NORTON ROSE FULBRIGHT

The Big Read Book series Volume 19

Norton Rose Fulbright South Africa Inc. in collaboration with Walker Kontos: Review of 2001-2020 insurance judgments of Kenya

July 2024

Introduction

Dearest Reader

Welcome to Norton Rose Fulbright's The Big Read Book Series.

This is Volume 19 of the Series – A review of insurance judgments of Kenya (2001-2020).

Like our Zimbabwe edition, which you can access here, the cases discussed in this edition are binding in Kenya but not in South Africa. The findings in some of the judgments do not match South African law and the case law should not be relied on in South Africa. This makes interesting reading nonetheless and will stimulate thought about South African insurance conduct and policies.

An online version of this publication is available through our Financial Institutions Legal Snapshot blog at https://www.financialinstitutionslegalsnapshot.com/. By subscribing to our blog you can also keep up with developments in insurance law including South African judgments and instructive judgments from other countries.

You can access the previous volumes in the series, here.

Contents

Kenyan Insurance Law

Insurance law in Kenya is largely governed by their Insurance Act (Chapter 487 of the Laws of Kenya) (the **Act**). The Act empowers the Cabinet Secretary of National Treasury and Planning to make regulations providing for all matters prescribed by the Act.

The Act establishes the Insurance Regulatory Authority (**IRA**), which is tasked with ensuring the effective administration, supervision, regulation and control of insurance and reinsurance business in Kenya.

The IRA licenses those involved in insurance business including insurers, reinsurers, brokers, agents, risk managers, loss adjusters and assessors, insurance surveyors, and claims settling agents. The Act prescribes the minimum capital requirements that insurance companies carrying on insurance business in Kenya must comply with.

All insurers are required to reinsure a proportion of each policy of insurance issued or renewed in Kenya in such proportion, manner and subject to such terms and conditions as prescribed with the Kenya Reinsurance Corporation Limited established under the Kenya Reinsurance Corporation Act (Chapter 487A Laws of Kenya).

The Insurance (Motor Vehicles Third Party Risks) Act (Chapter 405 Laws of Kenya), which deals with third party risks arising out of the use of motor vehicles, also serves as a source of insurance law in Kenya.

Kenya follows the doctrine of precedent. Kenyan insurance law is therefore supplemented by the decisions of Kenyan courts, which offer valuable insights into the practical application of insurance principles in varied contexts. Apart from the courts, the Insurance Tribunal has been established under the Act, to deal with insurance matters expeditiously, and has powers similar to a magistrates court.

Norton Rose Fulbright South Africa Inc

Brokers

Victoria Insurance Brokers Limited v Jubilee Insurance Company of Kenya Limited (2020)

HCC. No. 480 of 2015 [2020] eKLR

Keywords: broker commission / reasonable fees / tender documents / consultancy services

The broker sued the insurer for the commission it alleged was due for assisting the insurer in tendering for the provision of medical insurance cover for members of the Kenyan judiciary. The broker alleged that its team prepared and concluded the response to the Judicial Service Commission and generally acted as brokers for the insurer throughout the process. It was common cause that the insurer won the tender.

The broker claimed a 10% commission on the premium.

The broker argued that it was brought in as an expert to assist the insurer in winning the tender. The insurer argued that its in-house business development and actuarial team worked on the winning tender documents and that the broker did not work on or prepare the technical proposal of the tender.

The alleged agreement between the parties was not reduced to writing. The broker said that it should be inferred from emails and discussions that the insurer engaged its services and created a legitimate expectation of payment.

The court accepted evidence that the broker had offered its consultancy services to the insurer in writing. Even though the insurer did not explicitly accept the offer, it had done so through its conduct (by receiving the broker's services and acknowledging them). The court therefore found that the elements of offer and acceptance had been proved.

There was however no proof that the third element of the contract, consideration for services rendered, had been met. The broker did not provide any evidence of a promise by the insurer to pay fees or any other form of consideration for the services. Even if the court accepted that, by accepting the broker's services, an inference should be drawn that those services must be paid for, the broker still had to prove what that consideration was.

The broker based its claim on the maximum commission paid for brokerage services as charged under the relevant insurance regulations. The court however held that the services offered to the insurer were neither brokerage nor agency services as contemplated under the Insurance Act. The commission allowed in terms of legislation was therefore not available to the broker.

The insurer argued that if the broker had been entitled to a fee, it would not be a brokerage fee. A separate agreement regarding fees was required.

The court accepted that the insurer may have promised to pay fees for the broker's services. Because the quantum or manner of fixing the fees was not agreed, the broker would be entitled to fees at a reasonable rate. However, the onus of proving that reasonable fee rested on the broker.

The broker failed to lead evidence regarding remuneration for comparable services or evidence of the actual work done and expenses incurred, or other evidence that could have assisted the court at arriving at a reasonable charge.

The court therefore held that the claim failed and dismissed the broker's claim. The court felt sympathy for the broker and ordered each party to bear its own costs.

Pan Africa Insurance Company Ltd and 2 others v Clarkson & Southern Limited (2008)

(Civil Case 4828 of 1987) [2008] eKLR

Keywords: brokers / professional indemnity insurance

The defendant insurance broker negotiated with three insurers (the plaintiffs in the first case) on behalf of a property developer to secure a loan that the developer took out with a bank. When the bank called up the guarantee, it was discovered that the property developer did not own the property that was used as security for the loan. The plaintiff insurers paid the guaranteed loan (15 million Kenyan shillings) to the bank. The insurers sued the broker for breach of duty, alleging that it failed to ascertain the secured property's ownership before finalising the guarantee. The trial court found in favour of the insurers.

The broker then approached its professional indemnity insurers (the **PI insurers**) to recover the amount paid to satisfy the judgment debt. The PI insurers rejected the claim on the grounds that the broker had acted fraudulently and was grossly negligent in assuring the plaintiff insurers that security over the property had been obtained. Dissatisfied with this rejection, the broker joined the PI insurers as third parties to the claim it defended (and lost) against the plaintiff insurers.

The PI insurers argued that the broker was not liable to the plaintiff insurers because it was the property developer's duty of good faith that had caused the plaintiff insurers' loss, and therefore that the broker was not the proximate cause of the loss.

The court held however, that the claim against the broker had been heard in full, that judgment had been handed down against the broker, and that the broker had satisfied the judgment debt. The court therefore had no jurisdiction to re-hear the issue of the broker's liability and found that any evidence purporting to reopen the issue of the broker's negligence would be inadmissible.

The PI insurers were therefore asked to present evidence and argument on its liability under the policy, and not regarding the broker's liability to the plaintiff insurers.

The PI insurers argued that they were not bound by the court's finding on liability in relation to the plaintiff insurers and the broker, and that the court could review its decision on the broker's liability because the PI insurers had not participated in the original proceedings and therefore their arguments had not been heard. Further, the judge in the original case had directed that the trial between the plaintiff insurers and the broker would precede the matter between the broker and the PI insurers (cited as third parties in the original case).

The broker argued that the PI insurers should have appealed that judgment under their rights of subrogation if they wished to challenge the broker's liability to the plaintiff insurers. The PI insurers had a right, at the time of the original trial, to take over the broker's defence. At one time they had represented the broker, but then chose to withdraw from that representation and instead remain third parties to the action.

The court noted that the trial court's direction regarding the conduct of the matter was not unusual in cases where the defendant claims indemnity from a third party. That direction did not deny the third-party PI insurers a hearing regarding the question of the broker's liability to the plaintiff insurers. It meant that the plaintiff insurers' claim against the broker and the claim for indemnity by the broker against the PI insurers had to be tried separately.

The PI insurers could have sought the court's leave to fully participate and make submissions in the earlier trial. They could have also applied for leave to raise additional defences if it appeared that the defendant was not defending the suit effectively.

The PI insurers failed to do so, and the question of the broker's liability to the plaintiff insurers could not be considered afresh.

The PI insurers argued that the issue was whether the broker's claim was covered by the policy. The PI insurers had not pleaded anything to this effect, but instead focussed on whether the broker caused the plaintiff insurers an actionable loss.

The court held that the PI insurers were liable to indemnify the broker because the broker's negligence was covered under the policy, and this had not been challenged.

Medical insurance

Mapara v Commissioner of Insurance; AAR Insurance Kenya Limited (Interested Party) (2020)

In the Insurance Appeals Tribunal: Appeal No. 2 of 2019

Keywords: notification of lapsing of policy / medical insurance / payment of premium

The appellant lodged a complaint with the commissioner of insurance when his insurer rejected his claim under a medical insurance policy. The policy covered various family members, including his deceased wife for medical expenses incurred. The deceased wife's 2017 medical bills were the subject of the appeal.

The insurer rejected the claim on the grounds that the policy had lapsed before the bills were incurred.

The appellant had had a medical insurance relationship with the insurer since 1997. The policy was initially handled by an external agent. It was then dealt with by the insurer's in-house agent, and later handed over to a new agency without the appellant's knowledge. The policy then supposedly lapsed without any communication from the insurer or any of its agents. The insured's sister financier-company nevertheless held the appellant's unbanked cheques.

The appellant argued that the policy lapsed due to the insurer's lack of communication and requested that the insurer be held liable to pay the medical bills.

The insurer argued that the policy's renewal was based on a premium financing arrangement between the appellant and the financier, which paid the premium on the appellant's behalf. If the appellant failed to pay the premium, the financier would have the policy cancelled. The insurer alleged that this agreement amended the parties' rights to cancel the policy by relieving the insurer of the obligation to give 21 days' notice in terms of the policy. The insurer added that the policy was cancelled because the premium was not paid and that the appellant was notified of the cancellation by the financier.

The financier had indeed cancelled the policy when a post-dated cheque bounced. The financier claimed to have sent, but the appellant denied receiving, notice to rectify the default. The appellant argued that he would have made good on the unpaid cheque if it had been brought to his attention and that a default notice could not override the insurer's obligation to give 21 days' notice of cancellation.

The appeal tribunal noted that section 156 of the Insurance Act obliges an insurer to assume risk only once premium is received or guaranteed. The insurer had renewed the policy, and the court stated that it was "inconceivable" that the insurer could have issued the policy in total disregard for the provision of section 156. There was no evidence that the insurer refunded any premium to the financier or that the unbanked cheques were returned to the insured. Payment of the premium had therefore been made.

The policy could only be cancelled in accordance with the policy, and it was common cause that the insurer had not given the appellant notice of cancellation. The financier was not a party to the policy and its interest in the policy, if any, was not noted in the policy document. The insurer was similarly not a party to the financing agreement and neither agreement contained a clause indicating that they should be read together.

The financier's remedy for the bounced cheque was not to cancel the insurance policy, but to demand payment. The tribunal therefore held that the issue of cancellation for non-payment of premium did not arise – the premium was paid to the insurer, and the insurer could not purport to cancel the policy on the strength of a notice of cancellation issued by a third party.

The insurer was ordered to pay the insured's claim.

Misrepresentation and non-disclosure

Kimani v Corporate Insurance Co. Ltd (2020)

(Civil Appeal No 621 of 2018) [2020] eKLR

Keywords: motor vehicle accident / motor vehicle theft / good faith / utmost good faith / misrepresentation / non-disclosure

The plaintiff claimed under its motor vehicle policy for damage to its vehicle following an accident. The insurer rejected the claim on the basis that the insured had breached the terms of the policy and because it had also claimed for the theft of the vehicle, which it alleged had been committed by its driver. The insurer argued that theft by an employee was not covered, and denied the vehicle's alleged pre-accident value.

The court noted that contracts of insurance are guided by the principle of "utmost good faith". This means that an insured must give an insurer all material information in its possession, including any information regarding circumstances that may influence the underwriter's opinion as to the risk to be incurred. Misrepresentation or non-disclosure constitute a breach of the utmost good faith principle and are grounds for avoiding a policy.

The insured did not provide enough evidence to explain its contradictory claims that the vehicle was both damaged and stolen. It could have cleared the confusion by leading the evidence of its allegedly thieving driver but failed to provide even a written statement from its driver to explain how the loss occurred. The police officer who had investigated the claim was also not called.

An insurer's duty to cover a risk is coupled with an insured's duty to disclose the material detail of the circumstances leading to the loss fully and truthfully. This allows the insurer to assess whether the loss is covered under the policy.

The court found that the insured was in breach of his duty to act with the utmost good faith at the time of reporting the incident and this allowed the insurer to reject the claim.

Co-Operative Insurance Company Ltd v Wambugu (2010)

(Civil Appeal 66 of 2008) [2010] eKLR

Keywords: personal accident policy / permanent versus temporary disability / non-disclosure of material circumstances / avoidance of policy

The insured sued his insurer under a disability policy. He was assaulted and injured during a robbery and sought payment of the amount payable under the policy for total permanent disability. The insurer had rejected the claim on the grounds that the insured's injuries were temporary, and that the maximum amount payable for temporary disability had already been paid.

The insurer also raised a counterclaim. It alleged that the insured was guilty of material non-disclosure, which entitled the insurer to avoid the policy. The insurer argued that the insured had failed to disclose that he was suffering from diabetes and gum inflammation when he applied for the policy. The insurer claimed that had those facts been disclosed, it would not have issued the policy or made payment for temporary disability.

The insured did not deny that his diabetes was material information that should have been disclosed in the insurance proposal form. Instead, he argued that his answer to the question on the form, which was whether he suffered from "diabetes paralysis", was correct because he did not suffer from such a disease and that no such disease existed.

The court reiterated that contracts of insurance are contracts of "utmost good faith" and that an insured must disclose all information that may influence an underwriter's opinion of the risk. Concealing a material issue, whether the insured thought it material or not, allowed the insurer to avoid the policy.

The court held that the insured was required to disclose that he suffered from diabetes. This was true whether or not he thought the question related to "diabetes paralysis", a disease which, by his own admission, does not exist. If he had assumed, as was logical, that there should have been a comma between the word "diabetes" and "paralysis", perhaps this case would not have arisen. But the insured chose his own interpretation. Further, if the disease did not exist, it is logical that the insurer could only have intended to know whether he suffered from diabetes and he had a duty to disclose that fact. Finally, even if he was confused about the term "diabetes paralysis", he should have confirmed that he suffered from "any recurring disease", which also appeared on the form.

The court therefore held that the insurer was entitled to avoid the policy. Having come to that conclusion, it was not necessary to determine the amount payable to the insured.

Motor Vehicle Accidents (MVA)

The Insurance (Motor Vehicles Third Party Risks) Act is relevant to many of the motor vehicle accident claims that involve insurers in Kenya.

Section 10 of the Act obliges an insurer to satisfy judgments against persons insured, in relation to motor vehicle accidents.

Section 10(1) states that

> "If, after a policy of insurance has been effected, judgment in respect of any such liability as is required to be covered by a policy under paragraph (b) of section 5 (being a liability covered by the terms of the policy) is obtained against any person insured by the policy, then notwithstanding that the insurer may be entitled to avoid or cancel, or may have avoided or cancelled, the policy, the insurer shall, subject to the provisions of this section, pay to the persons entitled to the benefit of the judgment any sum payable thereunder in respect of the liability, including any amount payable in respect of costs and any sum payable in respect of interest on that sum by virtue of any enactment relating to interest on judgments."

This means that if a third party sues an insured in relation to a motor vehicle accident (and the relevant motor vehicle was covered by insurance), the insurer must satisfy the judgment debt against its insured, with limited exceptions. If the insurer fails to do so, the third party suing the insured can apply to court to hold the insurer liable for the debt.

Section 10(4) of the Act only allows the insurer to raise misrepresentation or non-disclosure by the insured (within 3 months of the proceedings against the insured being commenced) to avoid the policy. The insurer usually applies to court for a declaratory order confirming that it is entitled to avoid the policy.

Many of the cases discussed below relate to judgment debts that an insured (or the injured party to whom an insured has been found liable) seeks to enforce against the insurer.

MVA: Identity of parties and joinder

Maweu v Occidental Insurance Co. Limited (2015)

(Civil Suit No. 130 of 2006) [2015] eKLR

Keywords: motor vehicle accident / Insurance (Motor Vehicles Third Party Risks) Act / identity of insured / interpretation of employee

The plaintiff was a passenger in a motor vehicle that was involved in an accident. The plaintiff was seriously injured and suffered from paraplegia as a result. The vehicle was registered to Bestways Plumbers Limited, and was insured by the defendant insurer. The plaintiff obtained judgment against Bestways Plumbers and the plaintiff sought, by this declaratory suit, to recover from the defendant insurer.

The insurer had issued a commercial vehicle insurance policy that covered the insured's employees. The insurer argued that the plaintiff was not the insured's employee but an independent contractor, and therefore that the plaintiff was not entitled to cover.

The court accepted the plaintiff's, his wife's, and Bestways Plumbers' evidence that the plaintiff was Bestways Plumbers' employee.

The plaintiff's claim succeeded, and the insurer was ordered to pay the judgment debt.

Gikonyo v Gateway Insurance Company Limited (2007)

(Civil Appeal 746 of 2002) [2007] eKLR

Keywords: motor vehicle insurance / insured driver / identity of insured

The appellant was a pedestrian, injured by a motor vehicle insured by Glass Fibre Reinforced Plastics Limited and driven by its director and authorised driver. The appellant sued the driver and received judgment in his favour. He was unable to recover the amount from the driver, and therefore sued the insurer.

The court had to consider whether the judgment against the insured's authorised driver was enforceable against the insurer. The insurer argued that for liability to arise, there must be a judgment against its insured.

The court did not accept this argument and stated that the person insured by the policy is any authorised driver, provided that they observe the terms of the policy as if they were the insured.

It was not in dispute that the driver was the authorised driver. He was also a director of the insured company, and if the insured's corporate veil was lifted, he would emerge as the insured. The insurer was ordered to pay the claim.

MVA: Insurable interest

Insurance Company of East Africa v Omodho (2005)

(Civil Suit 1650 of 2001) [2005] eKLR

Keywords: insurable interest / motor vehicle accident

The defendant insured a private commercial vehicle in his name. The vehicle was involved in an accident, and he claimed compensation from the insurer. He also asked the court to hold the insurer liable for third party claims arising out of the accident.

The insurer rejected the claim on the grounds that the claimant did not have an insurable interest in the vehicle. The vehicle was owned by a company, of which he was merely a shareholder.

The evidence showed that the company authorised the defendant to take out insurance on the vehicle in his own name. The court reiterated that insurable interest in an object does not require absolute or sole ownership of that object. Ownership itself is not a requirement.

The court therefore held the insurer liable to compensate the insured as well as any third party claims that arose in relation to the accident.

MVA: Proof of contract

M/S Fidelity Shield Insurance Co. Ltd v Kimotho (2020)

(Civil Appeal No. 10 of 2018) [2020] eKLR

Keywords: motor vehicle accident / Insurance (Motor Vehicles Third Party Risks) Act / evidence of policy

The insured sued the insurer to satisfy a judgment debt arising out of a motor vehicle accident. The insurer denied liability on the grounds that there was no contract of insurance between the insurer and the insured. Further, the insured did not serve the statutory notice as required by section 10 of the Insurance (Motor Vehicles Third Party Risks) Act.

The insured produced a police abstract as an exhibit. This abstract indicated that the vehicle was insured by the insurer and included the certificate number, policy number and period of insurance. The insurer did not rebut this evidence and so the court accepted that the details on a police abstract of this kind are, in the ordinary course of business, copied from the certificate of insurance an insured submits to the police. The evidence also showed that on a balance of probabilities, the insured had served the statutory notice.

The insurer did not present any evidence to challenge the insured's assertions, which were then accepted by the court. The court held that in the absence of evidence to the contrary, the police abstract provided sufficient evidence of the insurance policy and its validity at the time of the accident.

The insurer was ordered to pay the claim.

Blue Shield Insurance Company Ltd v Oguttu (2009)

(Civil Appeal 262 of 2003) [2009] eKLR

Keywords: motor vehicle accident / Insurance (Motor Vehicles Third Party Risks) Act / application to strike out defence / proof of policy

The respondent was involved in a motor vehicle accident that resulted in injuries to his person and damage to his vehicle. He sued Juma Construction Company Limited, the owner of the motor vehicle that caused the accident and received judgment against them. He then sued Juma Construction's insurer for payment of the judgment debt against its insured.

The insurer alleged that it had not insured the relevant motor vehicle, that it had not been served with the required statutory notice in terms of the Insurance (Motor Vehicles Third Party Risks) Act, and that the losses claimed did not fall under losses required to be covered by the Act.

The respondent attempted to have the insurer's defence struck out as frivolous and vexatious.

The court however found that the respondent's claim did not cite the proper policy number, and that the person cited on the policy was not Juma Construction (the defendant in the successful underlying claim). The court therefore ordered the matter to go to trial and did not order the insurer's defence to be struck out.

MVA: Statutory liability

JKG and another v General Accident Insurance Company Ltd (2019)

(Civil Suit No 205 of 2016) [2019] eKLR

Keywords: motor vehicle insurance / Insurance (Motor Vehicles Third Party Risks) Act / accident occurring outside Kenya / interpretation

The plaintiffs sued the insurer under section 10 of the Insurance (Motor Vehicle Third Party Risks) Act. They argued that the insurer was obliged to settle a judgment debt in their favour, against the insurer's insured.

The defendant argued that the alleged risk was not covered, because its liability was limited to claims arising in Kenya. The claim arose in Tanzania and so the plaintiff should have sought compensation under the COMESA Yellow Card Scheme and Reinsurance Pool Claims Operational Manual.

There was no dispute that judgment against the defendant's insured had been granted. The only question was whether the insurer could avoid settling the debt because the claim arose in Tanzania and was covered by the Yellow Card policy.

The plaintiffs argued that raising the Yellow Card policy issue amounted to appealing the original judgment, and therefore that this defence could not be raised. The insurer did not pursue avoidance under section 10(4) of the Act, which should have been done within three months of the judgment.

The insurer argued that the Yellow Card policy was unrelated to its insurance policy, and that the plaintiffs were aware of the procedure for seeking compensation under the Yellow Card policy.

The court noted that the Act required statutory insurance for motor vehicle accidents occurring on a "road" and that a road, in the context of the Act, referred to roads in Kenya. Therefore, the territorial jurisdiction of statutory motor vehicle policies, unless otherwise provided for, is limited to Kenya. The policy itself limited its territorial jurisdiction to Kenya.

Even though the insured's bus ferried lawful fare-paying passengers across the Kenyan border, accidents across the border were covered by the Yellow Card policy. Kenya and Tanzania had entered into a transport agreement (which included the Yellow Card policy) that recognised the countries' inter-dependence in respect of transport, and that neither country could assume all risks.

The plaintiffs' claim against the insurer was therefore dismissed.

Gitundu v Gateway Insurance Co. Ltd (2015)

(Civil Suit No. 224 of 2007) [2015] eKLR

Keywords: motor vehicle insurance / Insurance (Motor Vehicles Third Party Risks) Act / mitigation of loss / consequential loss / statutory duty

The plaintiff was involved in an accident, severely damaging the vehicle, and injuring several passengers.

The plaintiff lodged a claim with its insurer and paid an excess premium at the insurer's request. Several injured passengers instituted action against the plaintiff, and judgments were handed down against the plaintiff. The vehicle was attached in execution of the judgments. The plaintiff informed the defendant insurer about the attachment, and the defendant paid some, but not all, of the judgment debts. The vehicle was therefore sold.

The plaintiff sued his insurer for the value of his vehicle as well as loss of income derived from the use of the vehicle to transport passengers.

The insurer argued that the insured should have paid the outstanding judgment debts and then claimed reimbursement from the insurer. Further, the insured failed to mitigate his loss by failing to pay the debts and allowing the vehicle to be sold at auction.

The court noted that insurers bear a statutory duty to satisfy judgment debts against their insureds. Because that statute requires an insurer to pay the person entitled to the benefit of a judgment, this obligation cannot be shifted or abrogated through an insurance contract.

The insurer argued that the policy excluded consequential loss, and therefore that the insured's claim for loss of income should not be allowed. However, the court held that this claim was based on breach of the insurer's statutory duty to pay the judgment debts.

The insurer argued that the insured should have sought to recover a contribution from the auctioneer because the vehicle was sold for more than the amount required to satisfy the judgment debts. The court however found that the insurer should have joined the auctioneer to the proceedings and then realised its rights against the auctioneer by way of subrogation. This was not done.

The insured was therefore awarded 500 000 Kenyan shillings for the loss of the vehicle and 1500 Kenyan shillings per day for one year of lost income. The court found that the plaintiff was not entitled to loss of income for three years. While the court accepted that it would take time and capital to buy a new vehicle to restart his business, the plaintiff could not reasonably stop working or looking for other ways to derive income for three years while he awaited compensation. He had a duty to mitigate his losses.

Kensilver Express Ltd and 3 others v Commissioner of Insurance and 4 others (2007)

Misc Civil Suit 1345 of 2005 (OS) [2007] eKLR

Keywords: constitutional law / duties of statutory receiver manager (of collapsed insurer) / third party risk holders / Insurance (Motor Vehicles Third Party Risks) Act

An insurer provided motor insurance policies to its clients. The insurer collapsed and a reinsurance company was appointed by the Commissioner of Insurance (with approval of the Minister of Finance) as the "statutory receiver manager".

The statutory manager declared a 12-month moratorium on claims by creditors but declined to incorporate third party risk insurance policyholders (and their potential creditors) in the moratorium. These policyholders were therefore not provided with legal representation when sued and were not indemnified in relation to judgments awarded against them. Many of these judgment debtors had their assets attached to satisfy these debts, or taken to civil jail if they had no assets. These policyholders sued the statutory manager, the Commissioner of Insurance, as well as the Minister of Finance for breach of their duties and contravention of the policyholders' constitutional rights.

Evidence showed that the insurer had been in dire financial straits for years and that the Commissioner had known this but failed to act.

The court held that it was inappropriate to appoint a reinsurer as the statutory manager, as it had a conflict of interest. Further, the statutory manager was meant to provide a report, recommending liquidation of the company if necessary – it was not allowed to liquidate the company of its own accord. The statutory manager had nevertheless started selling the insurer's assets without the Minister of Finance's approval.

The court found in favour of the policyholders and issued an injunction on execution of judgment debts against policyholders, pending the resolution of the insurer's difficulties. The court ordered that a new statutory manager be appointed while the Minister of Finance implemented a policyholders' compensation fund to assist policyholders of insolvent insurers.

Chege v United Insurance Company Limited (2005)

(Civil Suit 90 of 2003) [2005] eKLR

Keywords: motor vehicle accident / Insurance (Motor Vehicles Third Party Risks) Act / liability of insurer to settle judgment debts

The plaintiff claimed against its insurer, for settlement of judgment debts relating to a motor vehicle accident. The insurer denied liability but the evidence showed that at the time of the accident, cover was in place. Further, the insurer asked for and accepted payment from the insured of the excess amount. There was also no evidence suggesting that it had repudiated the policy or rejected the claim.

The court ordered the insurer to settle the insured's debts.

United Insurance Co. Ltd v Kimunge (2001)

(Civil Appeal 666 of 2001) [2005] eKLR

Keywords: motor vehicle accident / passenger / Insurance (Motor Vehicles Third Party Risks) Act / statutory liability / interpretation

The respondent suffered injuries as a passenger involved in a motor vehicle accident. He successfully sued the vehicle's owner and driver.

He then sued the vehicle's insurer, arguing that the insurer was bound to honour the judgment in terms of the Insurance (Motor Vehicles Third Party Risks) Act. The insurer denied liability, stating that the policy did not cover, and was not required to cover, passengers.

The respondent applied to court to strike out this defence. The lower court did so, and the insurer appealed that ruling.

The appeal court agreed with the insurer, stating that this was not a clear-cut case of an insurer's liability under a policy. The Act is clear that compulsory insurance is not required for risk to passengers who are not carried for hire or reward. It was not clear from the facts of the case whether the respondent was a gratuitous passenger, a passenger for hire or reward, or a passenger under a contract of employment. This doubt created a sufficiently triable issue to require the case to go to a full hearing.

Consequential loss

Madison Insurance Company Ltd v Solomon Kinara t/a Kisii Physiotherapy Clinic [2004] eKLR

Civil Appeal No. 263 of 2003

Keywords: consequential loss

The insured defendant insured equipment and other items against burglary. While the relevant policy was in force, thieves broke into his premises and stole items worth 871 000 Kenyan Shillings. The insured claimed this amount from his insurer, as well as a further sum of 2.2 Million Kenya Shillings as special damages for lost income for a period of 41 months.

A copy of the policy was produced as evidence, and none of its provisions stated that the insured would be entitled to any other payment apart from the value of the insured goods.

In making its determination, the court held that ordinary or standard form policies or contracts of insurance do not cover consequential loss unless the parties specifically contract to cover such loss.

Payment of premium

Insurance Company of East Africa v Marwa Distributors Limited (2015)

(Civil Appeal no. 51 of 2015) [2015] eKLR

Keywords: effect on non-payment of premium / interpretation

The respondent took out several policies with the appellant insurer, including a money policy. The insured claimed under the money policy, alleging that money had been stolen from its employee while in transit.

The insurer alleged that the premium had not been paid. The insured had paid premiums, but those were for other policies held with the insurer. The main issue for determination was whether the policy was valid despite non-payment of the premium.

The court noted that there is no definitive rule on the issue, and that the matter depends on the obligations recorded in the contract. Therefore, if the parties do not make provision for the effect of non-payment of premium, the court will not imply that the policy is invalid. The effect of non-payment will be determined by the parties' intention expressed in the contract.

The policy said that cover was provided "in consideration of the payment to the company of the premium" and the court held that this meant that the insured must have paid the premium in order to be indemnified during the period of cover. Since the premium was not paid, there was no obligation to indemnify.

The insured's claim was therefore dismissed.

Property insurance

First Assurance Company Limited v Seascapes Limited (2008)

(Civil Appeal No. 246&263 of 2002) [2008] eKLR

Keywords: fire insurance / property insurance

The respondent had claimed roughly 45 million Kenyan Shillings for the loss of fifteen villas, related buildings, and furniture. The property and items were destroyed by a fire, which it alleged was covered by a policy with the insurer.

The insurer denied liability, stating that while it had agreed to insure the property, no contract of insurance existed between the parties because the respondent had not paid the premium. Payment of the premium was a condition precedent to liability.

The parties had met to discuss cover, but the proposal form was never completed and the arrangement between the parties was not reduced to writing. Premium was never paid. After the fire, the respondent attempted to pay the premium, but the insurer did not accept the cheque. The insurer denied that any credit facility had ever been granted to the respondent. The court noted that the respondent only paid the premium near the end of the alleged policy term, after the fire occurred, and had not previously acted on the broker's demand that it pay the premium.

The court held that no contract of insurance existed between the parties, and therefore that the insurer was not liable to indemnify the respondent.

Subrogation

Ndoro v Ahmed and Lardhib (2017)

(Civil Appeal No. 22 of 2015) [2017] eKLR

Keywords: indemnity / personal injury / subrogation / unjustified enrichment / double compensation

The appellant was involved in a road accident and successfully claimed general damages from the respondents. His claim for special damages was however dismissed by the trial court, and he appealed that decision.

The respondents argued that the claim for special damages should be dismissed because the appellant's insurer had already paid part of the special damages claim and allowing the claim would result in double compensation. While the trial court was of the view that the insurer should be the one to claim the special damages, the respondents submitted on appeal that would amount to double compensation to the insurer, because premiums were paid by the appellant.

The appeal court had to determine whether the doctrine of subrogation applies to personal injury claims and whether a claim by an insured, for an amount covered by the insurer, would amount to double compensation or unjustified enrichment. The respondent argued that subrogation is applicable to personal injury claims and therefore that the party that ought to have claimed was the insurer.

The court said that the relevant legal authorities established that subrogation does not extend to personal accident and life insurance claims because they are not contracts of indemnity. The court nevertheless found that this principle did not apply to personal accident policy claims, because that would allow negligent wrongdoers to escape liability due to their victims' prudence. The court therefore held the respondents liable.

The court noted that it is up to the insurer to decide on its arrangement with the insured. However, since subrogation does not apply to personal accident insurance claims, the insurer could not lodge a claim for any refund against the insured if the respondent settled the special damages.

Subrogation applies to indemnity insurance claims. This is because in cases of indemnity, the insured loss can be computed exactly. In personal accident claims, one cannot compute the extent of the injuries suffered. For example, the court noted that "a lost limb cannot be replaced by an artificial one irrespective of the latter's costs. If an accident victim can recover payment out of a personal accident policy, that is an added advantage which should not benefit the tortfeasor."

The court was satisfied that recovering special damages from the respondent would not amount to double payment. The court reasoned that because the respondents are not party to the insurance contract between the appellant and the insurer, if they had come to know about the settlement of the bills after they had paid the appellant, they would not have been able to recover.

The court therefore awarded the appellant special damages.

Mwema Musyoka v Paulstone Shamwama Sheli [2020] eKLR

Civil Appeal Number 58 of 2018

Keywords: motor vehicle insurance / indemnity / subrogation

The appellant's vehicle collided with the respondent's vehicle. The damage to the respondent's vehicle was covered by his insurer. The respondent then instituted action on behalf of his insurer, to recover the loss paid, under the doctrine of subrogation.

The trial magistrate allowed the respondent's claim, stating that the claim was properly and competently before the court under the doctrine of subrogation.

On appeal, the appellant argued that the trial court had misdirected itself on the basis that the insurer ought to have instituted the action on behalf of the respondent.

The court found that the insurer must first satisfy the claim in order to give it the right to sue in the insured's name, for it to recover the loss from the liable party. The insurer had done so, and therefore had the legal capacity to sue.

Donald Dinnie
Norton Rose Fulbright South Africa Inc

Donald Dinnie
Norton Rose Fulbright South Africa Inc, Director
Tel +27 11 685 8847
donald.dinnie@nortonrosefulbright.com

Paul Ogunde
Walker Kontos, Partner
Tel +254 20 3953121
pogunde@walkerkontos.com

Gregory Karungo
Walker Kontos, Partner
Tel +254 20 3953104
gkarungo@walkerkontos.com

Angela Gecaga
Associate, Walker Kontos,
Tel +254 20 3953132
agecaga@walkerkontos.com

NORTON ROSE FULBRIGHT

Norton Rose Fulbright is a global law firm. We provide the world's preeminent corporations and financial institutions with a full business law service. We have more than 3700 lawyers and other legal staff based in Europe, the United States, Canada, Latin America, Asia, Australia, Africa and the Middle East.

Law around the world

nortonrosefulbright.com