given that they held no other significant assets, liability was disputed and they were allegedly prepared to take the matter to trial we consider this to be an excellent result.

Favourable settlement

The claimant injured his head and sustained spinal damage during construction of our insured's ship. Enquiries showed that the stairwell where the accident occurred was poorly designed. Liability was admitted with contributory negligence being alleged.

A JSM was organised to narrow down the issues between the parties given the differing views held by the medical experts in the joint statement. The claimant's expert suggested a ten-year acceleration period with our expert stating it to be between one and three years.

The claimant produced a schedule of loss claiming just over £200,000 at the JSM. He claimed the insured had changed the company doctor responsible for the Fit for Work at Sea Assessments. This new doctor was more robust than the previous one and as such, he would fail future assessments . We argued that the claimant had no proof of this allegation and that he had passed this test following the accident. A change in doctor did not mean he would fail it in the future. Nonetheless, he claimed post and future loss of earnings, post and future care, DIY, gardening and various other miscellaneous heads of claim.

The claimant rejected our initial offer of £40,000, but despite continuing to argue his future losses, the claim was eventually settled at the JSM for £43,000.

This was an excellent result and serves to show how well placed settlement offers supported by the evidence of robust, credible medical experts put the claimant under pressure when heads of losses cannot be justified or evidentially supported.

Counter Fraud Success - Misrepresentation defence

The claimant alleged that whilst cutting nails from a pallet a shard of metal flicked up and hit him in the eye. Safety glasses were being worn at the time but were not fully enclosed. The insured's First Aider referred him to A & E for treatment.

Our investigations revealed that the insured had many incidents of eye injury occurring pre- accident and yet did not see fit to alter their safety glasses. One that fitted flush with the face would have been more appropriate. Colleagues and CCTV footage supported the claimant's version of events. A breach of duty of care was admitted for failing to provide adequate personal protective equipment under Regulation 4 of the Personal Protective Equipment Regulations 1999.

Given liability attached to the insured and the accident book entry confirmed a minor eye injury was sustained our claims inspector decided to make a pre-med Part 36 offer in order to limit third party costs. No reply was received so a reminder was issued to the claimant's solicitor, which prompted an immediate fax acceptance with the provision that reasonable costs would be met; a copy of the claimant's medical report had also been sent that very same day. The claimant's medical expert stated that he was unable to find any evidence of an accident related injury to the eye and in fact upon attending A&E the claimant had been told that there was no evidence of an eye injury. He was told that he was suffering from optic neuritis an inflammatory condition, which may be caused spontaneously, or be a pre-curser to multiple sclerosis.

On receipt of this evidence, we immediately advised the claimant's solicitor that our offer would be withdrawn, due to misrepresentation. They asserted that there had been an offer and acceptance and that if we failed to pay the agreed damages they would issue proceedings for breach of contract.

The matter was heard at trial in Manchester on 13 October 2014; the claimant's case was that there had been a breach of contract. We argued that there had been no offer and acceptance and even if there had, the contract had been entered into due to misrepresentation. The judge awarded in our favour on the basis that the "acceptance" was in fact a conditional offer made on the basis that an accident occurred and injury was sustained. No actual injury was sustained however, and the judge considered that the claimant had not met the conditions of the offer.

Further information

If you would like any further information or advice on our claims service please contact the QBE Claims Team on **+44 (0)20 7105 4000.**

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