THE REPUBLIC OF UGANDA
IN THE INSURANCE APPEALS TRIBUNAL OF UGANDA
APPLICATION No. 002 of 2023
(ARISING FROM THE DECISION OF THE INSURANCE REGULATORY AUTHORITY OF UGANDA VIDE; COMPLAINT N0. IRAB/COMP.36/03/2022)

APA INSURANCE (U) LIMITED:: APPELLANT
VERSUS
MOIL (U) LIMITED:: RESPONDENT

CORAM: MRS. RITA NAMAKIIKA NANGONO - CHAIRPERSON
MR. GEORGE STEVEN OKOTHA - MEMBER
MRS. SOLOME MAYINJA LUWAGA - MEMBER
DR. JOHN BBALE MAYANJA – MEMBER

JUDGEMENT

1.0. BACKGROUND TO THE APPLICATION

This application seeks to challenge the decision of the Insurance Regulatory Authority (IRA) made on the 19th day of December 2022, on the basis that the said ruling was erroneous in so far as IRA found that the Respondent's claim had been repudiated which the Appellant found to be incorrect and improper. Further that the assessors' failure to use the information that was gathered to carry out investigations in Uganda rather than travel to Dubai, Sharjah, and Tanzania to do further investigations was intended to defeat the claim. The application was filed before the Tribunal on 19th January 2023.

2.0. BRIEF FACTS GIVING RISE TO THE APPLICATION

The Respondent took out an insurance policy under policy number APA/070/1/009344/2021 to cover two (2) motor vehicles. Subsequently, one of the two motor vehicles a Lexus LX570 Chassis No.URJ2021-4269901 and URJ201-4271892 were involved in an accident in Tanzania on the 16th day of June 2021 at about 05:45 hrs. An insurance claim was filed by the Respondent for settlement. The Appellant commenced investigations using the independent firm of Anand International Consultants Limited. During the investigations it was established in the preliminary investigations report that the Motor Vehicle's Chassis and Engine Numbers had apparent tampering among other preliminary findings.

The investigator sought key information from the Respondent and further investigation of the claim. It is alleged by the appellant that the Respondent refused to submit the additional key information to the investigator. The Respondent filed a complaint with the Insurance Regulatory Authority which found that the Appellant had enough information at its disposal to determine the claim and ordered the Appellant to pay the claim as presented by the Respondent.

Dissatisfied with the decision, the Appellant applied to the Tribunal, seeking to set aside the decision by the Tribunal, a declaration that the respondent's claim had not yet been repudiated, and seeking leave to conduct further investigation of the respondent's claim in Tanzania, Sharjah, and Dubai.

3.0. REPRESENTATION AND APPEARANCE

The Appellant was represented by Counsel James Muwawu assisted by Counsel Leticia Nanyomo from M/s Nampandu, Mugwanya, Muwawu & Co Advocates while the Respondent was represented by Counsel Micheal Okecha assisted by Counsel Alexander Kafero of M/s Okecha, Baranyanga & Co Advocates. The parties filed their respective pleadings.

The Tribunal hearing was held on the 16th day of March 2023 in the presence of Counsel for both parties, Mr. Anand Agarwal Chief Operations Officer of APA, Mr. Nsereko David, Head of Claims APA and Anand Sharma, Managing Director Anand International Consults Limited, the investigator.

4.0. GROUNDS OF APPEAL

The instant application was premised on issues/grounds cited by the Appellant as follows;

i) The ruling of the Regulator that APA /Appellant was not justified in repudiating the claim was an incorrect and improper decision and an error in fact and the law of the regulator as there was no evidence that the Appellant insurer has ever repudiated the claim and the claim was still at the investigation stage.

ii) The regulator erred in law and fact in wrongly finding that the assessor's failure to use the information to carry out investigations here in Uganda and only sought to travel to Dubai, Sharjah, and Tanzania to do investigations was intended to defeat the claim, when there was clear evidence that there was apparent tampering with the Chassis and Engine number of the vehicle, among other preliminary findings.

iii) The regulator erred in law in wrongly finding that the respondent's actions, submissions, and requests towards the complaint, requesting for some documents were farfetched and not justified.

iv) The regulator erred in law and fact in finding that the Respondent's claim was payable and thereby unfairly denying the Appellant insurer the right to fully and conclusively investigate the Respondent's claim and determine the claim's validity and claim value.

v) The Regulator initially directed the Respondent to provide the requested claim information and committed to assisting the investigator with relevant letters but unfairly withdrew the same without justification.

vi) Settling the Respondent's motor claim without subjecting it to the relevant full claim investigation and obtaining the relevant key information including information on tampering of the Chassis and Engine Numbers, are practically difficult and irregular and is contrary to insurance practice and law.

4.1. THE AGREED ISSUES FOR DETERMINATION BY THE TRIBUNAL

a. Whether there was repudiation of the claim by the Appellant insurer and if so whether it was justified?

b. What remedies/reliefs are available to the parties?

5.0. EVIDENCE AND SUBMISSIONS

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5.1. APPELLANT'S EVIDENCE SUBMISSION IN SUPPORT OF THE APPLICATION

The Appellant argued that it has never repudiated the Respondent's claim since no final claim decision has been made by the insurer. The Appellant further argued that not even a constructive repudiation of the claim could be imputed on the part of the Appellant since the claim was still undergoing investigations as embedded in its preliminary investigation report.

Secondly, it was the Respondent who refused to cooperate with the Appellant, and when informed that the vehicle was tampered with and upon request for more information, the Respondent chose to file a complaint with the Complaints Bureau instead of providing the additional information that was required by the investigator. The investigator explained and justified that the report of the preliminary investigation awaited key and material additional information from the Respondent and from Dubai UAE where the vehicle was imported from. To support this, counsel referred to the ***letters dated 6th May and 22nd June 2022 which appear on page 33 of the annexures attached to the Appellant's application***

It was argued for the Appellant that tampering with a vehicle was a material fact that had a direct effect of affecting or reducing the value of the vehicle. The insured therefore had justification for further investigation to conclude the investigation to fully and conclusively investigate the claim.

It was further submitted that although the Appellant promised to provide the additional information, the same was never provided even after a letter requesting the same was provided. The lack of cooperation from the Appellant was delaying the conclusion of the investigation according to the Respondent.

Further still, the Respondent had requested support from the IRA in the form of travel support to Dubai UAE because it was illegal to investigate without UAE authorities being notified by Ugandan Authorities. The IRA has initially given the support but allegedly withdrew it.

It was argued that the Complaints Bureau of the IRA improperly repudiated the claim and ordered that the same be paid in the absence of any evidence to support this and by basing its decision on the fact that the additional information which the investigator sought should have been sought during the underwriting of the risk.

5.2. SUBMISSIONS BY THE RESPONDENT

It was argued for the Respondent that the Appellant was informed about the accident within 14 days and the requested information/documents were availed as demonstrated by a letter dated 30/07/2021. Ever since then, the Appellant uses its hired investigator/loss assessor to argue that investigations have not been completed. Even after the investigator asked for three months which were granted, he came up with excuses as to why he had not concluded the investigation

Counsel argued that a prudent insurance practice demands that an insurance claim should be paid under the **Insurance Claims Guidelines 2021** as issued by the **Insurance Regulatory Authority of Uganda.** Counsel referred to the claims process and service standards required of an insurer to decide on settlement or repudiation within 16 days or 20 days if the claim is above **UGX 50,000,000**. ***Reference was made to Paragraph C of the Insurance Claims Guidelines 2021***

The Respondent submitted that since the Appellant acknowledged the claim and acquired the documents from the Respondent on 30/07/2021 a duration of over 598 days ago equivalent to one year and eight months thereafter, there is no logical explanation or justification for the Appellant's refusal to pay the claim. Counsel prayed that this Honourable Tribunal finds it fit to maintain and uphold the orders of the IRA-Complaints Bureau and dismiss the Application with costs to the Respondent.

Counsel emphasized the two major obligations of the parties to an insurance contract. First, the insured ought to disclose to the insurer material facts known to him/her and secondly, the burden is on the insurer to prove that the non-disclosure induced the making of the contract if the insurer is to avoid the contract. In support of this proposition, counsel relied on ***Pan Atlantic Insurance Company Ltd & Another v Pine Top Insurance (1995) AC 501***

Counsel further submitted that all facts material to the Respondent as known to its officials were disclosed and for the Appellant to require the Respondent to produce additional information which is not within the knowledge of the Respondent is to stretch the principle so far and is contrary to law and thus illegal. Instead, the Appellant ought to have based its decision on such information within the Respondent's knowledge to compensate rather than the unknown. Counsel relied on the case of ***Salini Construttori S.P.A V Jubilee Insurance Company of Uganda Limited Civil Suit No. 109 of 2016***

Further, based on the evidence provided in Annexure (ii) of the Respondent's trial bundle, all the documents requested by the Appellant for the investigation were shared. According to Counsel, all material facts known to the Respondent were disclosed and for the Appellant to require the Respondent to produce additional information which was not within the knowledge of the Respondent was contrary to law and thus illegal.

Hence the burden to prove non-disclosure and tampering with the Engine and Chassis Number was on the Appellant according to ***Section 103 of the Evidence Act Cap 6***. Further, the Appellant did not request the delivery of the important documents during underwriting and did not inspect the vehicle before insuring it. Rather, the Appellant has not formally rejected the claim but has not followed the claim management guidelines and is using further investigations as an excuse for withholding payment therefore the Appellant's submission that the decision by the Complaint's Bureau was premature is untenable. It was argued that at the hearing the investigator requested more time of three (3) months within which to conclude the investigation which was accorded to him but did not explain why he had not concluded the investigation. The Respondent relied on ***Mariscal v. Old Republic Life Ins. Co. (1996) 42 Cal.App.4th 1617, 1620 [50 Cal.Rptr.2d 224]*** to emphasize the duty to diligently search for evidence that supports its insured's claim as opposed to defeating the same.

The Respondent contended that the duty of an insurance company was to act in good faith towards their insured. If they take unreasonable investigative steps with the motive of denying legitimate claims, they violated this duty and were liable for claims based on bad faith. Some examples of bad faith included denying valid claims, failing to investigate claims properly, and delaying claims processing without a valid reason. To support this counsel referred to ***Egan v Mutual of Omaha Insurance Co. (1979) 24 Cal.3d 809, 817 [169 Cal. Rptr. 691, 620 P.2d 141] where it was held that "[A]n insurer may breach the covenant of good faith and fair dealing when it fails to properly investigate its insured's claim."***.

The Respondent therefore prayed that this Tribunal finds the instant Application without merit and dismisses the same with costs and upholds the decision of the IRA.

5.3. SUBMISSIONS IN REJOINDER

The Appellant's counsel submitted that the Respondent's claim regarding the investigation timeline should be dismissed as it lacks context and does not consider the unique and cross-border nature of the insurance claim. Further that the Insurance Claims Guidelines only apply to situations where the insured has provided all necessary claim information, and no unusual facts have been uncovered during the investigation. This information has been presented in the submissions and the Claims Guidelines do not address complex cases such as the Respondent's, where the insured failed to provide essential information despite a preliminary report citing important details such as the motor vehicle's engine number, chassis number, and nose cut.

In rejoinder to the Respondent's submission, the Appellant argued that the delay in processing the claim was caused by the insured's failure to provide information and cooperate with the investigation. They claim that the nature and circumstances of the case make it an exception to the 20-day requirement for processing insurance claims. Since the investigator needs the new information to commence cross-border investigations, the additional information sought is both relevant and material to the Respondent's claim. The Appellant also argued that any prudent insurer standing in their position would have sought the same additional information and cooperation. The Appellant cited the case of ***Shinedean vs Alldown Demolition (2006) EWCA Civ 939*** to support their argument that the insured must provide claim-related documentation within a reasonable time.

The Appellant maintained that it had not breached any contract of indemnity as it has never repudiated or made a claim decision regarding the Respondent's claim. Counsel sought to distinguish its case from the Salini case cited by the Respondent's counsel, as the two cases were at different stages of the insurance claim process.

6.0. DECISION OF THE TRIBUNAL

6.1 RESOLUTION OF ISSUE ONE

Whether there was repudiation of the claim by the Appellant insurer and if so whether it was justified?

The Appellant faults the Regulator for having found that the Appellant had repudiated the contract/claim in the absence of any evidence yet the claim was still under investigation.

The leading decision on the right to avoid a contract of insurance for non-disclosure is that of the House of Lords in ***Pan Atlantic Insurance Co. Ltd v Pine Top Insurance Co. Ltd [1995] 1 A.C. 501*** as relied on by the Respondent in its submissions and the Regulator in the impugned decision. For an insurer to be entitled to avoid a policy on this ground, the insurer must be able to show both that the fact that the insured failed to disclose was 'material' and that the failure to disclose it induced him to accept the risk when the insurer would otherwise have declined it or would have accepted it only on different terms. These are closely related, but distinct, requirements.

In the present case, counsel for the Appellant contended that the additional information required from the Respondent and from Dubai UAE where the vehicle was imported from including whether the subject matter insured is an original or an assembled vehicle was material information. The critical question is whether the Respondent's failure to disclose the purported tampering of the Chassis and

Engine Numbers (if at all that is true) did induce the Appellant to cover the risk under the policy on more favourable terms than it would otherwise have been willing to agree.

The root of the problem lies in the manner in which the Appellant undertook to cover the risk under the policy. As cited by both Counsel for the Appellant and Respondent borrowing the description of materiality as elucidated by **Preston and Colinvaux's Law of Insurance** the test applicable in what is material is '*everything which will guide a prudent insurer in determining whether he will take the risk and if so, at what premium and what conditions'.*

Apart from the information that is generally available in the market, insurers can only assess risks presented to them based on the information made available to them by their insureds. Accordingly, the effect of a failure to disclose material facts can only be judged by reference to the information that the insured has made available to the insurer at the time he accepts the risk.

A fact is considered material to an insurance contract if it would influence the judgment of a prudent insurer in fixing premiums or determining whether he/she will take the risk. In the case of ***Pan Atlantic Insurance Co. v. Pine top Insurance Co. (1994)***, the House of Lords noted that besides showing that a material fact was not disclosed, it was also necessary to show that the actual underwriter in question was induced by the non-disclosure into entering into the contract on the said terms.

If at the time of making the contract the insured fails to inform the insurer of a matter that would diminish the gravity of the risk, in this case, the fact that this was not an original, but rather assembled equipment that might otherwise have led to a claim under the policy, he may be offered less favourable terms than would otherwise have been the case. He may also find that the failure to disclose some other material fact indeed induced the insurer, in the light of the information then before him, to accept the risk on terms that he would not have been prepared to accept if it had been disclosed. ***See; Drake Insurance Plc v Provident Insurance Plc [2003] EWHC 109 (Comm) (03 February 2003)***

Counsel for the Appellant's argument before the Regulator and this Honorable Tribunal in effect is that the Appellant was induced by the non-disclosure of the additional information now sought to be investigated by the Appellant. This information is to be provided by the Respondent as well as investigated in Dubai, from SAS Africa General Trading Company Ltd and Bhaktar.

However, we find that the important question for this purpose is whether the insurer was induced by the non-disclosure to accept the risk on terms that would not otherwise have been acceptable, not whether he would have imposed different terms if he had had different information. In the present case, it so happens that the additional information that would have affected the underwriting decision was in the Appellant's possession. Notably, the Appellant did not lead any evidence to show what the state of the insured Motor Vehicle was at the time of underwriting. The Preliminary Motor Vehicle Investigation Report exhibited by the Appellant lists the Chassis and Engine numbers of subject No.URJ2021-4269901 and URJ201-4271892.

Whereas the Appellant concedes that the vehicles were inspected by the Respondent's representative Mr. Yassin and EAA on 20/12/2020 as exhibited in Annexures 25 & 26 no evidence was led by the Appellant to show that it inspected the vehicles before undertaking to insure the same.

At the hearing, it was submitted that there was no proposal form filed either by the insured or its broker. The Tribunal was informed that since the business was through a broker, the industry practice was that either the information was disclosed through mail or a disclosure form. It was also stated that the vehicle was not inspected as part of the underwriting process for the same reason that it was business through a broker.

Underwriting is the process by which an insurer determines whether, and on what basis, an insurance application will be accepted. It is the method used to calculate the level of risk that is involved and to determine under what rates the contract can be issued. In the circumstances at hand, it is not shown whether the insurer/Appellant properly assessed the risk to be insured as there was no proposal form on record. What was disclosed by the insurance broker who was acting on behalf of the insured i.e. the state of the car and particulars thereof at the time of the assessment is not known.

The authors Raoul and Colinvaux in their book **The Law of Insurance** 4th Ed (P 297 to 300) discuss the role and liability of insurance brokers.

They write (on Page 297)

> "...***Duty of assured's agent***
>
> .....***As the assured's agent, he should make inquiries as to material facts and will be liable to the assured for breach of duty if he (the broker) fails, through his lack of care in this matter, to disclose such facts as are material (e.g. claims history) with the result that the policy is avoided by the insurers...***"

The insurance broker acting on behalf of the insured is under a duty to act carefully and also to exercise proper care and skill when carrying out the assured's instructions. The Broker is required to disclose all material facts as given to it by its client the insured.

In this case, the problem appears to stem from the fact that the Respondent allegedly did not disclose material information about tampering with the engine and chassis number and also the fact that parts of the vehicles however in the absence of a proposal or disclosure form, it's hard to know what the broker disclosed on behalf of its clients.

The old English case of ***Manifest Shipping Co. v. Uni-Polaris Shipping*** **266 N.R. 50 (HL)** established that duty of disclosure is required at the claims stage. Although the insurer failed to prove that the insured knew of the Star Sea's unseaworthiness, the case confirmed the principle of good faith during claims. Even though the insurance company failed to prove that the insured knew of the unseaworthiness, the case is important because of the clarity it provided that the duty of disclosure is required even at the claims stage.

The alteration of risk occurs whenever something is done which affects the stipulated risk, whether as regards its subject matter. The alteration must be real making the risk a different risk, there is no alteration of the risk if the alteration made is one which was within the contemplation of the parties when

they entered into the contract of insurance. ***See; Lord Warrington in Law, Guarantee, Trust and Accident Society v Munich Re-insurance Co [1912]1 Ch 138***

In the event an insured fails to disclose relevant information, then their insurer is entitled to void the policy, provided they can show that had they received a fair presentation they would not have entered into the insurance contract, however, an innocent or unintentional non-disclosure would ameliorate this still position.

The reasons advanced by the Appellant for not honouring the Respondent's claim on time is that the claim is still under investigation. From the pleadings and requests advanced by the Appellant to the Respondent it is deducible that some of the information sought to be specifically obtained from the Respondent cannot be reasonably expected or found to be in the Respondent's knowledge. Among the documents submitted by the Respondent were a copy of the claim, and driving permit, logbook, police report, sketch map, IOV, policy, a quotation from Toyota Uganda Ltd, tax invoices of the vehicle, towing receipts, medical documents, bill of lading/shipping documents, tax payment receipts, exit ad entrance of the vehicle and police report which is said to be incomplete.

At the hearing, it was verified that the letter dated 6th May 2022 from the investigator to the Respondent was responded to on 9th May 2022. The Respondent provided the information that was within its knowledge and as submitted, the ones that were not shared were within its custody or could not be availed by the Respondent ***see letter dated 9th May 2022.*** It was held in the case **of SALINI CONSTRUTTORI S.P.A V JUBILEE INSURANCE COMPANY OF UGANDA LIMITED CIVIL SUIT NO. 109 OF 2016** ***"in a situation where the Plaintiff did not know certain particulars such as the age of the vessel, that ignorance should not be held against her…The Plaintiff truthfully answered the question on age stating it was not known to them. The insurer found this sufficient answer and went ahead to insure the Plaintiff's cargo…The total is that since Plaintiff did not hide any information from the insurers, Insurance Policy No. P/KLA/151/150L/07/1456, Exh D.2 was a policy properly issued and gave cover to the cargo. Which entitles the Plaintiff to indemnity.***
We find that the Respondent shared all the information within its knowledge before and after cover. We do find some of the requirements/documents that the investigator required are immaterial or generally not information that would be in the knowledge of the insured. ***For instance "question 9 - we learnt from the documents that SAS Africa General Trading Company/SAS is the intermediary of the deal and the supplier is Bhakar & Company – your comment please" question 17- "how the money has been transacted between Bhaktar, your C&F agent for the purchase of the subject vehicle because SAS has not responded to our mail dated 31/08/2021 and 03/09/2021 attached herewith.." question 18 – "Moil has paid for each vehicle USD65,000 suppose if, your would have known before buying the subject vehicle that it is with a nose cut and repaired then how much money, you would have offered to buy the vehicle"***

Some of these questions posed by the investigator need not be sourced from the insured but should be a point of discovery by a prudent investigator during investigations and in this case, the very essence of why the services of the investigator were retained by the insurance company. It was further submitted by the Appellant that the investigator asked for travel support from the IRA since it was illegal to conduct investigations without UAE authorities being notified for this purpose. It was alleged that the IRA granted the support but the same was later withdrawn. We failed to verify this allegation as there is no

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record although we were left wondering how an investigator of such great experience at least on paper would fail to navigate its way around cross-border investigations using its counterparts.

Concerning the police report generated by Manyoni police station in Tanzania, the same is dated 17th December 2020 capturing events that took place on 16th June 2020. Having contested the report not have reflected the actual events of the accident, had the Appellant been interested in the investigation it ought to have caused an investigation or probe of the report within a reasonable time. It is more probable than not that the scene of the accident has since been obliterated and may not be a relevant point of investigation at the moment even if the Appellant were to be given more time.

The Appellant also sought to be availed the name of the supplier of the subject vehicle and their communication, payment receipt of the supplier issued to SAS Africa, and Written Statement of SAS Africa General Trading & Others regarding the purchase of the subject vehicle along with all transactions. This is information not within the knowledge of the Respondent, which if it were in the knowledge of the Respondent, the Respondent would at the time of the contract be obliged to relay the same to the Appellant.

The Respondent alleged that the supplier of the vehicle who is suspected to be from Bhaktar was not within its knowledge at the time it purchased the motor vehicle from SAS Africa General Trading. For us to find that the Respondent ought to have disclosed the supplier or the origin of the car would be to hold the Respondent responsible to investigate third-party issues hence overstretching the duty of the insured.

As a general principle, the onus is on the insurers to prove that a condition has been broken, not on the insured to prove compliance on his part with every situation. The burden cannot be altered by a pleading which purports to put the insured to the proof of compliance with what he/she has been required of him by a condition.

The Appellant claims that failure by the Respondent to provide material additional information to the investigator has stifled and continues to delay the conclusion of investigations. The rule of thumb is that the insured has a contractual obligation to provide all information including the documents as is known to them.

We are therefore in agreement with the Respondent that all material information in its possession at the point of claim was shared and it was thereafter the duty of the insurer to investigate and determine whether the claim was payable or not.

The question that is left to determine therefore is whether the delay in concluding the investigation was unreasonable and therefore repudiated the claim.

Generally, an insurer must investigate once there is a valid reason that there is a claim to investigate. It is essential that an insurer fully inquire into all possible bases that might support the insured's claim. An insurer cannot deny payments to its insured without thoroughly investigating the foundation for its denial. The obligation to investigate varies and finding a balance between the obligation to thoroughly investigate a claim and not unreasonably delay payment of policy benefits may, at times, be difficult. The Consequences of slow Investigation sometimes can infer bad faith on the part of the insurer. The

duty to investigate may also incorporate an obligation to interview witnesses, including the policyholder, and to consult with appropriate experts.

Insurance policies rarely provide for claim payment times and to fill the gap, the Insurance Regulatory Authority issued the **Insurance Claims Guidelines 2021.** The Guidelines under **paragraph 5 C** provide for ***the claims process and service standards for insurers as follows;***

Up to Shs10 Million: within 10 working days after receipt of discharge voucher.

Above Shs10 M to Shs50 M: Within 15 working days after receipt of discharge voucher.

Above Shs50M: within 20 working days after receipt of discharge voucher or upon receipt

of cash call payment from reinsurers whichever occurs first.

Note: To avoid delays, insurers should do cash calls to reinsurers immediately upon receipt of the final adjuster's report.

In the instant case, the Appellant acknowledged the claim and acquired the documents from the respondent/claimant one year and eight months ago. A discharge voucher has never been issued which renders the Guideline above redundant since the time starts running after a discharge voucher has been issued. Issuance of a discharge voucher is an indication that the parties are in agreement on the claims settlement amount. The Guideline, therefore, does not envisage a situation where the claim was disputed. Such as in the instant case.

Looking at the Claims Settlement Guidelines, it becomes abundantly clear that no specific time has been provided for an investigator and the insurer to conclude the claim. Therefore where there is a statutory period, that period will have to be observed and if there is no statutory period provided for, then the claim must be discharged within a reasonable period. What should be a reasonable period is a matter to be considered in the facts and circumstances of each case until the Regulator introduces Guidelines on claims investigations.

In the case of ***Quadra Commodities SA v XL Insurance Company SE & others [2022] EWHC 431 (Comm),*** The High Court of England and Wales clarified that the burden of proof fell on different parties with different assertions. Taking all of that into account, the Court ruled that in light of the complicating circumstances of the insurance claim (including the fact that the fraudulent parties would have concealed details and destroyed documents), a period of around one year from the original notice would be a "reasonable time" for the insurer to have investigated, evaluated and paid the claim. Whereas this decision is not binding on the Tribunal, we are persuaded that it is the correct position of the law.

Of course, that timescale was based on the "hypothetical" premise that there were no reasonable grounds for the insurer to have disputed the insurance claim (which was an issue considered separately by the Court). On that second point, the Court confirmed that even if the Court ultimately found that the insurer's grounds for disputing an insurance claim were wrong, that did not mean that those grounds had been "unreasonable".

In the present facts of the case we find that the claim has been investigated after almost 2 years from the occurrence of the accident though inordinate to an extent, the claim has not been rejected ultimately. According to our discussions above the investigations remain incomplete given the complexities of a

multi-border investigation compounded by a somewhat imprudent investigator. The insurer has reasonable grounds to want to investigate the claim given the material information needed to conclusively determine the merits of the claim. Although we generally find some of the investigator's required information untenable, this should not impede on the right to investigate the insurer.

Therefore, in the circumstances, we believe that it is in the best interest of all parties that the investigator be allowed to complete its investigation within 30 days from the date of issuance of this judgment.

6.2. RESOLUTION OF ISSUE TWO

Considering the facts and circumstances of this case and the authorities reviewed above, we are satisfied that the Appellant's delay to pay the Respondent's claim on account of further information and investigation is sustainable. We would therefore allow the appeal.

6.3. COSTS

We make no order as to costs for the reason that the Tribunal is satisfied that in deferring processing the claim, the respondent bonafide believed that it had a justifiable reason for doing so based on the preliminary report.

7.0. CONCLUSION AND FINAL ORDERS

The Tribunal makes the following orders:

1) The appeal is allowed
2) The Appellant is given 30 days to complete the investigation from the date of judgment.
3) The Insurance Regulatory Authority is hereby ordered to render all required support to enable the investigator to travel to Dubai, United Arab Emirates
4) Each party bears its costs.

Any party dissatisfied with this decision may appeal to the High Court within 30 days from the date of this Decision.

DATED and **DELIVERED** at **KAMPALA** on the 26TH day of April 2023.

Rita Namakiika Nangono
Chairperson - Insurance Appeals Tribunal

Solome Mayinja Luwaga
Member - Insurance Appeals Tribunal

George Steven Okotha
Member - Insurance Appeals Tribunal

Dr. John Bbale Mayanja *Member – Insurance Appeals Tribunal*