DRN-3372293

The complaint

L complains about the decision of QIC Europe Ltd to decline its business interruption insurance claim for losses arising out of the COVID-19 pandemic.

What happened

L operates as a pub and held an industry specific commercial insurance policy underwritten by QIC. L says that on 18 March 2020 it closed due to at least one occurrence of COVID-19 at its premises. A couple of days later the Prime Minister announced that all pubs should close, and regulations were made on 21 and 26 March 2020 ("the March Regulations") formalising this requirement. As a result, L was unable to reopen its premises until July 2020.

L contacted QIC to claim for its losses resulting from this closure. Third parties have been involved in much of the exchange of communication, but I have referred to L and QIC alone for the sake of simplicity and because they are the parties to the complaint.

QIC declined L's claim. It said that the core business interruption cover provided by L's policy was based on there having been damage to property, and such damage was not the cause of L's closure. QIC also said that there was an extension to this cover that related to diseases. The relevant clause provides cover for losses caused by:

> "*closure or restrictions placed on the Premises on the advice of or with the approval of the Medical Officer of Health for the Public Authority as a result of a Notifiable Human Disease occurring at the Premises*
>
> *…*
>
> *subject to a maximum of £50,000 for any one loss*
>
> …"

QIC said that this clause would provide some cover in relation to COVID-19, as the disease would fall into the definition of a Notifiable Human Disease. However, QIC said that L had not shown that an occurrence of such a disease had happened, nor that if there was such an occurrence this had led to closure on the advice of or with the approval of the Medical Officer of Health for the Public Authority. QIC confirmed that it did not consider the March Regulations would have been as a result of an occurrence at L's premises, even if one could be demonstrated.

L complained about the decision in respect of the disease clause, but QIC did not change its stance. So, L brought its complaint to this service. L provided evidence to try and demonstrate there had been an occurrence of COVID-19 at the premises.

This evidence included comments, provided in testimony L's general manager gave in January 2021, that some staff members had apparently said they were unwell with flu-like symptoms and high temperatures.

One of L's customers, who I'll call "Mr D", provided testimony in January 2021 of being at the

premises on 15 March 2020 and then developing symptoms around five days later. Evidence was provided to indicate that he was at the premises on 15 March. His testimony was also supported by notes of a phone consultation with his doctor on 24 March 2020, in which Mr D had reported symptoms developing from around 21 March and then progressing. These symptoms included aches, a very heavy chest, coughing, temperature with associated shortness of breath. Mr D was advised to contact NHS 111 and apparently then self-isolated as a result.

Another of L's customers, who I'll call "Mr W", also provided testimony in January 2021. In this he said that he had been at L's premises on 14 March 2020 and then "*began to feel unwell and had zero energy*" on 17 March. He said that on 18 March, as his symptoms were unresolved, he contacted L to let them know as their premises were the only place he had visited. That this call occurred is supported by the general manager's testimony. Mr W says he remained in self-isolation for the following week, until his condition began to deteriorate over the subsequent few days before he was hospitalised on 30 March. L has provided a discharge note from Mr W's hospital dated 7 April 2020 which confirms he had tested positive for COVID-19.

Our Investigator was ultimately persuaded by this evidence that there was more likely than not an occurrence of COVID-19 at L's premises in the period before it closed. He felt it was most likely that the feeling of being unwell that Mr W said he had experienced on 17 March was as a result of the same illness he tested positive for when hospitalised, i.e. COVID-19. And he thought it most likely that Mr W had already sustained this illness at the point he was most likely at L's premises on 14 March 2020.

The Investigator also shared a copy of a previous decision of this service which found that there was cover for the impact of the government-imposed restrictions, following a similar insured event as in this case. His opinion was that the same conclusion should be reached in L's case.

Effectively, the Investigator's opinion was that whilst the courts in *The Financial Conduct Authority & Ors v Arch Insurance (UK) Ltd & Ors* [2021] UKSC 1 and the related judgment in the court at first instance ("the FCA test case") were not asked to consider terms, as in L's policy, where the relevant event of disease happened at the premises ("at the premises clauses"), the findings of the Supreme Court in relation to policies requiring that event happen with a particular radius of the premises ("radius clauses") were useful in considering at the premises clause related complaints.

The Investigator said that the Supreme Court had essentially found that each case of COVID-19 was a separate but broadly equal cause of the Government's response to the pandemic and the business interruption that resulted from this. That they were each concurrent proximate causes of the Government's decisions. And that these decisions had taken into account reported and unreported cases. As such, the Investigator considered that the case of COVID-19 that he considered had most likely occurred at L's premises was a concurrent cause of the March Regulations.

So, the Investigator considered the impact of the restrictions on L was something that was covered by the policy. He thought L's claim should be met, subject to any remaining terms of the policy, on the basis that the closure of its premises from 20 March 2020 was caused by an insured event. He also thought interest should be added to the settlement of the claim.

However, QIC were not persuaded by the Investigator's opinion. As such this case has been passed to me for a decision.

Before I go onto explain my decision, I will summarise the key arguments made by QIC.

Generally, they fall into two categories – whether there was an occurrence at L's premises and, if so, whether this can be said to have led to the March Regulations.

In terms of the evidence of an occurrence, QIC said:

- The evidence provided in relation to a number of individuals L had indicated may have had COVID-19 and been at the premises was very limited.
- QIC did not dispute that Mr W had most likely attended L's premises on 14 March and accepted that Mr W most likely had COVID-19 when admitted to hospital on 30 March 2020. But said that this did not demonstrate he'd had the disease when at the premises. A positive test result does not amount to evidence of when Mr W had first sustained COVID-19.
- The symptoms Mr W describes as having on 17 March do not demonstrate he had COVID-19 at that time.
- QIC said it was extremely unlikely Mr W didn't visit any other location between 14 and 17 March, and could have contracted COVID-19 at some point between 14 March and when he began self-isolating.
- Mr W could have phoned L for any number of reasons on 18 March and no supporting evidence beyond the testimonies referred to has been provided in relation to this.

In relation to whether, if there was an occurrence of COVID-19 at the premises, this was the cause of L's losses, QIC said:

- QIC did not accept that the closure or restrictions placed on L's premises were as a result of that occurrence. And said the closure would have occurred irrespective of that occurrence.
- QIC considered the proximate cause of the insured's business interruption losses was not the occurrence of Covid-19 at the insured premises but the closure of the insured premises ordered by the UK Government in response to the Covid-19 pandemic generally.
- Any occurrence at the premises was not reported until after the Prime Ministers announcement, if at all, and so could not have been a cause of that announcement.
- The Supreme Court in the FCA test case was not requested to consider "at the premises" extensions to cover. And Investigator's opinion, in applying the court's reasoning, does so in a matter the court did not intend.
- The at the premises clause is fundamentally different to the radius clauses considered by the court, which might provide a large geographical area in with occurrences of a disease might fall. The at the premises clause is, in QIC's view, plainly intended to respond to business interruption losses caused by an isolated, local, occurrence of a disease and not to any wider consequences of that disease.
- QIC considered that at the time the policy was incepted, the intention of the at the premises clause was to provide cover for losses caused by extremely localised occurrence i.e. occurrences occurring only at the premises. And was not intended to provide wider cover for losses caused by Government action due to a wider pandemic.
- An occurrence at the premises would also amount to an occurrence outside of the premises, as they are not residential premises and any person who had sustained the disease would therefore only be present temporarily.
- The alleged occurrences of COVID-19 were prior to the inception of the policy on

17 March 2020.

Prior to coming to my decision, I shared with QIC some of my thoughts around the timeframes that might be relevant when thinking about when someone had sustained COVID-19. The Supreme Court has said that an occurrence of COVID-19 happens when a relevant individual becomes diagnosable with the disease. And that the guidance from, amongst others, the World Health Organisation ("WHO") suggests that a person often becomes diagnosable 1-3 days after infection. It is then likely that another few days will elapse before a person displays any symptoms of the disease. Again, using the WHO guidance this is commonly around 5-6 days after infection. And then it apparently often takes another week or so before a person is hospitalised.

I pointed out that whilst these are merely an indication of what might be expected in an individual, the progression of the disease in each individual would likely be different. And that in some cases it apparently took several weeks for individuals to display symptoms or to be hospitalised, if either of these actually happened.

Based on this, I felt that the evidence I had considered at that point suggested the initial key question for me to determine was, assuming the evidence around Mr W's condition was persuasive, whether the 13-day gap between him initial developing symptoms and his hospitalisation meant his initial symptoms were of the same illness that he was later diagnosed with; i.e. COVID-19.

QIC responded emphasising the figures included in a couple of online reports I had myself referenced. QIC said one of these advised the time between the onset of symptoms and hospitalization varies between 1-6.7 days with the average period being 4 days in the 20-80 year age bracket. QIC referred to the fact this report was from 2021, indicating it was likely based on more complete information that the other report. The other report had referred to the median time between symptoms and hospitalisation as being between 3 to 10.4 days.

QIC effectively said that based on either of these timeframes, Mr W's symptoms had occurred outside the period suggested. And that if he had been suffering with symptoms of COVID-19 on 17 March, he would have been hospitalised sooner. So, QIC considered Mr W likely did not have COVID-19 at that point, or on 14 March 2020 when he was at the premises. As such, QIC asked me to provide my final decision on this complaint.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

The clause above, as it appears in L's policy, has a number of elements. In their correct causal sequence, these are:

1. an occurrence of a Notifiable Human Disease at L's premises, which causes
2. closure or restrictions placed on the premises on the advice or with the approval of the Medical Officer of Health for the Public Authority, which cause
3. an interruption or interference with L's business that is the cause of financial loss.

I agree that the key issues for me to determine in this complaint fall into the two categories of QIC's own representations. Firstly, whether there was more likely than not an occurrence of COVID-19 at L's premises. Secondly, if so, whether this caused a closure or restrictions being placed on L's premises on the advice of or with the approval of the Medical Officer of Health for the Public Authority. I will deal with these in turn.

Was there most likely an occurrence of COVID-19 at L's premises?

In March 2020 COVID-19 was reasonably prevalent and L's premises are located within a major city centre. However, it is necessary for a policyholder to demonstrate that an insured event has occurred before a claim will be met. This must be demonstrated to have occurred on the balance of probabilities – i.e. that it is more likely than not that the event happened.

Whilst it is possible the location of L's premises mean that someone may have attended the premises will COVID-19, this is not enough to satisfy this test. However, it must also be borne in mind that general testing for COVID-19 was not available. So, a pragmatic approach is generally necessary, taking into account all of the available evidence.

As with any assessment of evidence, several aspects mean that more weight can be placed on certain evidence as opposed to others. For example, a document produced contemporaneously for a purpose unconnected to the matter at hand is likely to be more persuasive than testimony produced some time after the events for the express purpose of the claim. That is not to say testimony is not useful. But it is recognised that memories can and do change over the course of time.

In this case, some of the evidence provided is lacking in detail or corroboration. For example, there are comments that some staff members displayed symptoms of illness. But no contemporaneous evidence of this has been produced, and the symptoms described are not clearly indicative of COVID-19. As well as COVID-19, people in March 2020 would have been suffering from other illness with some of the similar symptoms. Indeed, the symptoms are described as being "flu like" and it isn't clear these individuals didn't just have flu.

The evidence in relation to Mr D is supported to an extent by the medical records provided. These are contemporaneous. It also isn't clear why Mr D would have been reporting his illness other than to seek medical advice. So, I think it is likely he was suffering from the symptoms described at the time he says he was. However, the timeframe involved with these symptoms is not the most helpful in demonstrating he most likely had sustained COVID-19 at the time he was at the premises. It certainly isn't out of the question that he did have the disease when at the premises.

However, the clearest evidence of someone having sustained COVID-19 is of course a positive test result. Mr W did receive such a positive test result, so it is reasonably certain that he did sustain COVID-19. The issue is that this test result is some time after he says he was at the premises and then developed initial symptoms.

QIC has referred to the timeframes in the two reports I myself referred to. I should point out that the 2021 report actually relies in part on the other report. And the report also says that relevant the period was more than 6.7 days in a quarter of the relevant patients. So, whilst the indicated timeframe is a useful average, this should not be seen as a maximum. These two reports are of course not the only such documents that discuss the relevant timeframes. Other peer reviewed medical journals available online refer this issue and express slightly different average timeframes. However, the general indication is that a period of 13 days between the onset of symptoms and hospitalisation is longer than most, though not all, patients experienced.

These are though, as I have previously said, only an indication of what might be commonly expected and the progression of the disease is different in different individuals. These timeframes merely provide a guide when thinking about the balance of probability. It is more likely that someone whose disease progresses in line with the suggested timeframes had the disease at the relevant points, than someone whose disease progresses along a different

timeframe. The further outside the timeframe the less likely they had the disease at the relevant points.

Along with these timeframes, it is also necessary to consider the other evidence available in order to build a picture of what is more likely than not.

In Mr W's case, I think it is most likely that he was at L's premises on 14 March. The testimony on this point has been consistent and supporting evidence has also been provided. This supporting evidence includes photos that seemingly do not give a clear picture of Mr W, as they apparently only show him from the back. But taken as a whole, I am persuaded that Mr W was most likely at the premises on 14 March.

Mr W has said that he developed symptoms on 17 March 2020, and then called L to let them know the following day. Whilst the only direct supporting evidence of this is the general manager's testimony, I also note the L apparently made the decision to close on 18 March 2020. It isn't clear why it would have taken this decision if the circumstances described are incorrect. As a pub in a central location, it seems likely to me that it would still have been busy – indeed many pubs enjoyed a busier period in this week than usual. It may be that Mr W did not call, and the decision L took was based on its own staff displaying symptoms of what it was concerned was COVID-19. But the testimony around the events has again been consistent and I see no reason not to believe the statements provided on this point. So, I think it is most likely Mr W called L on 18 March 2020.

I also think it is most likely that this call was made because Mr W was feeling ill and felt a responsibility to let L know. So, I consider it is most likely Mr W was displaying symptoms of illness on 17 March.

Based purely on the symptoms described, I would not say these are conclusive that Mr W had COVID-19 at this point. The symptoms are more general rather than some of the more specific issues caused by COVID-19. However, having concluded Mr W was most likely displaying symptoms of some form of illness on 17 March, it is necessary to consider whether this was most likely the same illness as that he was diagnosed with after his hospitalisation on 30 March.

As mentioned, this timeframe does sit outside that indicated would be the average. However, it is necessary to consider whether this means it is more likely that Mr W suffered from an initial illness that led to symptoms on 17 March, and then a separate illness that led to his hospitalisation on 30 March.

If I were to consider when Mr W likely became infected based on the timeframes above, this would be about two weeks prior to his hospitalisation. Meaning he would most likely have been infected on or around 16 March 2020.

Mr W has said he did not attend any other location between 14 and 17 March 2020. QIC has said this is extremely unlikely, but has not indicated why it thinks this. This is not an extensive period of time, and if Mr W was either not working or was working from home, it seems perfectly feasible that he would not have left his home for 3 days. And this is supported by the call I believe it is most likely he made to L. Had Mr W been at other premises over this time, I consider it less likely he would have felt obliged to contact L in particular.

It is possible Mr W did not then remain at home after 18 March 2020. But he has said that he did remain at home for the following week. Given his testimony that he was concerned that he had COVID-19 at this time, and the Government advice for people to self-isolate, I find this persuasive. It is also possible that Mr W contracted COVID-19 whilst at home, perhaps

from his partner. But there has been no indication that this was the course of events. And whilst many potential chains of events are possible, my role is to consider whether I think it is more likely than not that the symptoms Mr W said he was experiencing on 17 March were those of a disease that led to his hospitalisation.

Overall, I am not persuaded it is more likely than not that Mr W suffered from two illnesses, with some similar symptoms, one occurring on 17 March 2020 and a second leading to his hospitalisation on 30 March 2020. Whilst this is a possibility, I think it is most likely that Mr W was displaying symptoms on 17 March of the same disease that led to his hospitalisation. And given the hospital test result, I think this disease was most likely COVID-19.

I also consider it is most likely that Mr W had sustained the disease at least three days prior to him initially developing symptoms. And I consider it is most likely that he was at L's premises on 14 March 2020 at a time when he had sustained COVID-19. It follows that I consider there was at least one occurrence of COVID-19 at L's premises prior to the Government's decision to introduce restrictions that interrupted L's business.

What remains is to determine whether these restrictions were introduced as a result of this occurrence.

Did the occurrence of COVID-19 at L's premises cause a closure or restrictions being placed on L's premises on the advice of or with the approval of the Medical Officer of Health for the Public Authority?

In determining this point, I need to consider whether the approach taken by the Supreme Court to radius clauses should also be applied to the above clause, given the content of that clause and the context of the rest of policy and circumstances.

Largely speaking, the question of whether the placing of restrictions on L's premises by the announcement and March Regulations was as a result of the occurrence of COVID-19 at L's premises, is one of causation. The appropriate test of causation here is to consider, objectively and in the context of the policy as a whole, what the intended effect of the policy term was as it applies to the circumstances of the claim.

So, the first question to determine is whether the reasoning of the Supreme Court in the FCA test case, on radius clauses, applies to at the premises clauses. As indicated by the Investigator, this is an issue that has already been considered by this service and a copy of a relevant final decision has been shared with QIC. However, they disagree with the approach of this service.

But whilst different policies have different wordings, there is no significant difference between the contractual construction of the radius clauses to the at the premises clauses. The only difference between these clauses is the geographical area that they cover.

The Supreme Court had not been asked to determine the correct interpretation of at the premises clauses. But it did make some comments, at paragraph 71 of its judgment, in relation to a specific policy that some insurers have suggested means the reasoning behind the court's approach to causation does not apply. But the policy being considered by the court at this point included both "in the radius" and "at the premises" subclauses, and this was likely to be context the court bore in mind when considering the potential meaning of the term. This is not the case with L's policy.

The Supreme Court was also, at this point in its judgment, considering the scope of the insured peril, rather than matters of causation. And, whilst the Supreme Court said that the scope of the insured peril for an at the premises clause was not the entire outbreak even if

there was an occurrence on the premises, this was also the conclusion it reached in relation to the radius clauses. The Supreme Court found that the insured peril for radius clauses was also not the entire outbreak provided it came within the radius. There was no distinction between radius and premises clauses drawn by the Supreme Court here. And I consider both types of clause provide cover for cases within their geographical limits and not cover for cases elsewhere.

The Supreme Court's reasoning – that the insured peril is each case of COVID-19 that falls within the geographical limit of the clause – applies equally to at the premises clauses as it does to radius clauses.

Additionally, the Supreme Court did not make any distinction between radius clauses and premises clauses when these were combined in the same policy. A single case – even at the premises – was considered sufficient for the cover to respond and to cover the losses sustained by the insured party as a result of that occurrence. The Supreme Court confirmed that a single case can be enough for causation to be established under a radius clause, and there would be cover under a clause containing both a premises and radius subclauses if the only case of COVID-19, within the geographical limits of the clause, was at the premises.

The only significant difference in the construction of the at the premises clauses with the radius clauses is the geographical area they specify. This can be undefined, the whole country, a 25-mile radius, a 250-metre radius, or the policyholder's premises. A clause that sets out a smaller area only acts to limit the possibility of a case occurring, and so limit the chances of a claim being made. This is a reasonable and understandable commercial intent by an underwriter.

I should also point out here that the premises of some policyholder's will be greater than a 250-metre radius. And it would be illogical to consider that a policy requiring a case of COVID-19 within a radius smaller than a policyholder's premises would provide cover for the consequences of the March Regulations, but that this would not be the case if the policy specified a larger area – that of the entire premises.

Ultimately, the court found that the approach that applied to the interpretation of the insured peril was the same for both radius clauses and at the premises clauses. And that this was that clause only covers the cases of COVID-19 which happen within that radius. The cover is for the cases of disease within the radius (or at the premises, depending on the wording of the policy), not for the disease itself nor for the consequences of diseases outside the radius/premises.

The impact on the cover of requiring the disease to occur on the premises is the same as is provided by a policy limiting the relevant radius to one mile, rather than 25 miles. It does not change the form of cover provided, it merely lowers the chance of the policy term being activated. There is less chance of occurrence at the premises than within one mile of the premises, and there is less chance of an occurrence within one mile of the premises than within 25 miles. Each individual case of COVID-19, regardless of where it occurred, was an equal cause of the restrictions being imposed. But for the impact of that occurrence to be covered, the occurrence must be within the geographical limit set by the policy.

Taken at face value, radius clauses offer the same type of cover as at the premises clauses – the only difference being a smaller geographical area where the occurrence needs to take place before resulting business interruption is covered.

I also consider the type of disease covered by the policy is also a relevant consideration. L's policy, as with many similar policies – both those with radius clauses and at the premises clauses - provides cover for a wide range of diseases. Many of these diseases are unlikely

to have originated at the premises, so an occurrence there is likely to be part of a larger outbreak. If QIC had wanted to restrict cover in L's policy to disease originating at the premises, it could have done so. But it did not.

The same risk of a widespread and unpredictable outbreak of disease applies to both radius clauses and at the premises clauses. If these wide-spreading diseases are on the policyholder's premises, they are also likely to be found outside of these premises. So, whether or not the disease is on the premises, it seems that the actions of the relevant authority will in fact largely be the same.

It is likely restrictions would be introduced covering a broad geographical area in relation to many of the diseases covered by L's policy. And this would have been something that both QIC and L might reasonably have been aware of at the time the insurance contract was entered. I note the Supreme Court's comments at paragraph 194 of its judgment in respect of this point:

> "…*we consider that the matters of background knowledge to which the court below attached weight in interpreting the policy wordings are important. The parties to the insurance contracts may be presumed to have known that some infectious diseases - including, potentially, a new disease (like SARS) - can spread rapidly, widely and unpredictably. It is obvious that an outbreak of an infectious disease may not be confined to a specific locality or to a circular area delineated by a radius of 25 miles around a policyholder's premises. Hence no reasonable person would suppose that, if an outbreak of an infectious disease occurred which included cases within such a radius and was sufficiently serious to interrupt the policyholder's business, all the cases of disease would necessarily occur within the radius. It is highly likely that such an outbreak would comprise cases both inside and outside the radius and that measures taken by a public authority which affected the business would be taken in response to the outbreak as a whole and not just to those cases of disease which happened to fall within the circumference of the circle described by the radius provision*".

I consider this reasoning also applies in relation to a policy which provides cover only where there is an occurrence of such a disease at the premises of the insured. Whilst some of the notifiable diseases covered by the policy would in some cases be limited to a very localised outbreak – potentially contained to the premises – many of the diseases covered by the policy would inherently be those that would be found beyond the premises if they ever occurred at the premises. As with radius clauses, it would be contrary to the commercial purpose of the policies for cases of disease occurring outside the premises to deprive the policyholder of cover for cases at the premises.

I consider it likely that if there were occurrences of many of the diseases covered by L's policy, the actions taken would likely have been similar. The actions taken by other governments in relation to outbreaks of SARS and Ebola which led to broad geographical areas or multiple types of business having restrictions imposed on them would provide examples of this. It seems that the more likely the disease is to be wide-spreading, the more wide-spread the restrictions will be that are imposed to control that disease.

By including cover for a number of diseases where the likely actions to be taken would be those that would impact more than a single premises, I considered QIC has seemingly agreed to provide cover where actions are taken (in relevant situations) that impact more than just the insured's premises.

The Supreme Court found that each and every occurrence of COVID-19 was an approximately equal and proximate cause of the Government's decision-making process.

The Supreme Court set out some general principles or standards to be applied when considering the proximate cause of loss. These included determining whether a peril that is covered by the policy had any causal involvement and, if so, whether a peril that was excluded from the cover provided by the policy had any such involvement. And then determining whether the occurrence of one of these made the loss inevitable in the ordinary course of events.

The court went onto say that whilst the Government's decisions to introduce the restrictions in March 2020 could not reasonably be attributed to any individual occurrence of COVID-19, this decision was taken in response to all the cases in the country as a whole. And the Supreme Court agreed with the High Court here that, "*all the cases were equal causes of the imposition of national measures*". The Supreme Court found that here was no reason why one insured event, acting in combination within a number of uninsured events, should not be regarded as a proximate cause of loss even if that insured event was not necessary or sufficient to bring about the loss on its own. And that; "*Whether that causal connection is sufficient to trigger the insurer's obligation to indemnify the policyholder depends on what has been agreed between them*."

As such, a key issue was what risks QIC agreed to cover. This is a question of contractual interpretation of L's policy, answered by applying the intended effect of the policy to the circumstances of L's claim.

QIC has said that the intention of the clause could only have been reasonably understood as providing cover for losses caused by an extremely localised occurrence, and would not reasonably have been understood as providing cover for a wider pandemic. QIC also said that if there were occurrences on L's premises, these would be present both at and outside the premises once the individuals left.

In making its findings in the test case, the Supreme Court relied on the presumption that an infectious and contagious disease – like many of those QIC chose to cover in L's policy – can spread rapidly, widely and unpredictably, so that an outbreak which is sufficiently serious to lead to a policyholder suffering an interruption to their business was highly likely to include cases inside and outside the radius relevant to the policy. The court found it would not be feasible, and would be contrary to the commercial intent of the policy, for cases outside of the radius to deprive the policyholder of cover in relation to cases within the radius. I note the comments of paragraph 206 of the Supreme Court judgment which support this.

Radius clauses did not limit cover to situations where the interruption of the business was caused only by cases of disease occurring within the area, as distinct from other cases outside the area. And, in such circumstances, other concurrent effects on an insured business of the underlying cause of the business interruption, i.e. the pandemic generally, do not reduce the indemnity under the relevant clause.

I see no persuasive reason why the considerations that the Supreme Court applied generally to radius clauses do not equally apply to at the premises clauses. And feel the same applies here to L's complaint. As the Supreme Court said, all that is necessary for a radius clause which also requires the closure to be as a result of, for example, government action, is for the closure or restrictions to be in response to cases of COVID-19 which included at least one case existing within the geographical area set out in the relevant clause. In L's case, this geographical area is its premises and I consider there was at least one occurrence of COVID-19 within this area. And I consider the Government's actions and advice were in response to cases of COVID-19, which included the case(s) that occurred at L's premises.

It might be that the case(s) of COVID-19 at L's premises would not have been reported to

the Government at the time it made its decision. But I do not consider this point to be crucial in terms of the discussion of causation. It is clear that as well as the reported cases that the Government was specifically aware of, the decision it took was also made due to the estimated number of unreported cases.

It was the number of these unreported cases, as well as the reported ones, that would have led to the Government making its decision. Each one of these reported and unreported cases will have arguably been a proximate cause of the Government's decision-making process. But it would not be possible for an "estimated occurrence" to lead to an insurance claim where an actual occurrence was required by the policy.

It is also clear that in thinking about both the reported and unreported cases the Government was making its decision based on historic data. The models being considered were predictions of future hospitalisations taking into account, amongst other things, the reproduction ratio of the infection (the R-number), which is affected by numerous factors that govern pathogen transmission and is, as I understand it, therefore usually estimated using different complex mathematical models. And the data referenced in the Government's briefings was based on the events that took place over the preceding weeks.

By the time the decision to introduce the March Regulations was taken, a number of individuals included in the figures of who had sustained COVID-19 may already have recovered. But I consider these cases would still be those that, together with the other cases around that time, were the concurrent causes of the Government's decision. The Government and its advisors were not looking at individual cases in isolation, they were considering the accumulation of these which would have formed the framework of the rate of infection and allowed for a prediction as to the future R-number and resultant hospitalisations.

I note that the courts indicated that a person passing through an area, involving no contact with anyone and therefore no risk of transmitting the disease, might not be enough to trigger the insured peril under a radius clause. However, I consider this is entirely different from someone who remained in the area for some time and had numerous interactions with various people. Whilst that person may then have left the area in question, their presence created a risk of the disease having been transmitted. And it is this risk, and the potential of this leading to hospitalisation and the overwhelming of the NHS, that led to the Government's decisions at this time.

Although each case of disease was individual, the effects of the disease – the Government's measures – were indivisible. And as the Supreme Court said at paragraph 212 of its judgment:

> "…*each of the individual cases of illness resulting from COVID-19 which had occurred by the date of any Government action was a separate and equally effective cause of that action*…"

QIC did also argue that if there was an occurrence on 14 March 2020, this was prior to the inception of the policy on 17 March. But as the Investigator has said, the clause in question is a composite one and an insured event cannot be said to have occurred until all the relevant elements have taken place. In this case, the Government's announcement was after the inception of the policy. So I do not consider this causes a problem with L's ability to claim in the circumstances.

L's policy does require that the actions taken by the Government were based on "*the advice of or with the approval of the Medical Officer of Health for the Public Authority*". The term Medical Officer of Health is not defined within the policy. As such, it needs to be interpreted

as it would be understood by a reasonable person at the time of entering the contract.

“Medical officer of health” is largely a historical term. It was used in the Public Health Act 1961, but it is not in more recent public health legislation. Section 37 of this Act relates to the sale of verminous articles and appears to be the only legislative term relating to the medical officer of health. The role itself is also historic and no longer exists. I note that when the role was in existence, it did have a focus on local authority matters rather than anything national. But I consider this to be a reflection of the make-up of healthcare services generally at the time medical officers of health were introduced, rather than the current situation which is more of a mix between national and localised healthcare.

I consider the current set-up of the healthcare system is also significant when considering the potential actions taken in the face of many of the diseases covered by L’s policy. As set out above, the responses to many of these diseases would be wide-spread and would require more nationally-orientated action. To say that the policy provides cover for a disease that would likely only be acted upon by national government, but then to limit cover to the actions of a local authority would, to my mind, provide an irrational result.

QIC has said that, in the terms of L’s policy and specifically the definition of Notifiable Human Disease, a relevant human infectious or contagious disease would need to be notified to the “competent local authority” and that this is a different entity to the Medical Officer of Health for the Public Authority. I don’t consider the definition in the policy to be the best drafted, but I do agree that these two entities are likely different. However, I don’t see the fact the has having a significant bearing on the outcome of this complaint.

Under the Health Protection (Notification) Regulations 2010 a doctor is required to notify the proper officer of a local authority when a notifiable disease is found, or suspected, in a patient. The list of notifiable diseases is updated by the Government, and COVID-19 was added to this list in early March 2020. QIC apparently consider that the definition of Notifiable Human Disease is, in part, a reference to this list. However, when a local authority is informed about such a disease occurring, they were then obliged to inform the Health Protection Agency (as existed previously). Depending on the events in question, the matter will be escalated as appropriate and advice might be given, potentially by the Chief Medical Officer for England, to the Government on whether to take action. Effectively, this is what happened during the COVID-19 pandemic. And it is unclear why QIC has said that the difference between the two entities referred to means the clause does not apply to the circumstances.

Ultimately, the at the premises clause in L’s policy refers to a term that is dated and it would not be reasonable to expect a customer taking out an insurance policy of this nature to understand the historical positioning of a redundant role, and then apply that to how the clause in question should be interpreted in relation to cover for a wide-spreading disease. An alternative question is whether a reasonable customer would consider that a clause referring to the advice of the Medical Officer of Health would include the advice of the Chief Medical Officer for England. I consider that this is how a reasonable person would have interpreted this clause at the time the policy was taken out.

As such, taking all the circumstances of the complaint into account, I consider that L’s policy should cover it for the losses it sustained when it was interrupted by the Prime Minister’s announcement and the subsequent regulations made on 21 March and 26 March 2020. This means I consider QIC is liable for the full extent of the period L was closed by the Governments restrictions, subject to the relevant policy limits.

I am satisfied that L’s policy with QIC is a contract with its own terms. I have considered how these terms would likely have been interpreted by a reasonable person at the point the

contract was entered into, bearing in mind that it is a policy sold to SMEs.

I don't think a reasonable person would interpret a clause that provides cover in relation to various diseases, including those most likely to be wide-spread and hence requiring far-reaching measures to tackle them, to be limited to consequences directed solely at the insured's premises.

I think it is reasonable to read L's at the premises cause, in the context of the rest of the policy and the circumstances of the claim, as providing cover for losses resulting from the occurrence(s) of COVID-19 at its premises. Although I can't be sure, I also this this was more likely than not that this is how a court would interpret this term.

Given the findings of the Supreme Court, I also think the occurrence(s) at L's premises was an equally effective concurrent cause of the decision to introduce the March Regulations, as the occurrences beyond the limits of L's premises. And the cases off the premises are not an excluded cause.

Referring back to the elements of the insured peril I set out earlier in my decision, in their correct causal sequence, and taking the points above into account, I am satisfied that:

- An illness caused by COVID-19 occurred at L's premises.
- This occurrence was a proximate and concurrent cause of the Government's decision to introduce the March Regulations.
- These March Regulations were introduced on the advice or with the approval of a person or persons who would be considered the Medical Officer of Health for the Public Authority.
- These Regulations placed restrictions on L's premises. And,
- These restrictions caused an interruption or interference with L's business that likely caused a loss.

As the elements of L's disease clause have been met in the circumstances, I consider QIC's decision to decline L's claim for the losses sustained as a result of the Government's restrictions was not made correctly. And I so don't consider QIC dealt with L's complaint fairly or reasonably.

Putting things right

I consider L's complaint should be upheld.

In order to put things right, QIC should:

- Reconsider L's claim on the basis that there was an occurrence on its premises that caused an interruption to its business from 20 March 2020 to 4 July 2020.
- If, taking into account the remaining terms of the policy, any settlement is due to L QIC should pay this. Any excess that is payable should deducted from the total claim amount, before any policy limit is applied.
- QIC should pay L interest on this settlement.

The interest payable on the settlement should be based on L having been deprived of four monthly interim payments that should have been made during the course of the claim.

The first of these payments should have been paid on 20 May 2020 and should have covered L's indemnified losses for the period 20 March 2020 to 19 April 2020 inclusive. Subsequent monthly payments should have been based on losses for the periods; 20 April 2020 to 19 May 2020, 20 May 2020 to 19 June 2020, and 20 June 2020 to 4 July 2020. These payments should have been made on 20 June 2020, 20 July 2020, and 4 August 2020 respectively.

QIC should pay L interest on the amount of each of these interim payments, for the period from the date of each of these interim payments should have been made to the date of settlement. This interest should be paid at a rate of 8% simple per annum.

My final decision

My final decision is that I uphold this complaint. QIC Europe Ltd should put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask L to accept or reject my decision before 28 April 2022.

Sam Thomas
Ombudsman