ANALYSE

PREPARE

PROTECT

Cover to Cover

Issue 33

Our publication for New Zealand insurance professionals

MinterEllisonRuddWatts.

Contents

Foreword

[Andrew Horne](#)
Partner

[Nick Frith](#)
Partner

[Lloyd Kavanagh](#)
Partner

[Hannah Jaques](#)
Partner*

[Olivia de Pont](#)
Senior Associate

Welcome to our second issue of Cover to Cover for 2025.

In this edition, we explore recent developments shaping the insurance sector. One of the most significant is the impact of generative AI. We interview the founder of PolicyCheck, which is about to go live with an AI driven product that offers insurance brokers new tools to analyse customer profiles and match them with the most suitable insurers and policies, among other tools, streamlining the process and improving customer outcomes.

We offer insights into the Financial Markets Authority's Climate-related Disclosures report, which continues to serve as the best available guide to regulators of what should be improved in year 2 of the reporting obligation.

In previous issues of *Cover to Cover* we reported on the various types of insurance claims that may arise from cyber fraud. In this issue, we look at a recent decision of the High Court of England and Wales, *Logix Aero Ireland Limited v Siam Aero Repair Company Limited*, as an example of the increasingly sophisticated cyber-crimes that are emerging and how this risk might be sheeted home to insurers.

This issue also unpacks the practical takeaways of the Supreme Court's decision in *Kaniere Family Trust v PGG Wrightson Real Estate Ltd*, which clarifies the scope of liability for negligent misstatement. Notably, the ruling allows for the possibility of liability extending to include costs incurred to restore a property to the condition it would have been in had a representation been true, which may exceed the loss claimable under the traditional measure of a comparison between the value if as represented and the actual value.

We consider a significant English Court of Appeal decision on damage, deductibles, and delayed deterioration. The ruling confirms that insurers may be liable for losses resulting from deterioration occurring after the policy period, provided it is a natural and foreseeable consequence of insured damaged sustained during the policy period.

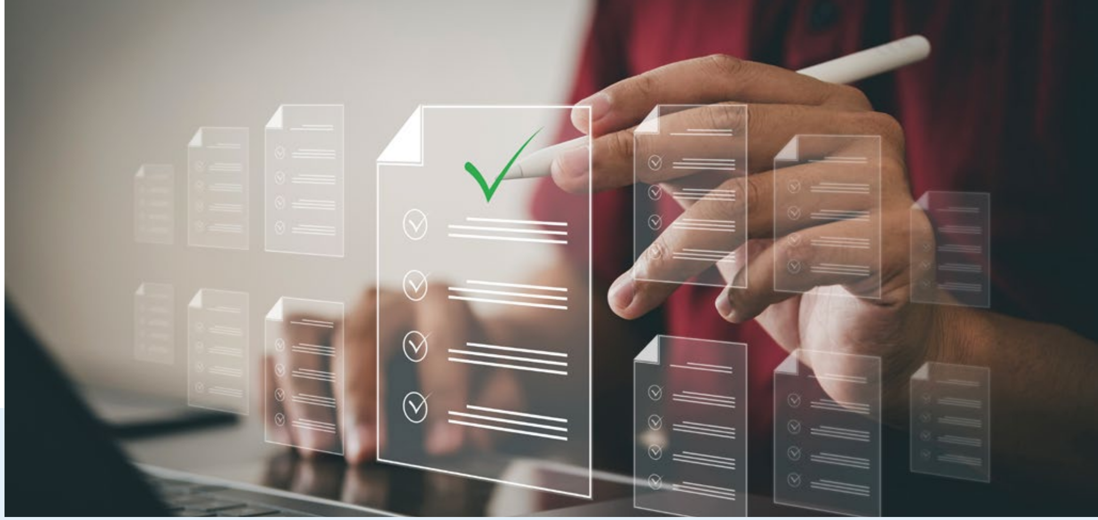
Finally, we review the English High Court's decision in *Watford Community Housing Trust v. Arthur J Gallagher Insurance Brokers Limited*, where a broker was found liable for failing to notify all insurers of a claim. The judgment sheds light on brokers' notification duties and the complexities of claims where there is double or triple insurance.

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

AI and insurance broking:

The first solutions come to market

Partner, Andrew Horne interviews Simon Archer, co founder, PolicyCheck



In issue 28 of Cover to Cover, we reported on the transformative power generative AI is likely to have on the insurance industry, and the role it could play. We predicted that generative AI would have the potential to offer insurance brokers tools to analyse customer profiles against insurers' offerings to match customers with the most appropriate insurers and policies, saving time for brokers and improving customer outcomes.

It is crucial for brokers to keep up to date with these developments. Two years on, we are learning of exciting new AI tools for insurance brokers that are now coming to market that promise these benefits and more. Partner, Andrew Horne, spoke to Simon Archer, co-founder and director of innovation at PolicyCheck, a new AI-based product for insurance brokers that is expected to be released soon in New Zealand.

Q What will PolicyCheck offer brokers?

PolicyCheck is an AI-based product we are developing that will offer brokers a range of tools to help them advise customers better and more efficiently. It will also help brokers target customers, and comply with their regulatory obligations.

Brokers will begin by inputting a customer's requirements into PolicyCheck, either by typing them into templates or simply by downloading emails or transcripts of calls with the customer for PolicyCheck to interrogate. Brokers will also be able to invite PolicyCheck to a call with a customer so it can learn their requirements in real time. It will produce a list of requirements which the broker and customer can check and add more if necessary.

Once that's done, the system will compare those requirements against its database of insurance policies and identify those that look as though they best respond to the customer's requirements. We are expecting many of the policies in the database to be provided by insurers, and we're working with insurers to make them available. Brokers can also add policies they have obtained from other sources, including their own proprietary products.

PolicyCheck will then analyse the customer's requirements against the policies and produce a table listing the customers' requirements down the side, the names of each insurer across the top, and a summary of what each policy offers for each requirement in the table. The summary is colour coded, so brokers will be able to see at a glance which of the policies best meet the customer's requirements, along with other relevant information such as deductibles, premiums and additional benefits. The policies can be sorted and listed based on criteria the broker specifies.

PolicyCheck can then produce a report and a recommendation for the customer, using automated templates. This will describe what the customer is gaining or losing if it takes different policies. It won't list everything, because there are too many differences between policies for that to be practical, so it will prioritise those that look to be most important to the customer based on its instructions. A screen will show premiums and commissions.

Once the customer has made a decision, PolicyCheck can produce a draft proposal form to the insurer, based on the customer's documents and instructions.

The system will also track customer interactions and use approved messaging to help brokers with regulatory compliance. It will keep a record, for instance, of customers' decisions to opt out of cover, or whether they declared prior claims or provided other relevant information.

What else does it offer?

We're working on a number of additional features we think brokers will find useful. For example, we are working on a feature to help brokers working in areas in which they may be less familiar or where they want reassurance that they have asked questions that are relevant to the customer's risk. We see this as a 'risk coach', where the system suggests questions the broker might ask a customer who is in a particular line of business. For instance, if the customer is in the hospitality industry, the system might suggest questions about food standards compliance.

The system will also be able to go through the customer database and identify where customers may have opted out of cover that other customers are taking, or suggest other possible conversations.

We are also looking at developing an automated claims management tool.

Does this reflect what brokers are telling you they want?

Brokers are telling us they want one system that does everything in one place – taking customer instructions, comparing policies, providing reports and issuing documents. We're aiming to provide that with PolicyCheck.

How reliable are the answers?

We're starting with AI-driven highlights as AI is still some ways off from fully accurate policy interpretations, especially when confronted with complex wording. Rather than delivering black-or-white inclusion/exclusion verdicts, our goal is to speed up the review by flagging the sections and clauses that deserve closer inspection. Brokers, lawyers, and clients remain responsible for confirming suitability but can leverage the AI's insights to empower deeper understanding and to focus their expertise and attention where it matters most.

With every policy uploaded and each interaction feeding back into the model, the AI-driven highlights will become increasingly precise, making the review process faster and more reliable over time.

What types of policies will be offered?

We are starting with home and vehicle insurance, which are relatively straightforward products. Once we are happy that the system is working as we want it to, we expect to expand the offering to a wide range of policies including life, health, travel, business, professional indemnity, cyber, and even speciality policies such as agricultural and aviation risks – even reinsurance.

When do you expect PolicyCheck to go live for brokers to use?

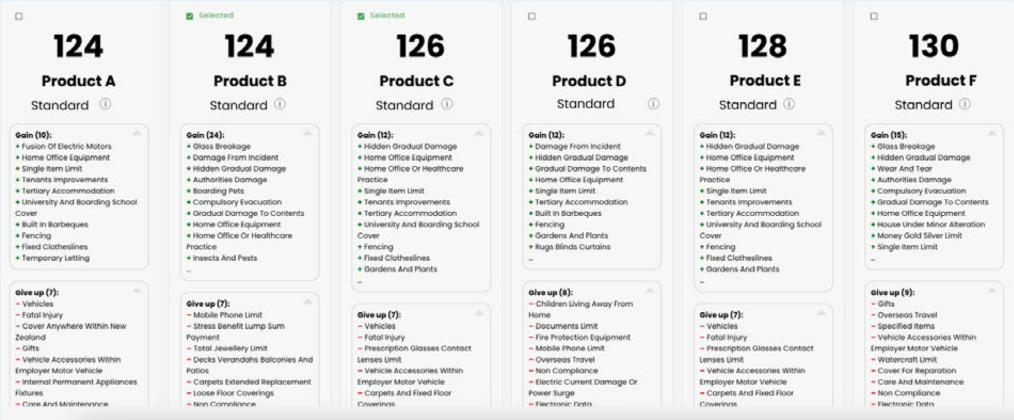
We're expecting the first tools to go live this year. We'll start with the tool that takes customers' requirements and compares them against a database of policies to produce a table of recommendations, and expand it from there.

Should brokers be worried that AI tools such as Policy Check will take their jobs?

We see this as an enabler for brokers, rather than a threat. We think these features will help brokers do much less procedural and administration work which will free them up to spend more time on sales and business development.

Where do you operate?

Our founders are in NZ and Australia, so our focus is on the needs of local brokers and insurers. We are keen to speak to brokers who may be interested in using our products, and they can contact us or book a demonstration through our website at policycheck.co.nz.



Example of a PolicyCheck comparison table

Practical takeaways from the Supreme Court's decision in *Kaniere Family Trust v PGG Wrightson Real Estate Ltd* for liability insurers

Authored by Partner, Nick Frith and Solicitor, Leticia Alvarez

In a landmark decision, the Supreme Court has clarified the scope of a defendant's liability for negligent misstatement. While that liability is limited to the foreseeable consequences of the breach, in some circumstances the decision will expand liability to include the cost of steps taken to improve the property subject to the misrepresentation to the condition it would have been in had the representation been true.

Why this matters

Defendants (and their insurers) are potentially exposed to much greater liability than before this decision.

The Supreme Court's decision marks a departure from the relatively settled principle that a tortfeasor's liability was limited to the difference in value of the property between what it would have been worth had the relevant representation been true, and what it was actually worth, at the date of sale. The decision potentially expands tortious liability to costs incurred in attempting to improve the property to equate with the represented attribute, so long as those costs were foreseeable and within the scope of the duty. This will impact how insurers and brokers assess professional risk for those insureds who make representations and convey information in the course of their business. This refined approach has implications for underwriting, how limits and excesses are set, and how insurers evaluate claims exposure.

Professional liability insurers must now pay close attention to the scale and context of their clients' businesses, particularly when assessing the scope of services, reliance placed on advice, and the foreseeable consequences of misinformation. The core question remains whether the type of loss claimed falls within the scope of the duty the defendant assumed. What did the professional know, what was their relationship to the claimant, and how was the information to be used?

Background

In 2010, the Routhans, as trustees of the Kaniere Family Trust, purchased a dairy farm near Hokitika, alongside their existing run-off farm. Before purchasing the farm, they asked a PGG Wrightson Real Estate Ltd (PGG) agent to confirm the farm's historical average production of milk solids per season. This information was important to the farm's value.

The misrepresentation

PGG's agent represented to the Routhans that the farm had recent historical average production of 103,000 kgMS per season. He knew the vendor had not verified the production data but did not disclose this, nor did he pursue the vendor for more information. He also overstated the number of cows milked and understated the quantity of fertiliser applied. Not only was the farm's recent production substantially lower than what was represented, it was in decline and so the average was not 103,000 kgMS per season. Had they known the truth, the Routhans' evidence was that they would not have purchased the farm.

The Routhans' efforts to achieve represented production

The Routhans purchased the farm in reliance on PGG's statement about milk production. They then set about trying to achieve it. They increased their borrowing and invested significantly. This included purchasing supplementary feed, using additional fertiliser, re-pasturing, and extending the milking season. These efforts all failed. They were unable to service their debt over a decade, and both of their properties were eventually sold at a combined loss of nearly $2 million.

The claim

Claiming that they would not have purchased the farm had they known the true milk production value, the Routhans' trust sued PGG in negligence and under the Fair Trading Act 1986. They initially sought not less than $3 million in damages, reflecting the position they said they would have been in had they bought an alternative farm that in fact produced at the represented level of milk solids. In the alternative, they claimed ongoing operating losses, interest and costs. The core issue was whether those downstream losses were attributable to PGG.

The High Court decision

The High Court found the Routhans would not have bought the farm but for PGG's misrepresentation. It awarded damages not on the basis of a hypothetical alternative property, but on actual loss, including costs incurred in post-purchase efforts to improve production. The Routhans were entitled to compensation for their lost equity in the farm and the run-off property, and their investment in capital improvements to improve production.

The Routhans had lost their capital investment when they realised that the farm was not as represented to them. This included: "overpayment" for the farm; costs of fertiliser; re-pasturing and feed; lost production revenue; interest and increased debt taken on to fund various steps as part of efforts to improve milk production, long-term capital improvements and partial loss on the resale of the farm.

The Court held that since the misrepresentation affected both the purchase and subsequent decisions, the resulting losses were compensable. The Court awarded $1,697,600, comprising the forced sale loss ($1,442,000), costs of improvement not recovered on resale, and interest. The Court deducted 20% on account of contributory negligence linked to unproductive capital expenditure.

The Court of Appeal decision

While upholding the High Court's finding that PGG was liable to the Routhans, the Court of Appeal held PGG's duty was limited to providing accurate production data, not to advising the Routhans on business strategy.

The Court concluded that downstream financial losses such as expenditure on attempting to achieve the represented features of the farm were outside PGG's duty. Efforts to increase production, inability to manage debt, and subsequent equity loss were beyond the scope of risk assumed by PGG.

Furthermore, the Court found that the Routhans could have sold the farm at cost in 2014, meaning the claimed long-term losses were too remote. Ultimately, the Court of Appeal applied a commonly cited UK case called SAAMCO to limit PGG's liability to the difference between the price paid for the farm, and the farm's market value given PGG's misrepresentations. That difference in value equated to $300,000.

Practical takeaways from the Supreme Court's decision in *Kaniere Family Trust v PGG Wrightson Real Estate Ltd* for liability insurers.

The Supreme Court decision

The Supreme Court allowed the plaintiffs' appeal by majority, but did not fully reinstate the High Court award. While it confirmed the centrality of the scope of duty principle, it also rejected the *SAAMCO* "cap" on damages, qualifying its application to cases where A owes B a duty in tort but does not also owe B a concurrent contractual duty for the same breach – presumably cases analogous to contract.

The "scope of duty" principle

To assess whether a loss falls within scope, the Court must ask:

- For what types of risks was the defendant undertaking responsibility?
- Was the allocation of risk fair in the circumstances?

Rejecting the rigid SAAMCO cap

The majority held that the Court of Appeal erred by using the SAAMCO cap as the "normal" measure of damages. The risk of compensating one party for losses unrelated to the impugned advice or information can be mitigated by carefully considering the scope of duty and the remoteness of damage. If the breach of duty merely served as the occasion for the losses e.g. it allowed a transaction to take place, rather than being their cause, it will not meet the threshold for legal causation.

Moving beyond the advice/ information dichotomy

The Court was critical of a rigid distinction between "advice" and "information". These labels were found to be artificial and of limited use in complex, real-world, professional relationships.

Instead, the Court endorsed a "risk-spectrum" approach, asking whether the kind of loss claimed was of a type for which the professional assumed responsibility. This better aligns with commercial expectations and recognises the practical realities of professional services.

The outcome for the Routhans

The Court limited compensation to losses within the scope of PGG's assumed duty, namely:

- Overpayment based on the farm's true value;
- Cost of additional fertiliser applied in reliance on the misstatement;
- Cost of a re-pasturing programme undertaken on expert advice.

Other operational and equity losses were deemed too remote or outside the scope. The total damages awarded were $780,500, plus interest and $50,000 in costs.

Our view

This decision provides clarification, if not comfort, for liability insurers.

The Supreme Court confirmed that, even if loss would not have occurred "but for" a misstatement, it is not recoverable unless it falls within the assumed duty. However, the scope of the assumed duty has crept beyond the traditionally understood "difference in value" approach to one that will likely invite claims for greater amounts, including costs incurred to seek to cure a misrepresentation. The decision does, however, limit potentially open-ended exposure and affirms that professionals are not guarantors of commercial success.

Key takeaways

- Courts will now inquire into the nature of the professional's role, what was reasonably foreseeable, and how information provided to recipients was used.
- Where a contractual relationship exists, the law of contract will usually govern the scope of duty and remoteness of loss. In such cases, SAAMCO limits are less relevant. This aspect reinforces the importance for insurers of scrutinising professional insureds' standard engagement terms to ensure they clearly define scope and limit liability.
- Conversely, reliance-based damages are limited to the actual loss incurred by relying on the misrepresentation: such as overpayment, wasted expenditure, and will be equally confined by questions of causation and reasonable foreseeability.
- PGG was not responsible for downstream losses that arose from broader commercial risk. The Court drew a clear boundary: professionals are responsible only for the specific risks they undertook, not the client's overall financial position.
- Liability turns not so much on what was said, but on what the recipient was reasonably expected to do with the information.

Higher expectations for second year climate statements:

Key insights for insurers

Authored by Partner, Lloyd Kavanagh and Solicitor, Darlene Hu

In December 2024, the Financial Markets Authority (FMA) published its '*Climate-related Disclosures: Insights from our review*' report (FMA Insights Report) which remains the best available guide to the regulator's view of what should be improved in year two, under New Zealand's mandatory climate-related disclosure (CRD)

Of the 16 "large" licensed insurers (CREs), who are subject to the CRD regime, six have already lodged their second year's climate statement, as at 16 July 2025. We are looking forward to the remaining insurers that are left to lodge in the balance of this year or by 30 January 2026.

This article is aimed mainly at that latter group who are currently working on what year 2 CRD will look like for them. It shares our observations of the climate statements lodged to date, feedback from the regulators (especially the FMA's Insights Report), and learnings from a research report by Mosaic Financial Services Infrastructure (Mosaic FSI) on metrics and targets, which was released on 23 June 2025.

Why CRD matters to insurers

Climate risk is not a distant or abstract concern for the insurance sector — it is core business. From underwriting and claims to solvency and reinsurance pricing, climate change is already reshaping the risk and investment landscapes. The physical impacts of more frequent and severe weather events, the transition risks arising from policy and market shifts, and the liability risks all have the potential to directly affect insurers' bottom lines. Insurers must demonstrate that they understand and are actively managing climate risk, or risk losing the confidence of regulators, investors, and policyholders alike.

As section 19B of the Financial Reporting Act 2013 says:

The purpose of climate standards is to provide for, or promote, climate-related disclosures, in order to:

- encourage entities to routinely consider the short-, medium-, and long-term risks and opportunities that climate change presents for the activities of the entity or the entity's group; and
- enable entities to show how they are considering those risks and opportunities; and
- enable investors and other stakeholders to assess the merits of how entities are considering those risks and opportunities.

This is reinforced by the "ultimate aim" of Aotearoa New Zealand Climate Standards (NZ CS) which is (as stated in NZ CS 1) "to support the allocation of capital towards activities that are consistent with a transition to a low-emissions, climate-resilient future".

Both of these emphasise the relevance of understanding climate impacts to an entity's strategy and risk management. However, how that plays out is different for the three insurer categories: general insurers, life insurers, and health insurers.

For the seven general insurer CREs, the most immediate implications for their businesses typically come from physical impacts, and their direct consequences. These include increasing claims costs (e.g. due to increasing frequency and severity of weather events), rising reinsurance premiums, and increasing taxes and levies from Fire and Emergency NZ and Natural Hazard Fund. But opportunities are also emerging such as new products like parametric insurance.

For the nine life and/or health insurers, climate impacts may be harder to assess at this stage. Physical impacts like increasing extreme weather events could lead to increased health risks, which, in turn, could lead to increased demand for cover and increase insurance claims. Some attribute deaths in the current European heatwave to climate change. In the shorter term, it is the transition impacts in investment markets, distribution channels and customer preferences that are emerging. In this, they may have more in common with the CREs who are licensed fund managers, than with the general insurers. One of the particular challenges for health insurers will be whether the GHG emissions of hospitals they pay for are scope 3 "financed emissions" of the insurer.

Regulator guidance from year 1 and increased expectations in year 2

The FMA Insights Report explicitly directs CREs to:

- **Strike the right balance on the amount of information disclosed:** CREs need to weigh the risk of over disclosing, and potentially obscuring material information, against the risk of disclosing too little and omitting material information.
- **Fairly present disclosures**: applying the information and presentation principles in NZ CS 3, in conjunction with the materiality principle, to ensure the disclosure is relevant and useful to primary users. Transparency is the watchword when dealing with the ambiguity and uncertainty inherent in climate-related disclosures.
- **Disclose material information to explain underlying methods and assumptions, and data and estimation uncertainty:** This includes the specific requirements for scenario analysis and greenhouse gas (GHG) emissions disclosures.
- **Describe how processes are undertaken and, where required, the frequency of those processes:** more than saying processes exist — it's necessary to provide material information to explain what is involved (i.e. how the process is undertaken), and how often it occurred during the reporting period.
- **Explain the connection between climate-related matters and other organisational activities:** to make clear the degree to which the consideration of climate-related risks and opportunities is embedded across an organisation.
- **Understand and apply the meaning of "current climate-related impact":** i.e. when something that has moved from being a risk or opportunity (both future looking) to something that has occurred in the reporting period — i.e. an impact, how the entity has been impacted.
- **Disclose all material information to explain climate-related risks and opportunities:** e.g. providing contextual information (e.g. severity, exposure and vulnerability), and allocating them across the short-, medium- and long-term time horizons). At the same time, the FMA noted it is only those risks and opportunities that are material for CRE's primary users that should be disclosed.
- **Disclose all material information to describe GHG emissions targets:** including any "net zero targets". In particular, disclosures must be clear and transparent when describing why any GHG emissions targets are aligned with limiting warming to 1.5 degrees Celsius.
- **Enhance scenario analysis:** e.g. improving disclosure of how scenarios were constructed, and analysed, including all available material information to disclose how that future may play out, and explaining how the CRE's entity-level scenarios have used (or not) sector-level scenarios.
- **Ensure CRD is consistent and coherent with other information disclosed:** e.g. financial reporting, or product offering documentation.

While some of these directions could have been more focused on other types of CREs (e.g. large NZX-listed entities or banks), insurers would be well-advised to consider the FMA's expectations of materiality, readability, succinctness, and specificity to them.

As an example, it is clear the FMA expects CREs to minimise the number of generic statements they make. A key example of a generic statement relates to the impacts of weather events, including Cyclone Gabrielle. From first year climate statements, only one insurer dissected the impact of Cyclone Gabrielle and provided quantified impacts on its business. Other insurers simply stated there was an impact (e.g. by stating an increase in claims) but did not provide quantitative or qualitative analysis.

Additional requirements in year 2

In the first year, seven Adoption Provisions were available (and 13 of 16 insurers utilised all of them). In second year statements, NZ CS 2 allows CREs to utilise up to six adoption provisions. Adoption Provisions 1 and 3 now have expired, while a new adoption provision 8 has been introduced exempting CREs from including scope 3 GHG emissions disclosures in the scope of its assurance engagement.

The effect of this is that in year 2 it is mandatory for CREs to include in their climate statements:

- **Current financial impacts:** CREs must disclose the current financial impacts of their physical and transition impacts, and include an explanation of any quantitative information that is unable to be disclosed, as required by paragraph 12 of NZ CS 1; and
- **Transition plans:** CREs must disclose the transition plan aspects of its strategy, and the extent to which the transition plan aspects of its strategy are aligned with its internal capital deployment and funding decision-making processes, as required by paragraph 16 of NZ CS 1.

In relation to Scope 3 emissions, Adoption Provision 4 (initially set to expire alongside 1 and 3) was extended by the XRB for an additional year. The change was introduced to acknowledge stakeholder feedback in which concerns were expressed regarding the uncertainty and difficulty experienced in gathering scope 3 GHG emissions data. Adoption Provision 8 complements this difficulty by exempting these emissions from assurance requirements.

Approach so far in year 2

As at 16 July 2025, the six insurers have filed their second-year statements, and it is apparent that they are responding to the FMA's expectations, in the Insights Report, and the additional requirements.

Statement style and length:

First year insurer CRE statements range from approximately 19 to 50 pages in length[1], with all insurers publishing special purpose statements for their CRDs.

Of the six insurers that lodged second year statements as at 16 July 2025, we observed:

- The statements are on average slightly longer than their corresponding first year statements — primarily because of the additional content requirements referred to above with the other text being similar or shorter than the first year.
- Two have changed their approach. In year 2, AIA and Partners Life integrated their climate statements into their annual reports by having a climate statement-specific section in their annual reports, so the climate statement remained clearly identified and integration does not impede readers' access to CRD-required information. Their climate sections are 21 and 22 pages long, respectively.
- The four other insurers (Chubb Life, Resolution Life, QBE, and Swiss Re) have maintained the approach of a separate special purpose statements, but they are also typically a few pages longer on average — they range from 23 to 34 pages in length.

Across all six, we see a stronger impact of the fair presentation principle in NZ CS 3. For example, we have seen less positive framing and fewer general descriptions in the year 2 statements, with more balanced tones, clearer articulation of risks and stronger acknowledgement of limitations.

Adoption provisions:

In year 2, there continues to be heavy reliance on the adoption provisions. So far in the second year, four of six insurers have utilised all six now-available adoption provisions. All insurers so far have utilised the new adoption provision 8, so that assurance is not required on scope 3 emissions.

Governance:

We observed stronger integration and operationalisation of climate governance within insurer CREs from comparing their year 1 and 2 statements. Insurers have included more details about the frequency at which climate material is considered by various boards, committees, and responsible persons within their entities.

There was also better delineation of climate responsibilities within insurer CREs in year 2. One insurer disestablished its CRD working group as CRD obligations oversight is now embedded in entity processes in year 2, and another insurer established a dedicated climate working group and more clearly defined climate roles.

One insurer has significantly uplifted its governance section and we look forward to its year 3 statement as it is likely further detail about its groups, committees, and persons involved in climate decision-making will be included.

1 Statement length is determined by the page numbering contained on each statement.

Scenario analysis:

In relation to scenario analysis, all six insurer CREs so far utilised the same scenarios in year 2 as they did in year 1. Chubb Life, Partners Life and Resolution Life (three life insurers), continued to use the Financial Services Council recommended scenarios (Orderly, Too Little Too Late, and Hothouse). AIA, QBE, and Swiss Re (one health and life insurer, one general insurer and one reinsurer) again used The Network for Greening the Financial System scenarios (Orderly, Disorderly, Hothouse) which are broadly comparable.

It makes sense not to change scenarios at this early stage and is, in our view, in line with the NZ CS 3 principle of consistency, enhancing comparability of statements for primary users from reporting period to reporting period.

Anticipated developments from the remaining year 2 climate statements

We will watch with interest to see whether the remaining insurers remain with the standalone climate statement approach, or follow the lead of the two who have integrated them into their annual report. In terms of other non-insurer CREs, we see both approaches. But the standalone climate statement, or a statement integrated into a wider sustainability report seems to be favoured by the strong majority of large financial institutions. Either way, as the FMA's Insights Report points out, it is important that the climate statement and other reporting such as financial statements are compatible.

We do expect CRD statement length to among the remaining insurer CREs yet to lodge either be similar to year 1. Statements from the first to second year should not vary hugely in length. Some of the disclosures required last year may be able to be shortened as CREs focus on the fundamental NZ CS 3 principle of fair presentation.

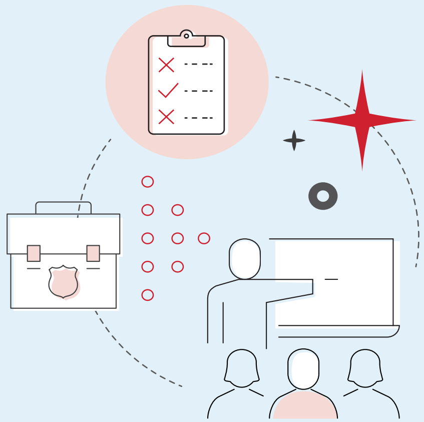
At the same time, the two new, additional disclosure requirements for current financial impacts and transition plans are likely to require CRE's to add more pages. There may also be additional material required, if it is necessary to restate any FY24 disclosures. The FMA has flagged that it expects that there may be errors in the early years, and drawn attention to the requirement to restate in the subsequent year's climate statement under NZ CS3.

We expect all remaining CREs, including insurer CREs, will also reduce the number of generic statements made in their disclosures in the second year. This includes CREs clearly stating how CRD information is dealt with within the CRE: by whom (the Board and any relevant committees), what format the information is presented, how many times CRD information is reviewed, and the level of engagement with the CRD. This was specifically called out in the FMA's Insights Report.

CREs must disclose information in a manner that is relevant, accurate, balanced, and comparable, among other principles. With the breadth of CRDs filed across all types of reporting entities, we expect insurers to be able to better strike the balance between disclosing too little and too much information better in their second year statements.

Finally, in the process of assisting fund managers with preparing their FY25 climate statements (which typically have a 31 March year end), we have seen careful consideration of potential transition impacts on investments due to Donald Trump becoming President and his Executive Orders rolling back climate initiatives of the prior US government. While there is arguably a material transition impact that could be described qualitatively, it was not possible to quantify it separately from the impacts the non-climate related executive orders made at the same time.And we also note the impact on stock indexes in the last quarter of their reporting periods largely rebounded in the following quarter (i.e. after the end of the reporting period).

We expect insurers, particularly life insurers, whose businesses also have significant investment portfolios, may also need to consider whether these impacts were material current financial impacts for them.



Other insights

Mosaic FSI recently published a CRD research report on registered bank and building society (BBS) and insurer year 1 climate statements against the metrics and targets requirements in the climate standards. MinterEllisonRuddWatts provided legal input to the report.

Mosaic FSI found that there is a statistically significant difference in approaches to investment emissions disclosures between insurers and BBSs, with only 13% of insurers reporting values compared to 38% of BBSs. Leading CREs were often able to provide more specific metrics and targets and compare data spanning over a greater period to clearly demonstrate the effects of their climate strategy.

However, the small sample size makes the analysis very sensitive and these differences may be as a result of the fundamentally different natures of the BBS business (primarily deposit-taking lenders) versus the insurers who face methodological barriers and limited access rights to client emissions data. Also, as we point out above, the insurance sector itself can be split between general insurers and life/ health insurers given their respective businesses are significantly different.

Despite those limitations, the report provides useful food for thought going into year 2.

Please get in touch with one of our experts if you would like to discuss any of our observations and insights, or your climate reporting obligations generally.

Case study

Notify or pay:

The £5 million cost of a broker's failure to notify all insurers

Authored by Senior Associate, Olivia de Pont and Solicitor Sione Roberts

In April 2025, the English High Court handed down its decision in *Watford Community Housing Trust v Arthur J. Gallagher Insurance Brokers Limited* [2025] EWHC 743 (Comm). The Court found the insurance broker liable to pay up to £5,000,000 for failing to notify all of the plaintiff's insurers of a claim promptly.

The insurance broker, Gallagher, admitted that it was negligent, but argued that its breach of duty had not caused any loss. This was on the basis that each of the insured's three insurance policies contained double insurance provisions which, Gallagher said, had the effect of limiting the total indemnity recoverable to less than the amount insurers had agreed to pay. The High Court was asked to rule on this defence as a preliminary issue.

The judgment is of interest because it throws light upon brokers' duties to notify insurers as well as the complexities of claims where there is double or triple insurance.

Background

In March 2020, a staff member of Watford Community Housing Trust (WCH) sent an email to 3,167 recipients, accidentally disclosing sensitive information about over 3,500 of WCH's tenants and employees. This included information about individuals' sexual orientation and ethnicity. It resulted in an immediate backlash. 1,136 complaints were made. WCH considered that 1,050 of these were valid claims which it either settled or was attempting to settle when it asked its broker to assist it to make an insurance claim for its liabilities arising from the breach.

WCH had three separate insurance policies which provided cover in respect of losses from data breaches:

1. £1 million of cover under a cyber insurance policy, underwritten by PEN Underwriters, on behalf of various Lloyd's syndicates;
2. £5 million of cover under a "Combined" policy, underwritten by QBE; and
3. £5 million in professional indemnity (PI) cover, underwritten by Hiscox.

Following the data breach, WCH's broker, Gallagher, advised it to notify only PEN of a claim. It failed to advise WCH to notify either QBE or Hiscox, with the effect that they were not notified until after the expiry of cover under the Combined and PI policies.

Case study

Notify or pay:
The £5 million cost of a broker's failure to notify all insurers

Both QBE and Hiscox initially declined cover. QBE subsequently agreed to provide cover and to indemnify WCH up to its £5 million policy limit. This meant that the total amount of cover available to WCH was £6 million, however WCH anticipated that its losses would exceed that sum.

Gallagher's defence was, essentially, that the maximum amount of cover available to WCH across all three policies was £5 million, on the basis that:

- On a literal reading, the "other insurance" clauses in each of the three policies made each contract of insurance an excess policy, such that WCH did not have any primary cover. Given that would be absurd, these clauses should cancel each other out, leaving WCH with triple insurance providing horizontal layers of primary cover of £1 million, £5 million and £5 million.
- Had all of the insurers been notified, the maximum total indemnity to which WCH would have been entitled was limited to £5 million, even if its total loss exceeded that. This was on the basis that the "other insurance" clauses had the effect that the maximum total indemnity could not exceed the highest limit in the horizontal layer of primary cover.
- As WCH had an indemnity of £6 million, it had not suffered any loss.

The High Court judgment

The High Court ruled in favour of WCH. The Court agreed with WCH that the three "*other insurance*" clauses cancelled each other out, meaning WCH held triple insurance providing horizontal layers of primary cover of £1 million, £5 million and £5 million. The Court went on to find that in such a case, an insured may claim against any or all of its insurers in whichever order it wishes, and if it fails to recover the whole loss from one insurer, it can recover the balance from one or more of the others. Importantly, this gave WCH a total of £11 million of cover.

In reaching this view, the Court distinguished a line of authorities relating to contribution between insurers where there is double insurance. The Court held that where there is double or triple insurance, the insured may recover, at most, the amount representing their actual or agreed loss up to the amount of each policy, so that if the insured is over-insured, part of the total sum insured will not be recoverable. However, an insured can choose how to make up his or her indemnity so that, subject to each policy indemnity cap, the insured may pursue the insurers in such order and for such proportions of the loss as the insured sees fit. It is then for insurers to settle their respective liabilities between themselves, when the usual contribution rules apply.

The Court also considered an argument made by Gallagher that the policies restricted the plaintiff's total indemnity. While the Court, there was insufficient wording in any of the policies for such a restriction to have effect in this case.

Key takeaway

This case serves as a reminder to insurance brokers that, where a client holds multiple insurance policies which may respond to the same event, all insurers ought to be notified of a claim, because the client may be entitled to the benefit of all of the policies. This is necessary to ensure that the maximum amount of coverage is available. A failure to do so can be costly.

A sophisticated cyber fraud and a liability claim

Authored by Senior Associate, Olivia de Pont and Solicitor, Raksha Tiwari

Previously, we have reported on the various types of insurance claims that may arise from events of cyber fraud. To recap, there are four major categories:

Cyber insurance

This is the most obvious cover, as it is specifically intended to cover losses resulting from malicious cyber-attacks. However, some cyber policies do not provide cover for losses stemming from non-malicious outages, or actions by authorised users such as misdirected payments – a key source of cyber fraud loss.

Fidelity or crime insurance

This cover generally protects policyholders from losses due to dishonest acts such as fraud or theft. Some policies may extend protection to losses resulting from cyber-fraud perpetuated by employees or third parties. However, this cover also often falls short of protecting against losses originating from non-malicious cyber failures.

Professional indemnity insurance

While professional indemnity insurance is increasingly subject to cyber exclusions or limits, particularly in the London market, where it is not, it provides useful cover for liabilities to customers or other third parties resulting from negligence or another breach of professional duty resulting from a cyber event that could have been avoided.

Statutory liability insurance

This cover can be relevant if a policyholder is found to be in breach of regulatory obligations, such as privacy laws, as a result of a system outage or data loss from a security breach. Statutory liability insurance can help cover legal costs and penalties associated with a breach.

Cyber events can therefore result in a complex web of insurance claims. A single cyber event, such as a breach of an email system that enables a fraudster to instruct an insured's employees to misdirect payments of customer funds to a fraudster's account, can result in:

- A cyber insurance claim for the costs of the IT work required to identify and remedy the breach (and possibly for the liability to the customer for their funds, but that liability is often excluded or heavily sublimited)
- A professional indemnity insurance claim for the liability to the customer for the loss of their funds and possibly consequential losses
- A fidelity or crime insurance claim, depending on who the perpetrator was
- A statutory liability claim if the payment resulted in a regulatory breach by the company

Insurers have an obvious interest in following developments in cyber-crime, because they need to understand the developing risks and costs of cyber attacks of all types with a view to their future claims exposure. Insurers have increasingly moved to introduce exclusions and sublimits to control their exposure to cyber risk.

A recent decision of the High Court of England and Wales, *Logix Aero Ireland Limited v Siam Aero Repair Company Limited* [2025] EWHC 1283 (KB), is a useful update and reminder of cyber risks and losses that are increasingly occurring, which result in disputes and claims that affect insurers. This is an example of a fraudulent misdirected payment scheme, which are some of the most costly and damaging types of cyber frauds.

Misdirected payments

In this case, the parties negotiated the sale and purchase of two aircraft engines by email, only to find that a fraudster had inserted themselves into their email correspondence and caused the payment of the purchase price to be misdirected.

The parties signed Letters of Intent (LOIs) in relation to the sale and purchase of aircraft engines which were, in part, conditional on their executing sale and purchase agreements (SPAs). The SPAs were negotiated via email. Emails from Logix (the buyer) were sent from a "@logic.aero.com" domain, while emails from Siam (the seller) were sent from a "@siam-aero.com" domain. Once negotiations were well under way, however, a third-party fraudster inserted itself into the email correspondence by setting up similar fake domains under "@logic.aero.co" and "@siam-aero.co".

Using these fake domains, the fraudster interposed themselves into the parties' emails at crucial points of the negotiations, including correspondence concerning updated versions of the LOIs and the terms of the SPAs. The fraudster cleverly copied in the genuine email addresses of all recipient parties but substituted the email addresses of all sender parties with those of the fake domains, making it difficult to identify that the manipulated email correspondence was not genuine. The flow of emails was, in short, Logix > the fraudster > Siam and vice versa. All communications therefore went via the fraudster, without the knowledge of either party. Through this sophisticated set-up, Logix and Siam believed that they were dealing directly with one another.

During this process, the fraudster intercepted correspondence containing an updated draft of the SPAs, substituted Siam's bank account details for its own, and sent the altered versions of the SPAs to Logix. Logix, having no reason to suspect fraud up to this point, then following the payment instructions in the amended SPAs and unknowingly deposited its payment into the fraudster's bank account. This meant that while Logix had paid, Siam had not received the purchase price.

An unusual feature of this fraud was that the parties never signed the same SPAs. The fraudster ensured that the SPA that Siam saw and signed had the correct bank details – it was only Logix that saw and signed the version with the fraudster's account details. This made it difficult for Logix to argue that it had paid the purchase price in accordance with the terms of the SPAs, although it did claim that it had paid the purchase price.

It never became clear how the fraudster had become aware of the transaction. Neither of the parties' IT systems showed any sign of being compromised.

Logix's case

Once the parties discovered the fraud, Logix made a claim against Siam, seeking declaratory relief, damages and/or delivery up of the engines. Siam, naturally, had declined to do so until it was paid. In particular:

- Logix sought declarations from the Court that the two engines were its property and that it had paid the contract price for them. It sought delivery of the engines.
- The claim also referred to a confidentiality clause in the LOIs and alleged that it was within the parties' contemplation that disclosure of confidential details of the sale process to a third party might allow a fraudster to divert payment to itself, and that this clause was breached when Siam unwittingly provided confidential information to the fraudster. Logix claimed, in the alternative, that Siam placed the fraudster in a position which carried with it the usual authority to negotiate and execute the SPAs on its behalf, such that the fraudster had apparent authority to do so. On this basis, Logix claimed that Siam was bound by the terms of the SPAs that Logix had signed with the fraudster's account details, albeit Siam had never seen those SPAs.

A sophisticated cyber fraud and a liability claim

Siam applied to strike out Logix's claim and sought defendant summary judgment in the alternative. The Court granted Siam's application for strike out. This was on the basis that:

- Logix's argument that a binding SPA was entered into was dependent upon the proposition that the fraudster acted with Siam's apparent authority. However, the Court was satisfied that Siam did not make any representations that another party was authorised to act on its behalf. Logix believed it was corresponding with Siam, not an agent, and enabling an agent to commit fraud does not give rise to apparent authority even if negligence was involved. The concept of apparent authority does not apply to imposters.
- The Court considered the pleaded confidentiality claim to be "highly artificial", with no realistic prospect of success. The fraudster caused Logix's loss, not the disclosure of confidential information.
- Logix also claimed that Siam owed a duty of care, arising under an implied term of the LOIs or in tort, to take reasonable precautions for the security of its computer and email systems. The Court referred to this claim in the judgment but did not address it separately in its reasoning, instead addressing it along with the claim for breach of confidentiality. The claim would not have succeeded separately in any event because there was no evidence that Siam had failed to take reasonable care.

The Court therefore ordered Logix's claims to be struck out.

The Court also passed comment upon Logix's original claim, which it later abandoned, that Siam was involved in the fraud itself, and had obtained preliminary seizure orders over the engines for a time. Unfortunately, Logix had overstepped the mark by implying that Siam had been involved in the fraud, as there was no evidence of this. While Logix did not accept that it had accused Siam of fraud in its own capacity, the Court expressed a view that its original claim was objectionable because there was no proper basis to plead fraud.

With no claim against Siam, and with the funds having disappeared from the fraudster's bank account, Logix was left without recourse for the losses that it suffered as a result of its misdirected payment.

Our view

This decision provides some reassurance to insurers that claims arising from fraudulent misdirected payments, that could potentially come within either cyber policies or professional indemnity policies, are likely to face challenges where it is unclear – as it often is – how the fraudster gained access to the information that enabled them to impersonate one or both parties. Indeed, attempts by the defrauded party to blame the other party may result in heavy criticism by the Court.

The case is also a useful reminder of the importance of vigilance and robust verification processes when entering into agreements using email or other online communications, and, critically, when making payments to third parties.

Insurers may wish to examine in more detail processes that insureds have in place to protect against impersonation fraud where this is more sophisticated than the usual form in which a fraudster sends an email requesting a payment is made to a different bank account. Insurers may wish to consider whether insureds have adequate processes in place for the:

- signature of contracts, to take place using a secure third-party e-signature service with advanced identity verification processes, to ensure that all signatories have been thoroughly verified before proceeding to payment; and
- two-step verification for payments, even where the account details are contained within an agreement.

Speak to our insurance experts

Andrew Horne
Partner

P +64 9 353 9903
M +64 21 245 1545
andrew.horne@minterellison.co.nz

Nick Frith
Partner

P +64 9 353 9718
M +64 21 920 292
nick.frith@minterellison.co.nz

Hannah Jaques
Partner*

P +64 4 498 5034
M +64 21 177 6340
hannah.jaques@minterellison.co.nz

Jane Standage
Partner

P +64 9 353 9754
M +64 21 411 728
jane.standage@minterellison.co.nz

Lloyd Kavanagh
Partner

P +64 9 353 9976
M +64 21 786 172
lloyd.kavanagh@minterellison.co.nz

Jeremy Muir
Partner

P +64 9 353 9819
M +64 21 625 319
jeremy.muir@minterellison.co.nz

Olivia de Pont
Senior Associate

P +64 9 353 9738
M +64 27 202 1400
olivia.depont@minterellison.co.nz

April Payne
Senior Associate

P +64 9 353 9946
M +64 27 699 9802
april.payne@minterellison.co.nz

Siobhan Pike
Solicitor

P +64 9 353 9859
siobhan.pike@minterellison.co.nz

*From 1 July 2025, subject to meeting New Zealand Law Society requirements.

ANALYSE

PREPARE

PROTECT

minterellison.co.nz

MinterEllisonRuddWatts.