OUTER HOUSE, COURT OF SESSION

[2025] CSOH 52

A204/21

OPINION OF LORD SANDISON

In the cause

GILLIAN COWIE
as Executrix-Dative of the late
MARK FRASER ALEXANDER COWIE

Pursuer

against

(FIRST) VITALITY CORPORATE SERVICES LIMITED, trading as VITALITY LIFE
(SECOND) CASTLEBANK FINANCIAL PLANNING LIMITED; and
(THIRD) PAUL REYNOLDS

Defenders

Pursuer: O'Neill KC, Welsh; Balfour + Manson LLP
First Defender: McBrearty KC, Mitchell; Burness Paull LLP
Second and Third Defenders: No representation
Dr Alistair McLennan: E. Campbell; BTO LLP

25 June 2025

Introduction

[1] In this action for payment, the pursuer seeks payment from the first defender of £500,000 plus interest from 25 October 2016 as the sum assured on the life of her late husband, Mark Cowie, in a policy issued by the first defender. The second defender is or was a financial planning business and the third defender was its agent in the advice and

assistance it gave to Mr Cowie in connection with the inception of the policy in question. However, no remedy is any longer sought against the second or third defenders and they are not represented in the proceedings.

[2] The first defender, which I shall refer to as "Vitality", denies that it is liable to make payment of the sum assured because it maintains that Mr Cowie failed when completing the proposal form for the policy to comply with the duty imposed on him in terms of section 2(2) of the Consumer Insurance (Disclosure and Representations) Act 2012 to take reasonable care not to make misrepresentations to it as an insurer. It claims that, if he had taken reasonable care, and provided true and accurate responses, it would not have put the policy in place. I previously determined that medical records relating to Mr Cowie and unlawfully obtained by Vitality were nonetheless admissible in evidence: [2024] CSOH 65, 2024 SLT 713. The matter came before me for a diet of proof before answer for a final determination of the substantive issues in the case.

Background

[3] The life assurance policy in question was concluded between Mr Cowie and Vitality on or around 13 November 2015, with cover beginning on 2 December 2015. Mr Cowie died suddenly and unexpectedly on 25 October 2016 as a result of an intracerebral brain haemorrhage; his death certificate also recorded coagulopathy and liver cirrhosis as causes of death.

[4] Following Mr Cowie's death, the pursuer contacted Vitality to advise them of that fact. Vitality asked her to provide it with various documents, including the authority to seek a targeted general practitioner's report from Mr Cowie's GP, Dr Alistair McLennan. On receipt of that authority, Vitality requested and obtained from Dr McLennan a variety of

medical records held by him and relating to Mr Cowie. After considering the content of those records, it advised Dr McLennan that it had decided that Mr Cowie had not disclosed to it in proposing the policy a long history of disorders of the digestive system; abnormal liver function tests; the postponement of neck surgery following abnormal liver function tests on two occasions; and Barrett's Oesophagus (a condition of that organ also known as Barrett's Oesophagitis). It told Dr McLennan that had it been made aware of those matters by way of the proposal, it would have asked for a GP report which in turn would have alerted it to those elements of Mr Cowie's medical history reflecting deranged liver function tests with questionable alcohol intake, and to the existence of Barrett's Oesophagus which had not been under adequate surveillance. That would, it said, have caused it to decline Mr Cowie's application for life cover. It simultaneously wrote to the pursuer, advising her in somewhat in specific terms that had Mr Cowie correctly disclosed his medical history in his proposal form, his application for cover would have been declined, that it regarded his non-disclosure as reckless, and that it was cancelling the policy, refunding the payments made, and refusing to pay the claim. It invited her to contact Dr McLennan for details of the medical information which had caused it to take that course of action. Mrs Cowie appealed that decision through Vitality's internal appeal process, but her appeal was rejected with no further elucidation of the reasons why being provided. This litigation ensued.

[5] It became apparent relatively soon that there was a serious dispute between Mrs Cowie and Vitality about the admissibility in evidence of the medical records concerning Mr Cowie which had been obtained by the latter from Dr McLennan, and that it would be sensible to deal with that issue in advance of any substantive diet of proof. A preliminary proof took place in April and May 2024 to that end, in advance of which Vitality voluntarily undertook not to refer for the purposes of any part of the litigation to certain

listed documents from the corpus of records recovered. The stated rationale for that undertaking was that the documents in question had either been identified by Dr McLennan in his witness statement provided for the preliminary proof as irrelevant to the cause of Mr Cowie's death, or else postdated the period in respect of which Vitality had sought information from Dr McLennan. After the preliminary proof, I issued an opinion holding that the medical records recovered by Vitality were admissible in evidence. The undertaking which had been given, however, naturally remained in place. I also criticised Dr McLennan for having adopted a witness statement which was plainly in part factually inaccurate, from which he recanted in the course of the proof, and the content of which, it transpired, had been prepared for him and overly influenced by agents for the Medical Defence Union. Unfortunately both of these matters re-emerged, with further complications, at the substantive proof.

Relevant statutory provisions

[6] The Consumer Insurance (Disclosure and Representations) Act 2012 contains *inter alia* the following provisions:

> "**2 Disclosure and representations before contract or variation**
>
> (1) This section makes provision about disclosure and representations by a consumer to an insurer before a consumer insurance contract is entered into or varied.
>
> (2) It is the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer.
>
> (3) A failure by the consumer to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation for the purposes of this Act (whether or not it could be apart from this subsection).

(4) The duty set out in subsection (2) replaces any duty relating to disclosure or representations by a consumer to an insurer which existed in the same circumstances before this Act applied.

3 Reasonable care

(1) Whether or not a consumer has taken reasonable care not to make a misrepresentation is to be determined in the light of all the relevant circumstances.

(2) The following are examples of things which may need to be taken into account in making a determination under subsection (1)—

(a) the type of consumer insurance contract in question, and its target market,
(b) any relevant explanatory material or publicity produced or authorised by the insurer,
(c) how clear, and how specific, the insurer's questions were,

…

(e) whether or not an agent was acting for the consumer.

(3) The standard of care required is that of a reasonable consumer: but this is subject to subsections (4) and (5).

(4) If the insurer was, or ought to have been, aware of any particular characteristics or circumstances of the actual consumer, those are to be taken into account.

(5) A misrepresentation made dishonestly is always to be taken as showing lack of reasonable care.

4 Qualifying misrepresentations: definition and remedies

(1) An insurer has a remedy against a consumer for a misrepresentation made by the consumer before a consumer insurance contract was entered into or varied only if—

(a) the consumer made the misrepresentation in breach of the duty set out in section 2(2), and
(b) the insurer shows that without the misrepresentation, that insurer would not have entered into the contract (or agreed to the variation) at all, or would have done so only on different terms.

(2) A misrepresentation for which the insurer has a remedy against the consumer is referred to in this Act as a *"qualifying misrepresentation"* .

(3) The only such remedies available are set out in Schedule 1.

5 Qualifying misrepresentations: classification and presumptions

(1) For the purposes of this Act, a qualifying misrepresentation (see section 4(2)) is either—

(a) deliberate or reckless, or
(b) careless.

(2) A qualifying misrepresentation is deliberate or reckless if the consumer—

(a) knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and
(b) knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.

(3) A qualifying misrepresentation is careless if it is not deliberate or reckless.

(4) It is for the insurer to show that a qualifying misrepresentation was deliberate or reckless.

(5) But it is to be presumed, unless the contrary is shown—

(a) that the consumer had the knowledge of a reasonable consumer, and
(b) that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer."

Paragraph 2 of Schedule 1 to the 2012 Act provides:

"**2**

If a qualifying misrepresentation was deliberate or reckless, the insurer—

(a) may avoid the contract and refuse all claims, and
(b) need not return any of the premiums paid, except to the extent (if any) that it would be unfair to the consumer to retain them."

In relation to careless misrepresentations, paragraph 5 of Schedule 1 provides:

"**5**

If the insurer would not have entered into the consumer insurance contract on any terms, the insurer may avoid the contract and refuse all claims, but must return the premiums paid."

Witnesses

[7] Standing the onus incumbent on Vitality in consequence of the terms of the 2012 Act, it was ordained to lead at the proof, and adduced the evidence of the following witnesses.

Dr Nigel Lord (56) MBChB, FRCGP, MEWI, PG Cert in GP Education

[8] Dr Lord, a GP with 30 years' experience and a council member of the Medical Defence Union, spoke to a report prepared by him and dated 6 November 2024. He had been asked for his professional opinion on the medical conditions Mr Cowie suffered from in the relevant period before 13 November 2015. In his opinion a GP exercising reasonable skill and care would have had informed discussions with a patient about all their significant healthcare conditions as standard practice, such that the patient would be aware of the name and nature of each such condition, any investigation and treatment required for it, and any long term concerns potentially related to it.

[9] Mr Cowie's redacted medical records detailed a history of Barrett's Oesophagus and upper gastrointestinal disease dating from at least 2010. Barrett's Oesophagus was a disorder of the digestive system in that it was a chronic condition in which there was abnormal cell change (metaplasia) in the distal squamous cell mucosa of the oesophagus. That change carried an increased risk of cancerous change in the oesophagus of between 3 and 13% over a lifetime, depending on the severity of the oesophageal changes. It was a significant medical condition that he would have expected Mr Cowie's GP to have informed him about. It could sometimes have no symptoms, but was more commonly associated with symptoms of chronic gastro-oesophageal reflux. It was treated with long-term stomach acid suppression using proton pump inhibiting drugs such as Omeprazole and Esomeprazole. In more severe cases, where acid suppression was not preventing deterioration, treatment was

required with laser or radiofrequency ablation (or burning), with some cases requiring surgical resection. Some sufferers required regular endoscopy to assess their Barrett's and to look for cancerous change. The decision on screening requirements would be made by the patient's consultant gastroenterologist and would depend on the severity of the Barrett's, the treatment received and other risk factors for oesophageal cancer. In Mr Cowie's medical records, Barrett's Oesophagus was referenced in a referral letter for a 24-hour blood pressure test sent on 22 April 2013 and in a letter from a gastroenterologist, Dr El Nujumi, dated 20 March 2012. The records confirmed that Mr Cowie had a history of Barret's Oesophagus and upper gastrointestinal disease.

[10] The redacted records also detailed a history of abnormal liver function tests in 2014 but also a normal liver ultrasound scan in the same year. The ultrasound scan had been done to look for structural abnormalities in the liver, gallbladder and pancreas that could explain the abnormal liver function blood tests, such as gallstones, liver cancer, fatty liver, cirrhosis etc. Liver function blood tests detected abnormal liver function. That could be abnormal due to liver disease even with no structural abnormalities showing up on a liver ultrasound scan. Abnormal liver function tests even with a normal liver ultrasound scan indicated a liver problem. He would have expected Mr Cowie's GP to have informed him that he had abnormal liver function tests (a sign of damage to liver cells due to underlying liver disease) but a normal liver structure on ultrasound scan, and to have explained that these findings indicated a liver problem. No specific diagnosis for Mr Cowie's abnormal liver function was ever reached.

[11] In cross-examination, Dr Lord opined that a disorder was similar to a disease. It might be that a disease could be said to be something with a known cause. He had provided an earlier expert report in January 2022 based on a wider range of medical records, whereas

his later report was based on a more restricted set. He understood that it had previously been decided that Vitality had obtained some records unlawfully, and presumed that the restricted set reflected that decision. Medical confidentiality was important, and he was aware that Mr Cowie's widow had not consented to the provision of the restricted set, but it had been provided to him by a law firm and it seemed that the court had approved that. He would defer to specialist consultant opinion on any particular matter. He had not seen Mr Cowie's death certificate or any insurance documentation.

Dr Alistair McLennan (52) MBChB

[12] Dr McLennan spoke to a witness statement provided by him and dated 16 December 2024. He had worked as a GP since 2006 and held a position at Glasgow University as a GP University lecturer in General Practice and Primary Care. He had been a GP trainer since 2012 and had been involved in undergraduate teaching for medical students for longer, including being a year three communications skills tutor for many years. He taught the importance of patient-centred care which included having the patient be well-informed so as to be able to make good decisions regarding his health.

[13] He would tell a patient what treatment he was receiving and let him have information such as test results. He had always worked that way. He discussed treatment and test results with patients in a variety of ways, sometimes in person and at other times by telephone. In relation to explanations of medication, he would try to provide some understanding of why it was being prescribed, and to discuss important potential side effects. Not every note in a patient's records would necessarily have been discussed with the patient, and some discussions with patients during an appointment would not be recorded.

[14] It was standard practice to discuss with a patient why he was attending for tests. If there was a consequence arising out of a patient's test results, he would advise the patient of that. If the results were normal they might just get filed. If a subsequent test was ordered, this would be discussed with the patient.

[15] He first became Mr Cowie's GP in July 2007, and remained his GP until the date of his death, without any breaks. He recalled Mr Cowie as a patient. He had consulted with Mr Cowie in person and also over the telephone. He regarded him as a fairly typical patient in that he would seek medical help when he thought something was wrong.

[16] He identified the redacted set of medical records before the court as pertaining to Mr Cowie. In those records it was noted that Mr Cowie had Barrett's Oesophagus, but he did not recall discussing that with him. He would assume that Mr Cowie was aware of his condition but could not say for sure from the records that he definitely knew. Mr Cowie had undergone a procedure to treat the condition; he must have consented to that, and the process of obtaining consent would have involved an explanation of the condition and the treatment. He could not comment on Mr Cowie's understanding of the condition or on his state of knowledge at the time of applying for the Vitality policy or in the 5 years immediately preceding that date. The records contained a letter dated December 2010 from Mr Grant Fullerton, a consultant general and upper gastro-intestinal surgeon, referring to an upper GI endoscopy and Halo ablation treatment having been carried out on Mr Cowie, and stating that he had previously been treated for Barrett's. Dr McLennan did not know what any such previous treatment had been, or whether Mr Cowie had had the follow-up endoscopy recommended by Mr Fullerton; there was nothing in the records about that. He could not comment on when Mr Cowie's first use of the prescription medication Esomeprazole commenced, as the records did not go back far enough. Esomeprazole was

prescribed to reduce acid production in the stomach. The records available did not confirm why it had been prescribed. In the records there was an entry of 20 March 2012 which was a letter from a Dr El-Nujumi to Dr McLennan concerning Mr Cowie's bowel upset and noting a history of acid reflux. Mr Cowie must have been referred to Dr El-Nujumi, presumably by Dr McLennan, but there was no record of that and he had no recollection of it.
Dr McLennan could not comment further on the subject of acid reflux from the content of the redacted records. There was a link between acid reflux and Barrett's, in that the latter was a potential outcome of the former. None of the redacted records showed that Mr Cowie obtained input from a gastroenterologist about acid reflux, and it was not something Dr McLennan recalled discussing with him.

[17] As to liver function, the records showed that on 9 October 2014 Dr McLennan had referred Mr Cowie to Dr Datta, a gastroenterologist at the Victoria Infirmary, Glasgow, because of significantly raised test results concerning enzymes in the blood affecting liver cell function but which were not specific to a particular clinical scenario, namely AST (aspartate aminotransaminase) and ALT (alanine transaminase). The former had been at 247 as against a normal level of below 40, the latter at 135 as against a normal level of below 50. Mr Cowie would have been aware that Dr McLennan was making the referral.
Dr McLennan had discussed the reasons for it (i.e. that the liver test results were deranged) with him during a telephone call on 3 October 2014. The levels in question were significantly raised, and he would have told Mr Cowie that, and that further investigation was required. By the referral, he was asking for specialist opinion regarding liver dysfunction. He could not recall why the referral had been to Dr Datta on the NHS as opposed to a private specialist of the kind such as Mr Cowie would normally consult.
Mr Cowie had had multiple liver function tests from 2012 onwards. He had discussed the

results of such tests with him in a telephone call on 16 March 2012, although he could not recall what had been said. A planned neck operation in early October 2014 had been cancelled, partly because of the test results then pertaining, although there was no record of what exactly the relevant levels then were, only that they were deranged. By 20 October 2014 the latest test results were still deranged, but he had noted that they were much improved. Dr McLennan assumed that this would have been discussed with Mr Cowie, but had no specific recollection of it. His recollection of all of these matters came from the records, not from independent memory. An ultrasound had taken place in October 2014 because of the abnormal liver function tests. It was normal. That did not absolutely rule out any liver dysfunction. He did not know what Mr Cowie was told in relation to his ultrasound, but it was likely that he would have discussed the result with Mr Cowie, not to say that his liver was functioning normally (the liver function tests indicated otherwise), but that the ultrasound had not shown up anything specific.

[18] In cross-examination, Dr McLennan stated that the records to which he was referring were his practice's own internal records and were not routinely shared with patients. They were the source of what he could say about the matters of interest in the litigation. They summarised what had been discussed, but would not necessarily cover everything. He had read the previous opinion of the court concerning the unsatisfactory manner in which his written evidence for the earlier proof diet had been prepared. For this proof, he understood that questions had been formulated by Vitality's lawyers and sent to those acting on the instructions of the Medical Defence Union, with whom he had then sat down. He had not asked for Mrs Cowie's consent to consider and talk about the restricted set of records, relying instead on the advice of the MDU to give the statement he had given. He did not recollect exactly what had been said about the issue of consent in that connection; he had

simply responded to the questions they had asked him, and had volunteered nothing else without prompting.

[19] Barrett's Oesophagus had not contributed to the causes of Mr Cowie's death. It was not related to those causes. No condition for which Mr Cowie had been taking prescribed medication had contributed to or was related to those causes either. Nor was any bowel condition from which he had suffered. It had become apparent by mid-2016 that Mr Cowie did not then suffer from Barrett's Oesophagus and that the numbers on his liver test results had settled well. There was no direct link between Barrett's and the deranged liver test results. The letter from Mr Fullerton recording the residual Barrett's Island treatment which had been given to Mr Cowie in December 2010 had not been copied to Mr Cowie directly.

[20] Dr McLennan could not recall whether he had been party to the decision taken in the course of the litigation as to which documents it was and was not appropriate for Vitality to rely upon.

[21] He had no record of Dr Datta reporting on the result of any consultation he had had with Mr Cowie consequent on the referral to him in October 2014. There ought to have been such a record if a consultation had indeed taken place. The liver function test results as they stood at the time of the referral sometimes pointed to a problem, and sometimes not. They had come down without medical intervention, and were much improved by 20 October. He might have told Mr Cowie that. A letter dated 2 December 2014 from a neurosurgeon, Mr Taylor (who had been due to carry out an operation on Mr Cowie's neck which had been cancelled) suggested that Mr Cowie might have been told simply that he had a sensitive liver. There might also have been a viral infection at that point. Dr McLennan presumed that, after an ultrasound had been carried out which did not show any structural liver issue, Mr Cowie had been told that he had no liver abnormality. The cause of the liver cirrhosis

with which Mr Cowie had eventually been diagnosed after the formation of the contract with Vitality was unknown; it might or might not have been alcohol consumption.

[22] Nothing further of materiality emerged from Dr McLennan's brief re-examination.

Grant Fullerton (67)

[23] Mr Fullerton, a consultant surgeon retired from clinical practice but still doing advisory work for NHS Scotland, stated that he had worked in upper gastro-intestinal surgery and had specialisms in the upper gut, surgery, endoscopy, Barrett's Oesophagus and cancer. He was an internationally recognized expert in Barrett's and had treated thousands of patients with it. It was a chronic condition involving changes in the epithelial lining of the oesophagus caused by chronic acid reflux, and was a pre-malignant condition. Cell metaplasia could become dysplasia, which could become cancer. Until around 2008 or 2009, there had been no active treatment for it, but since then endoscopic methods of treatment had been developed. There would be an initial ablation with an endoscopic balloon, and some patients required follow-up treatment with a "Halo 90" device, which carried out smaller-scale ablation of residual areas manifesting cell changes, called "Barrett's Islands". He would have advised patients undergoing that treatment to have a follow-up endoscopy after three months and then to be monitored for recurrence over a three-year period.

[24] He recognised the name Cowie, but had limited recollection of the details of his case. A letter written by Mr Fullerton to Mr Cowie's GP practice on 6 December 2010 stated that he had had the Halo 90 treatment on 30 November that year. The need for that treatment would have become apparent in the course of an endoscopy. He had no specific recollection of any discussion with Mr Cowie, but standard practice would have been to obtain his

consent to the endoscopy and explain the potential complications. It would have been standard after the procedure to explain that there were no guarantees about the future development of the condition and that continuing surveillance was required. Mr Cowie had been prescribed medication to suppress gastric acid and allow the epithelium time to regrow. He could not comment on whether or not Mr Cowie had attended for follow-up after the procedure in November 2010.

[25] In cross-examination, Mr Fullerton stated that Mr Cowie had had earlier treatment for Barrett's in August or September 2010, which might also have been the Halo 90 treatment, or might have been more substantial. The consent procedure gone through in November would have involved obtaining consent for the gastroscopy and for the treatment of anything found in the course of it. After the procedure, the patient would have been allowed time to recover, and then what had happened would have been explained to him and a letter sent to his GP, but not to him. Mr Cowie had certainly had Barrett's, and he still had it in November 2010. Tests in 2016 showed that he did not have it then. About 75% to 80% of patients did not have a recurrence after appropriate endoscopy treatment, but there was probably still a risk if acid reflux continued.

Adil Mohammed El-Nujumi (71)

[26] Dr El-Nujumi was a consultant physician and gastroenterologist who had retired in 2020. He had seen Mr Cowie in 2012, but had no recollection of him. He often required to consider the results of liver function tests. On 20 March 2012 he had written to Dr McLennan, copying in Mr Cowie, set out the results of tests which showed that Mr Cowie's AST and ALT liver enzyme levels were definitely raised and that there was an element of abnormality about them. He had recommended a full liver function test and

there would then have been the possibility of imaging being carried out. That would have been discussed with Mr Cowie. He was sure that he would have explained that there was an abnormality and that further tests would be required. He would have explained that the results were only from one test, and that they would have to be repeated and monitored. He had recommended an adjustment to the Omeprazole that Mr Cowie was taking to achieve control of his stomach acids. On 31 March 2012 he had written a further letter to Dr McLennan, copying Mr Cowie, recommending regular monitoring of test results, but stating that there was no clear need for imaging. On 7 April 2012 he had similarly written recommending ferritin studies, as raised levels of that blood protein could cause liver function abnormality.

[27] In cross-examination, Dr El-Nujumi stated that he was not a hepatologist and that someone in that discipline would have more valuable comment to make on the liver function test results. Tests repeated over time would be needed. He was unaware of any ultrasound examination of Mr Cowie's liver having been carried out.

William Taylor (63)

[28] Mr Taylor was a consultant neurosurgeon with 31 years' experience. He had seen hundreds of patients in that time and had no recollection of Mr Cowie. He had been referred to a letter he had written on 26 August 2014 after an operation he was to perform on Mr Cowie for nerve pain in the arm caused by a degenerative process in the spine had been cancelled, partly as a result of liver function tests taken on the day of admission. A general anaesthetic would have been required, and abnormal liver function could affect a patient's ability to deal with the requisite drugs. The other factor going to the cancellation of the operation was Mr Cowie's blood pressure, which was high and presented a risk of stroke or

heart attack in the context of the operation. The liver function issue was only picked up incidentally; Mr Cowie did not appear jaundiced. The liver function test results could have been caused by a wide variety of things. He would probably have had a consultation with Mr Cowie, asking about other symptoms and alcohol use, and explaining that it was a potentially serious issue which needed further investigation. It might have needed treatment, or it could have been a transient issue caused, for example, by an infection. Mr Cowie wanted the operation to go ahead as soon as possible, and he had written a letter to another consultant, Dr Dover, setting out the history he had got from Mr Cowie. The operation had next been scheduled to go ahead on 2 December 2014, but was again cancelled due to the results of liver function tests. It appeared that the liver issues might be due to alcohol, perhaps as a result of Mr Cowie's liver being particularly sensitive to it. There had been a separate referral to an NHS gastroenterologist. Test results in early October 2014 showed that there was an inflammatory process going on in the liver cells; further test results towards the end of the month showed that the relevant enzyme levels were still raised, but better than they had been. It was moving towards a chronic abnormality, and previous abnormal results suggested the existence of a nebulous liver problem.

[29] In cross-examination, Mr Taylor agreed that the test results at the end of October 2014 might properly be described as much improved, but he had not been involved in any discussion with Mr Cowie about that. Dr Dover had written to Mr Taylor in September 2014 suggesting that the liver function tests at the time of the first cancelled operation might have been merely acutely abnormal. That was a reasonable assumption and fell within Dr Dover's expertise. Further tests were done and there was nothing to suggest chronic

liver disease. The blood pressure issue might have been acute too, caused by anxiety, although the observed pressures tended to suggest otherwise.

Paul Reynolds (58)

[30] Mr Reynolds spoke to a witness statement provided by him earlier in the course of the action, dated 22 December 2023. He was now a self-employed marketing consultant, but had previously worked in financial services for the best part of 30 years. He had been self-employed but working for Castlebank Financial Planning Limited and advising on life and health insurance between 2014 and 2018. Mr Cowie had asked that company to assist with a joint application by himself and Mrs Cowie for life insurance. He had a recollection of speaking to Mr Cowie at virtual meetings. Mr Cowie had come across as straightforward to deal with. He had dealt with him via Skype or Zoom, using screen sharing to show the application to him at the stage of its completion. There would have been a prior meeting with Mr Cowie before the application process, involving research and discussion on what he needed. Mr Cowie was told to ask questions if he was unsure about anything that he was asked about. Mr Reynolds would have told him that it was important to answer the questions on the proposal form accurately, and that small discrepancies could lead to problems. What was put in answers on the form would have been what Mr Cowie had told him, although he had no specific recollection of what had been said. Affordability was important for Mr Cowie when looking at cover. He had previously had a Vitality policy but he had let it go. Once the application had been submitted and accepted, a welcome pack was issued, which would include the policy summary, application form and an updated quote from Vitality. Vitality would have sent this to Mr Cowie and would have included a Confirmation Schedule setting out the information provided by Mr Cowie to Mr Reynolds

and provided by the latter to Vitality. That would have been the first direct contact between Vitality and Mr Cowie. Mr Reynolds would usually have had a follow-up call with a client after the issue of the Confirmation Schedule and would have told the client that if anything was incorrect, he should notify Mr Reynolds or the insurance company.

[31] When the claim was turned down after Mr Cowie's death, he had heard about it through Mrs Cowie. No reason for the rejection of the claim had been given to him. He had had online access to the underwriting policies of Vitality as at 2015. Its system was automated and produced the questions to be answered.

[32] In cross-examination, Mr Reynolds stated that he had no recollection of having discussed the Confirmation Schedule with Mr Cowie.

Lebogang Tsebe (38)

[33] Miss Tsebe spoke to a witness statement provided by her and dated 17 December 2024. She was employed as a claims manager at Vitality. She had a BSc (majoring in Human Physiology, Biochemistry, Cell Biology and Microbiology) and a Postgraduate Diploma in Business Administration. She had joined Vitality on 7 July 2017 as a Senior Claims Assessor, became a Claims Specialist with effect from 1 March 2020, and a Claims Manager with effect from 1 July 2023. Her role as a Claims Specialist included assessing, reviewing and deciding on the validity of claims submitted. The Vitality claims team was telephonically notified of Mr Cowie's death on 28 October 2016 by Mrs Cowie. She sought to claim on the life policy. As was usual, she had been sent a list of standard requirements, including a claim form, Medical Certificate Authority form and a Benefit Instruction Form on 31 October 2016. The completed documents were received on 10 November 2016 and the claim was referred to a claims assessor, who on 22 November 2016 assessed it in line with standard assessment

protocols. The standard assessment protocols included reviewing the disclosures made on the application as well as the resultant underwriting decision. On this particular claim, the assessor noted that Mr Cowie had disclosed that he had undergone a "well person" blood test in the two years prior to his application for cover. The assessor also noted Mr Cowie's previous applications and disclosures. The death certificate received with the claim documentation confirmed Mr Cowie's cause of death as: (a) Intracerebral Haemorrhage (b) Coagulopathy (c) Liver Cirrhosis. While the primary cause of death was largely known to have a sudden onset, the underlying causes identified tended to develop over time. This was especially true for liver cirrhosis. Given that at the time of his death Mr Cowie's policy had been in force for less than one year, and based on the information on the death certificate, the assessor, with the support of a Claims Specialist, had requested additional medical information from Mr Cowie's General Practitioner in order better to understand the history of the contributory causes of death.

[34] In the proposal form, Mr Cowie had *inter alia* been asked whether, apart from any condition he had already told Vitality about, he had had in the last 5 years any disorder of the digestive system, and had answered "No". On receipt of the additional medical information provided, the assessor had found that he was on blood pressure treatment, had had a long history of dyspepsia for which he had been treated, was on steroid treatment for musculo-skeletal pain, had been diagnosed with degenerative cervical spine disease with pending surgery, was found prior to the surgery to have grossly abnormal liver function test results as well as raised blood pressure, resulting in its postponement, and that his doctor had noted concerns over increasing gastrointestinal symptoms, with known Barrett's Oesophagus not having been surveyed for 6 years. The claim was assessed with reference to a full set of Mr Cowie's records. However, since the court had subsequently decided that

Vitality was not entitled to recover Mr Cowie's full medical records, she had been provided with a redacted copy of those records, which she had reviewed for the purposes of giving her witness statement.

[35] In the case of the Barrett's Oesophagus, the initial mention of treatment for this condition lay two months before the commencement of the 5-year period leading up to the completion of the proposal form, but the available information showed that Mr Cowie was also treated for it within that period, with further investigations arranged. Based on the medical records, Mr Cowie should have answered positively the question about whether he had had a disorder of the digestive system. Further, although he had confirmed that he had undergone an investigation falling within the description of "blood tests, scans or biopsies" in the two years prior to filling in the form, he had said that the result was normal. He should have also told Vitality about his deranged liver function tests, and the ultrasound he had had in October 2014. If he had done so, the case would have been referred for manual underwriting and the underwriter would have requested a medical report from his GP. That report would have then furnished additional information and Vitality would have been able accurately to assess the risk from the outset. It was not the place of a claims assessor to decide what impact information that had not been disclosed would have had on an application, but simply to establish whether or not there was sufficient information to demonstrate that a particular application question had been answered incorrectly and, if so, to refer the matter to the underwriting team for further consideration.

[36] Had she been provided with the redacted medical records at the claims stage, she would have reached the same decision as the assessor in fact reached following review of the full medical records. The redacted medical records contained sufficient information to demonstrate that the application questions noted had been answered incorrectly by

Mr Cowie. The assessor had referred the claim, inclusive of the new information, to the underwriting manager, Fergus Bescoby, for his review. The decision made by Vitality was that Mr Cowie had been afforded sufficient opportunity to disclose his medical history and that had it been aware of that medical history, his application for cover would have been postponed. A postponement was effectively a refusal to offer cover but would allow the customer to re-apply at a later stage. Given that the underwriting decision would have been to postpone, no cover would have been available to Mr Cowie and the plan would not have existed. In order to be offered cover at a later stage, Mr Cowie would have had to reapply and provide updated information regarding his medical wellbeing.

[37] The course of action Vitality took in instances where no cover would have been made available was to withdraw terms. In instances where a claim had been made within one year of plan commencement and/or exceeded £250,000, Vitality would need to involve its re-insurer, Hannover Re, in its decision. In view of the sum assured (£500,000) as well as the age of the plan, the claim was referred to the re-insurer for its view. It was in agreement with the decision made by the underwriting manager. The sum assured required the decision to be approved by a Vitality Claims Specialist or Manager. Following receipt of feedback from the re-insurer, the details of the claim were reviewed by both a Claims Specialist and the Claims Manager. With the support of the re-insurer, it was agreed by the assessor, the Claims Manager and the Claims Specialist that the claim would be declined as a result of misrepresentation on Mr Cowie's part and that all premiums paid in respect of the policy would be refunded to Mrs Cowie. A letter confirming the outcome of the claim was sent to Mrs Cowie on 27 February 2017 intimating the decision and why it had been made. The letter explained that the application for cover had not been completed accurately and that as a result, the policy would be voided and the claim declined. On the same date a

letter was issued to Dr McLennan informing him that Mrs Cowie had been informed that the claim had been declined and informing him that Vitality had asked Mrs Cowie to make an appointment with him to discuss the decision.

[38] Mrs Cowie disputed the decision to decline the claim. That was taken through Vitality's internal appeal system, which required that the assessor who made the original decision on a claim be excluded from the appeal in order to promote a fair and independent review. In order to review a decision made on a claim, Vitality required the party appealing to submit supportive information demonstrating that the information used to make the initial decision was correct and accurate. It had been provided with additional medical information in addition to a detailed letter from Mrs Cowie. This was allocated to Miss Tsebe for consideration. She had reviewed all of the information in Vitality's possession at the time the initial decision was made and all of Mr Cowie's previous applications and disclosures, as well as the additional information provided by Mrs Cowie. That included Mr Cowie's full medical records. Given the volume and the detailed nature of the information received throughout the initial assessment as well as the supportive information received for the appeal, Miss Tsebe had decided to put together a timeline of all of the information that should have been disclosed, arranged by the relevant application question, to ensure she had considered all of the information in a logical, holistic manner. She had found that there was relevant information omitted on Mr Cowie's application for cover. This included his history of excessive alcohol consumption, of raised blood pressure, and of Barrett's Oesophagus, as well as the results of liver function tests which took place in the two years prior to him applying for cover. That information was referred to Vitality's Strategic Underwriting team for its review. It was then confirmed that the original decision received from the Underwriting Manager would remain unchanged. The claim was again

referred to Hannover Re for its review. It confirmed that the decision should remained unchanged in view of the misrepresentations. The claim was reviewed by a Claims Specialist, who agreed with Miss Tsebe's decision on the appeal. On 5 December 2017, Mrs Cowie was informed that Vitality's Claims Review Committee had considered her appeal and found that the decision to decline the claim was correct. The correspondence sent pointed out that there need not be a link between the ultimate causes of death and the information misrepresented, so long as the information misrepresented had an impact on the underwriting risk at the outset of a policy. Mrs Cowie had subsequently appealed to the Financial Ombudsman Service in 2018, who found that Vitality had acted reasonably in declining the claim.

[39] In cross-examination, Miss Tsebe stated that in 2017 she had been a senior claims assessor, assessing claims against the insurance contract that had been entered into, gathering information and ensuring that the terms of the policy were met. That involved taking a view about the meaning of the policy and what insured persons should have done. She was allocated claims to deal with at random. Vitality's operations staff were based in South Africa but the claims came from the UK. There was training and the staff were trained in the provisions of the Consumer Insurance (Disclosure and Representations) Act 2012 and the guidelines of the Association of British Insurers. Her training had been a long time ago and she did not recall how long it had taken.

[40] She had not been involved at the initial stage of assessment of Mrs Cowie's claim. That assessment had been done by her colleague Zandile Sithole, who had made a recommendation to Mr Bescoby which had been accepted. Neither of them remained employed by Vitality. When a claim came in, the claims assessor to whom it was assigned would decide whether, and if so what, further information was required and inform the

claimant accordingly. There was no specific policy on whether medical records would be requested. The claims assessor would draft any questions to be asked, adapting a standard template as required. What had been received in response to the request for more information was all gone through by Miss Sithole. Her work at the relevant time would have been signed off by Maureen Richards. She was a senior member of management, and no longer worked for Vitality either. Underwriters assessed risk at the stage of application for a policy; claim assessors assessed claims. Retrospective underwriters responded to claims assessors who had decided that there had been a qualifying misrepresentation of one kind or another at the time of policy inception. The claim had originally been turned down because it was considered that Mr Cowie had made a misrepresentation in response to the question on the proposal form about disorders of the digestive system. Hannover Re had agreed with that conclusion for the same reason.

[41] Miss Tsebe had become involved when Mrs Cowie appealed the initial refusal of the claim. A claim summary sheet had been produced, which included the underwriting team's notes on an earlier policy application by Mr Cowie. Miss Tsebe had not responded specifically to the comments made by Mrs Cowie in her appeal, because she did not think that that was appropriate. The primary issue was that questions in the proposal form had been answered incorrectly and that had invalidated the contract, whereas Mrs Cowie wanted to talk about causality. Miss Tsebe considered that there were grounds additional to those identified by Mr Bescoby for declining the claim, and had decided that the appeal should be refused. Ms Richards and Hannover Re had agreed with that. A template letter had been drafted by Miss Tsebe and adjusted by Ms Richards, intimating to Mrs Cowie the refusal of the appeal. It did not specify what information was said to have been undisclosed by Mr Cowie. It wrongly stated that a medical officer had been involved in considering the

appeal and was also incorrect in stating that no one involved in the original decision to deny the claim had been involved in considering the appeal; Ms Richards had been involved at both stages. Vitality's Chief Medical Officer had not been asked to consider the case, but medical input would have made no difference to the decision on the appeal, which turned on misrepresentation, not on any clinical matter. The CMO could not have helped with the definition of a "disorder". Miss Tsebe took the view that Barrett's Oesophagus was a disorder caused by acid reflux. She had recommended that the CMO be approached, but Ms Richards had disagreed. There had been no involvement of a legal advisor either. However, the matter had been reviewed fairly and independently. There was no deliberate attempt to mislead.

[42] Miss Tsebe had been trained in the 2012 Act and she was aware of, but had not been specifically trained in, the duty of utmost good faith owed by insurers when dealing with a claim. Claims assessors were told that they had to assess claims fairly, but she could not recall whether she had been told to disclose to a claimant everything that was being taken into account when dealing with a claim. She could not recall exactly why she had framed the letter refusing the appeal as she did; she remembered thinking that what she wrote was the appropriate thing to write, but did not recall why. A lawyer like Mr Cowie should have had a good understanding of the importance of answering the questions on the proposal form correctly, but a case involving a lawyer would be treated the same as any other. It was not irrelevant that Mrs Cowie appeared to have had assistance in putting forward her appeal. At the appeal stage, Miss Tsebe had looked at the policy Confirmation Schedule and the full medical records which had then been made available. The policy in question had been approved and issued without human input, unlike previous policies held by Mr Cowie.

[43] Miss Tsebe had prepared her witness statement from the records held by Vitality. She had been asked to write down what had happened, not to justify the decision that had been taken. She had written the statement herself in response to a template prepared by Vitality's legal department setting out questions for her to address. The legal department had not suggested how she should answer those questions. Her statement had gone through four or five iterations between her and the legal department before it was finalised. She could not comment on how or why some of the things she had said in it bore a startling similarity to things said by Mr Downes in his statement.

[44] In re-examination, Miss Tsebe stated that the medical information provided by Mr Cowie in previous applications for policies with Vitality would not have been taken into account in the "straight-through" automated processing system that had been used to deal with his application for the policy now in dispute.

John Downes (63)

[45] Mr Downes spoke to a statement provided by him and dated 17 December 2024. He was an Associate of the Insurance Institute of South Africa, held a Master's degree in Business Administration and had over 30 years' experience in the insurance industry in both insurance and re-insurance, holding the positions of Head/Director of Underwriting and Claims in organisations such as Scottish Widows and AIG Life and with reinsurers including SCOR and Munich Re during that time. He was currently employed by Vitality as Director of Underwriting and Claims Strategy, accountable for the development and maintenance of Underwriting and Claims practice and quality.

[46] Vitality specialised in providing life insurance. He had been employed by it since July 2018. He was a member of the ABI's Serious Illness and Electronic Health Records

working parties and until recently, a regular contributor on underwriting matters in "COVER" magazine. He managed a team of 16 underwriting and claims professionals and had responsibility for a further 50 or so operational claims assessors and underwriters. He reported to the Director of Underwriting and Pricing and prior to that, to Vitality's CEO. The underwriting team which reported immediately to him dealt with both underwriting and retro-underwriting, which involved reviewing initial underwriting decisions at the time when a claim had been made on a policy.

[47] An application for life assurance contained several health questions that the applicant was required to answer before acceptance terms were offered. Currently, about 78% of applications to Vitality for life assurance were accepted via "straight through processing". STP involved the use of an automatic underwriting process. If the automated system was unable to accept the application, it was referred to a human underwriter to evaluate. The human underwriter would make a choice as to whether to accept the risk (at standard rates or with an increased premium) from the information already disclosed on the application, or to obtain further information such by way of a GP report or a medical examination. There were strict guidelines which were built into STP underwriting decisions and to manual underwriting decisions, both of which were audited for quality. Re-insurers could refuse to support Vitality in a claim if they were of the opinion that it had not followed their guidance or departed from agreed underwriting guidelines, meaning that Vitality would have to pay all of the claim without recovery from the re-insurer. It was therefore very important that Vitality reached underwriting decisions in accord with the agreed guidelines, whether in accepting or declining applications.

[48] Once an application was made, the applicant's disclosures to medical questions would be considered by the underwriter to establish whether underwriting acceptance

terms could be offered, or if further information was required in order accurately to assess the mortality or morbidity risk presented. If the underwriter required more information about the application disclosures, a GP report or targeted GP report would be requested in order to assess the risk. Whether medical evidence would be requested depended on the disclosures provided by the applicant. There were some conditions that Vitality could accept without further medical evidence. However, if a condition such as Barrett's Oesophagus was disclosed, Vitality would always ask for medical evidence because of the potential consequences for a sufferer. If a liver disorder or abnormal test results were disclosed, it would ask for further information, including the results of any liver function tests. Abnormal liver function tests were usually the first indication of a liver condition, and Vitality would want to know the results of those tests before accepting a risk. If abnormal liver function tests were unexplained, it would not accept the risk. If the cause was known, that would be taken into consideration. Such applications would always be referred for manual underwriting.

[49] The relevant underwriting guidelines were based on liver function test results. After medical evidence had been obtained and assessed, the underwriter would refer to an underwriting manual. Underwriting manuals were generally produced by re-insurance companies. They were evidence-based and provided guidance on various medical conditions as well as recommendations as to whether cover could be offered and at what premium. It was important that all underwriters followed the same guidance in order to ensure consistency and the fair treatment of customers. There were objective criteria for assessing risk and the medical evidence was assessed against those criteria. Underwriters were audited continuously to ensure that they adhered to the guidelines. If guidelines recommended that cover should be postponed, that meant that cover would not be offered

at that time, but that subject to any terms specified in the postponement letter, the matter might be reconsidered at a later stage.

[50] Mr Downes was not personally involved in the events relating to the handling of the application made by Mr Cowie, nor with the claim by Mrs Cowie on the policy. His first involvement was in relation to the decision to appeal the declinature. He had considerable industry experience in relation to the handling of life insurance policy underwriting and claims. He was familiar with the relevant industry codes of practice applicable in relation to such claims and was fully able to speak to Vitality's actions in relation to Mr Cowie's application and the subsequent claim made by Mrs Cowie from his review of the contents of the relevant papers and business records, and from his extensive industry experience and knowledge of the applicable industry practice and regulatory frameworks.

[51] Mr and Mrs Cowie had entered a life insurance policy with Vitality which covered Mr Cowie. The application for the policy had been received through a financial advisor appointed by Mr and Mrs Cowie, Castlebank Financial Planning Limited. The application included Mr Cowie's responses to a number of questions relating to his health. No communication from Mr Cowie or his financial advisor seeking clarification on any of the application questions or suggesting that the application questions were ambiguous or difficult to understand had been received. The decision to offer cover was made based on Mr Cowie's application and his responses to the questions relative to his health. The application was dealt with by STP. It was not referred for manual underwriting.

[52] After the claim was made, a member of the Strategic Underwriting Team, Fergus Bescoby, had reviewed the case and provided a retrospective underwriting decision before referring the case to the re-insurers, Hannover Re, for review. Mr Bescoby had now left Vitality, but Mr Downes was able to explain its processes and the decision taken based on

his knowledge and experience, together with the business records he had reviewed. The claim had initially been reviewed by a claims assessor who had requested additional medical information from Mr Cowie's General Practitioner, Dr Alastair McLennan. The request made was for medical records from the relevant time period, which was during the 5 years immediately preceding the date of Mr Cowie's application, targeted with reference to the causes of death noted in Mr Cowie's death certificate. The claims assessor was sent, and subsequently considered, the full medical records of Mr Cowie covering the relevant time period which had been requested. Some records were sent which fell outwith the requested 5-year period. The claim was assessed with reference to all of those records. The court had subsequently decided that Vitality was not entitled to recover all of those medical records, and it had undertaken not to rely on certain records in the action. He had been provided with a redacted copy of Mr Cowie's medical records which reflected the terms of the undertaking and the court's decision on the admissibility of the records, and had reviewed them. From those records, it appeared that Mr Cowie might not have disclosed relevant information in the application for cover form that he had been asked about when he applied for his policy of life assurance. The claims assessor had identified that at the time of reviewing the claim. The assessor was then required to request a retrospective underwriting decision, which was done by way of a request to Mr Bescoby dated 9 February 2017 asking him to provide a retro-underwriting decision. That was typically requested where a claims assessor identified an aspect of the claim that had not been disclosed at application. The assessor referred the matter to underwriters for their opinion on whether such a disclosure would have altered the acceptance terms or whether cover would have been offered at all. The full medical evidence that had been obtained and the up-to-date claims summary was sent to Mr Bescoby, who had provided his decision. Although that decision was made by

reference to the full, unredacted medical records, Mr Downes considered that that the same decision would have been reached by any underwriter who had seen and considered only the redacted medical records.

[53] If Mr Cowie had answered "yes" to the question in the proposal form regarding disorders of the digestive system, etc., the result would have been referral of the case to manual underwriting. The underwriter would have then requested a GP report targeted with reference to disorders of the digestive system, liver or stomach. The targeted GP report request would ask the applicant's GP questions specific to the condition he had disclosed, and some other ancillary questions relating to his general health. If Mr Cowie had disclosed a liver disorder in addition to another health condition (including the Barrett's Oesophagus), Vitality would have requested a wider-ranging GP report, asking for answers to questions not only about the disclosed conditions, but also about historical health information, previous treatment undergone, family history etc.

[54] Mr Cowie's medical records disclosed that he had had Halo 90 radio frequency ablation done on a small residual Barrett's Island on 30 November 2010, that he was to remain on Esomeprazole until it was confirmed that full squamous re-epithelization of the oesophagus had taken place, and that he was to have an endoscopy in three months' time. That was relevant because the underwriting guidelines relating to Barrett's Oesophagus differentiated between applicants and assessed risk based on the historical treatment of the condition, and in particular, whether regular surveillance of the condition had been undergone. Where an applicant had not undergone surveillance for their Barrett's Oesophagus for more than two years, their application would be declined pursuant to the underwriting guidelines. Those guidelines were used by Vitality, but they were produced and provided by Hannover Re. The requirement to undergo a follow up endoscopy was

also important, since failure to undergo it would have resulted in the application for cover being declined. The underwriting guidelines provided that a person who had had a surgical resection of the oesophagus and had submitted for fewer than two studies over two or more years would have his application declined.

[55] In relation to the question in the proposal form about blood and other tests, Mr Cowie had disclosed that he had had such tests, but had stated that the results were normal. The redacted medical records showed otherwise in relation to liver function tests. In practical terms, if the abnormal liver function test results and the Barrett's Oesophagus had been disclosed, Mr Cowie would have had his application for cover declined on the grounds of the cumulative effect of the conditions combined. Investigations would have alerted Vitality to the history of deranged liver functions with questionable alcohol intake, along with the Barrett's Oesophagus which did not appear to have been under correct surveillance. Acceptance terms would not have been offered for a life cover application in light of this. Mr Bescoby had correctly identified that. The same outcome would have been reached for either disclosure, i.e. if a partial disclosure had been made in respect of either the Barrett's or the deranged liver function results.

[56] In cross-examination, Mr Downes stated that he was now aware that Mr Cowie had not actually had surgical resection for his Barrett's Oesophagus and had intended but forgotten to correct the suggestion to the contrary in his statement when it was with Vitality's solicitors. There was no co-authorship element to his statement. It was written and revised by him without solicitor involvement. There had been a template provided by the Vitality legal department which dealt with the structure of the required statement, not its content. The statement had gone through a number of drafts when the legal department commented on whether it was fit for purpose; their comments related to clarity of language

or phraseology, not to more substantive matters. There were stock phrases in the template, which he could have revised if he wished. In substance the statement was his own words, even though he had not started with a blank sheet of paper.

[57] He had not been personally involved in the handling of the claim or the appeal. He had looked at the case papers and had not spoken to any witnesses. Mr Bescoby had left Vitality some time previously and he had no idea whether attempts to trace him for the purposes of giving evidence had been made. The same went for Miss Sithole. Mr Downes had been presented with a package of documents by the legal department. He was aware of the existence of a duty of utmost good faith, but was not aware of whether any training was given by Vitality about it. The claims appeal process should not involve those previously involved in determining that the initial claim should be refused. It involved an *ad hoc* committee, which could involve medical and legal officers if their skills were called for. He was unaware that they had not been involved in the appeal in this case, and had been under the impression that the CMO had been asked for a general opinion about the liver function test results. Someone in claims operations would convene an appropriate group. The letter informing the claimant about the appeal outcome should be accurate; a template letter was used as its basis. The letter in this case had not said what misrepresentation was being relied on. Some letters gave more detail than others. He did not know why Vitality's letter in this case had not engaged with the issues advanced by Mrs Cowie, or why she had not been given the opportunity to explain any apparent misrepresentation; that was a matter for claims operations. Mr Cowie's GP had been told what the reasons for refusing the claim were at the outset. It was all based on Mr Bescoby's views. He had had the full medical records.

[58] The "straight through" processing method was used for dealing with applications as it was more efficient and quicker. Some questions on the proposal form had been answered "yes" by Mr Cowie. When a question was so answered, a drop-down menu appeared on the form, which was completed online, so that further details could be given. Vitality had had a doctor's report on Mr Cowie in connection with a policy he had taken out in 2010, where disclosure had been made of the existence of a disorder of the digestive system. The words "disease" and "disorder" were used in the proposal form to try to get as much information as possible. "Medical condition" was similarly used.

Andrea Gregory (54)

[59] Mrs Gregory spoke to a witness statement provided by her and dated 20 January 2025. She had been an underwriter since 1990. She was currently employed by Hannover Re UK Life Branch as Underwriting and Claims Manager, a role she had held since 2021. She had worked at Hannover Re for 15 years altogether, first employed as an underwriter and then promoted to Underwriting Manager in 2015. She had previously worked at Otter Risk Solutions for approximately 8 years as an underwriter initially and then an Underwriting Manager. Prior to that she had worked at Prudential as an underwriter and then as an Underwriting Team Leader. Altogether, she had 35 years of underwriting experience. In her current position, she reported to the Chief Underwriter and Head of Claims and had a team of Claims Specialists and underwriters reporting to her. Hannover Re was Vitality's reinsurer and as such agreed to pay a percentage of the amount of cover for any claims on policies which were written during the period of the relevant agreement. Hannover Re provided guidelines to Vitality and gave it an authority to enable it to decide on underwriting and claims to certain limits, above which Hannover Re would expect to

sign off on the decisions. At the time Vitality's own authority limit was up to £1 million. Applications for cover also would have been referred for Hannover Re's opinion if the evidence was particularly complex. In addition, there would have been areas in the underwriting guidelines where referral to Hannover Re was mandatory. Occasionally the guidelines would say 'Refer to Hannover Re, usually decline or postpone'. In these instances, Vitality would only need to refer to Hannover Re if it was not declining or postponing, but was proposing to take on the policy and expose Hannover Re to the risk of having to pay out.

[60] Guidelines were provided to ensure that Vitality charged the correct premium for a risk. Sometimes a risk was considered too great to insure or could not be quantified at the time a policy was applied for, which would result in cover being declined or postponed for reconsideration at a later date. The purpose of underwriting was to ensure that all people in an insurance pool (e.g. groups of people who had taken out certain policies of insurance) were treated fairly and paid the correct premium for the risk they brought. Underwriting guidelines were produced based on statistics representative of the insured population.

[61] Application forms were designed to capture relevant medical, occupational, avocational, geographical and financial information in order to be able to start to evaluate the risk an individual posed to the insurance pool. Sometimes the risk could be underwritten based on the application answers plus additional reflexive questions alone, and rules would be placed in an insurer's rules engine to deal with this. However, when a risk was more complex or if there was a very large sum assured, then further material would be needed and the application would need medical evidence and to be sent to an underwriter to assess it manually. Claims would be referred to Hannover Re for an opinion if they were complex or if the amount of the claim was outside of Vitality's authority. In

2015 Vitality's authority was up to £250,000 and for all claims made more than a year after the policy start date. Claims for over this amount and those within the first year of the policy starting needed to be referred. A policy claim would be referred to Hannover Re by providing all of the evidence gathered and Vitality's notes and opinion on the next steps that it thought should be taken. Typically, this would be at the point when all the evidence had been obtained and the decision on whether to pay the claim was being made. Hannover Re's Claims Specialists would assess the claim in the same way that Vitality would. In the case of a death claim, they would expect to see a death certificate and claim form plus the original application form showing what was initially disclosed. Depending on the cause of death, the application disclosures and the length of time a policy had been in force, they might wish to investigate whether there might have been any qualifying misrepresentation. They would be considering the cause of death that the death certificate showed and whether there was any likelihood that any of the conditions or any associated risk factors might have been present at the time of the application. They would then review the application form to check what had been disclosed. If there were any suspicions that something might not have been disclosed, they would proceed to obtain medical evidence. Once the evidence was to hand, they would decide whether the questions on the application should have been answered differently and whether this would have affected the terms on which the policy was issued. Claims Specialists followed the ABI Code of Conduct guidelines on treating customers fairly and the 2012 Act. The classification of any misrepresentation would be considered using the guidance provided in the Act and appropriate action taken. On receipt of a claim referral, Hannover Re would assess it independently, in the same way that Vitality would. Then it would compare its own decision to the suggested course of action proposed by Vitality before any final decision was communicated to the claimant. The final

decision would be relayed by Hannover Re to Vitality and in turn to the claimant. That might be to agree with the course of action suggested, to obtain further evidence before a decision could be made, or to disagree. Should Hannover Re disagree then Vitality could make a decision to proceed with the proposed course of action on their own but this would be a choice that would mean that it would not have Hannover Re's back up and might mean that it would have to pay the claim in full itself or that Hannover Re would not be involved in a contested decision to decline a claim.

[62] Mrs Gregory had first become aware of the claim in December 2021 when members of her team were approached to be witnesses in the court case. She had seen the original referral of this claim from Vitality to Hannover Re, and the papers which were sent to Ashley Paddock, the Claims Specialist at Hannover Re who reviewed the referral. He had subsequently fallen ill and had retired. The application form and full medical records were provided to Hannover Re and referred to and reviewed for the purposes of making a decision on the claim to then provide to Vitality. Mrs Gregory had not had any direct involvement in the investigation carried out by Mr Paddock but had reviewed the application form and the redacted medical records of Mr Cowie. Hannover Re had originally considered the full medical records of Mr Cowie which had been recovered by Vitality, but Mrs Gregory now understood that the full records included some material which Vitality was not entitled to have. She had now reviewed the records as redacted to meet that issue.

[63] Mrs Gregory would have expected Mr Cowie to have answered the application question about digestive disorders, etc. positively. There was an entry disclosing Barrett's Oesophagus in 2010 in his GP records, and a report by Dr El-Nujumi referring to a longstanding history of upper GI symptoms in March 2012.

[64] A report by Mr Fullerton dated 6 December 2010 mentioned an endoscopy in November 2010 and Halo treatment for Barrett's together with a requirement for a check endoscopy in three months. That fell within the 5-year period asked about in the application form. It was further apparent that Mr Cowie was still taking Omeprazole in September 2014. If Mr Cowie had disclosed his digestive system disorders, and the application had been referred to Hannover Re in 2015 with the redacted medical records, then Hannover Re would have referred to the underwriting guidelines and would have noted that ablation treatment required regular follow up which had not occurred. It would have declined cover because no follow up had taken place. The matter would not have been referred to Hannover Re if Vitality itself had decided to decline the application.

[65] Mrs Gregory would also have expected Mr Cowie to disclose his deranged liver function test results in answer to the question about blood and other tests in the two years before making his application. His liver was not in order and therefore he had a disorder. That was mentioned multiple times in his medical history, and scheduled surgery had been cancelled twice because of it. He had said that he had had a well person check, the results of which were normal. The liver function tests were not done in the context of such a check, and the results were not normal, although the most recent ones before the application, in December 2014, had improved. In the absence of a cause for the abnormal tests Mrs Gregory would not have been happy to disregard the elevated liver enzymes even with a normal ultrasound scan. If there had been appropriate disclosure, then if Hannover Re had been asked for a view and had been provided with the redacted medical records, it would have referred to the relevant underwriting guidelines and declined to provide cover.

[66] Having reviewed the file which was sent to Mr Paddock and the terms of the redacted medical records, Mrs Gregory would have reached the same conclusion in agreeing

with Vitality's referral decision, which was to retrospectively withdraw the terms offered to Mr Cowie for life cover. Had Hannover Re had access to the redacted medical records only, she considered that the same decision would have been reached. Theresa Taylor, Claims Specialist, and Tim Bowns, the Claims Manager at Hannover Re at the time, had reviewed the claim and approved Mr Paddock's decision. Multiple grounds of refusal would reinforce the decision.

[67] In cross-examination, Mrs Gregory stated that her witness statement was her own work. She had been approached by Vitality's lawyers, who had explained how it should be set out and what it should cover, and had asked questions. She had prepared a first draft and it had been revised by her perhaps two times to make it more clear. She had not seen any statements provided earlier by other employees of Hannover Re in connection with the dispute, or spoken to those employees. They were no longer well enough to give evidence. She could not explain apparent close similarities between some elements of her statement and elements of such other statements. Perhaps the questions asked had been similar. She had not been provided with any template statement, only questions.

[68] She was aware that there had been no specific diagnosis concerning the liver function tests. It was not her job to make a diagnosis, and she had not made any assumption that alcohol lay behind the results. Mr Bescoby had identified one question that had been answered incorrectly, and it had always been Hannover Re's view, too, that that question had been wrongly answered. She had initially had the whole medical records to consider, and then the redacted set. She had assessed the case, doing what she would normally do, and had reached her own conclusions, which were not exactly the same as those reached by others; she considered that more than one answer would have given rise to a right to reject the claim.

[69] Upon prompting by reference to an internal record of Hannover Re, she recalled that she had herself looked at the claim in December 2021. She could not remember why; perhaps one of her team had asked her for a view.

[70] No witness evidence was led on behalf of the pursuer. Parties had entered into a joint minute of admissions to the effect that copy documents lodged as productions were to be treated as principals and that all documentary productions were to be presumed to be what they bore to be unless the contrary was proved. No such contrary proof was essayed in respect of any such document.

Submissions for Vitality

[71] On behalf of Vitality, senior counsel began by summarising its case as follows: In answering in the negative the questions on the proposal form about whether he had suffered from any disorder of the liver or oesophagus in the previous 5 years, Mr Cowie had failed to take reasonable care not to make a misrepresentation. He similarly failed in answering positively the questions as to whether any blood tests or investigations he had undergone in the previous two years were part of a routine "well person" test and whether the results were normal. As a matter of fact, he had received Halo 90 endoscopy treatment for Barrett's Oesophagus in the 5 years prior to completing the proposal form. That was a disorder of the oesophagus, and he was aware that it was one he suffered from and for which he was receiving treatment. He was also aware that he had undergone multiple tests of his liver function in the previous 5 years that had returned results that were abnormal or deranged. His treating doctors discussed those results with him and referred him for further testing and specialist investigation. He was aware that elective surgery had been twice postponed due to abnormal liver function tests. Vitality had further demonstrated that had Mr Cowie

not made the qualifying misrepresentations, it would not have entered into a policy of life assurance with him. The misrepresentations were qualifying misrepresentations in terms of the Consumer Insurance (Disclosure and Representations) Act 2012. Vitality was accordingly entitled to avoid the policy in terms of the Act.

[72] The contract between Mr Cowie and Vitality was governed by the 2012 Act, which should be regarded as entirely occupying the field of law to which it addressed itself. It was enacted following a report by the Law Commissions of England and Wales and of Scotland: "Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation" in 2009. That report noted that the then-current law provided that a misrepresentation was only actionable if it was "material", in the sense that it would influence the judgment of a hypothetical prudent underwriter. That concept was not preserved by the draft Bill which informed the content of the 2012 Act; rather, the intention was that a court should simply assess whether the particular insurer involved would not have offered insurance cover had the misrepresentation in question not been made. Reference was made to McGillivray on Insurance Law, 15th edition at [18-028] and to Colinvaux's Law of Insurance 13th Ed at [7-032].

[73] Section 2(2) of the 2012 Act set out that it was the duty of the consumer to take reasonable care not to make a misrepresentation to an insurer. The standard for determining reasonable care was set out in section 3 of the 2012 Act. The test under section 3(3) was primarily an objective one, subject to the two subjective modifications inserted by subsections 3(4) and 3(5): Colinvaux, op.cit. at [7-025]. Section 4 dealt with the definition of "qualifying misrepresentations", and the remedies which flowed therefrom. Schedule 1 to the 2012 Act set out the remedies that an insurer had depending on the nature of the qualifying misrepresentation.

[74] Where a misrepresentation was either deliberate, reckless or careless (all as defined by section 5 of the Act), an insurer was entitled to refuse a claim where it could demonstrate that it would not have entered into the insurance contract had the misrepresentation not been made. The only distinction between the available remedies was that where the misrepresentation was careless, the insurer had to return the premiums paid. Vitality's position was that but for Mr Cowie's qualifying misrepresentations, it would not have entered into the insurance contract on any terms. It did not seek to prove that it would have entered into the contract on different terms. The result was that if the court found that there had been a failure to take reasonable care on the part of Mr Cowie, then the question of whether the misrepresentation was deliberate or reckless, or else merely careless, made no practical difference to the remedy sought by Vitality. It had already returned the premiums paid to the pursuer. Whether Vitality was entitled to the remedy sought turned solely on the question of whether it had established that it would not have entered into the contract but for the alleged misrepresentations.

[75] A careless misrepresentation was one which: (i) had not been reasonably made; (ii) was not deliberate and reckless; and (iii) was made in circumstances where the consumer failed to put his mind as to whether an answer was true, even if he genuinely thought the matter was irrelevant. Reference was made to section 5 of the 2012 Act; *Derry* v *Peek* (1889) 14 App Cas 337, per Lord Herschell at 374; McGillivray, *op.cit* at [18-030]; the Law Commissions' Report at [6.27]; *Southern Rock Insurance Co Ltd* v *Hafeez* [2017] CSOH 127, 2017 SLT 1159, per Lady Paton at [73]; *Tesco Underwriting Ltd* v *Achunche* [2016] EWHC 3869 (QB) per HHJ Simpkiss at [12]; and to *Ageas Insurance Limited* v *Stoodley* [2019] Lloyd's Rep IR 1 per HHJ Cotter at [64], [74], [82] and [83].

[76] An example of the proper application of the 2012 Act was to be found in *Jones* v *Zurich Insurance Plc* [2021] EWHC 1320 (Comm), [2022] Lloyd's Rep IR 219. HHJ Pelling considered at [31] that it was necessary to analyse three issues: (a) Had the insured made a misrepresentation to the insurer? (b) Had any misrepresentation made by him been made in breach of his duty to take reasonable care not to make such a misrepresentation? and (c) Had the insurer shown that without the misrepresentation, it would not have underwritten the policy, or would have done so on different terms? That was a clear and correct summary of the application of the 2012 Act.

[77] It was necessary in the first instance to consider certain issues of interpretation arising out of the proposal questions answered by Mr Cowie. He had been asked the following questions:

> "Your health in the last 5 years
>
> Apart from any condition you have already told us about, have you had any of the following in the last 5 years: …
>
> Any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel, including Gastric ulcer, hepatitis, Pancreatitis, Colitis or Crohn's disease"

Mr Cowie had answered "No" to that question. The proposal went on to ask:

> "Recent and Current Health
>
> Apart from anything you have already told us about…within the last 2 years have you undergone any investigation such as blood tests, scans or biopsies?
>
> If so for what condition (or suspected condition)?
>
> Was the test part of a routine 'well person' check or pregnancy?
>
> Was the result normal?"

Mr Cowie had answered "yes" to all of those questions.

[78] The pursuer relied upon sections 68 and 69 of the Consumer Rights Act 2015 for the proposition that if a term of the insurance contract could have different meanings, the meaning that was most favourable to the consumer was to prevail. The pursuer contended that the use of the word "including" in the first question noted above created an ambiguity. Vitality did not dispute the effect of section 69 generally, but it had no application to this case. In order for the section to operate, there required to be: "two rival constructions, both of which are objectively reasonable": *Ristorante Ltd (t/a Bar Massimo)* v *Zurich Insurance Plc* [2021] EWHC 2538 (Ch), [2022] Lloyd's Rep IR 109, per Snowden J at [35]. As was further noted in *CC Construction Ltd* v *Mincione* [2021] EWHC 2502 (TCC), [2022] BLR 48, per HHJ Eyre at [63]:

> "The section does not come into play simply because it is possible to argue for differing interpretations at the start of the exercise of interpreting a contractual term. Instead, for the provision to operate there must be genuine ambiguity after the normal process of analysing the language used in its context to determine the intention of the parties has been undertaken".

[79] That was consistent with the application of the *contra proferentem* principle where it applied in contexts other than those covered by section 69. The principle only had application where the wording of the provision left the court unable to decide by ordinary principles of construction which of two reasonable meanings was the right one: MacGillivray, op.cit, at [11-035]; *MW Wilson (Lace) Ltd* v *Eagle Star Insurance Co* 1993 SLT 938, per Lord Justice-Clerk Ross at 942I – J, citing *Bolands Ltd* v *London and Lancashire Fire Insurance Co Ltd* [1924] AC 836, per Lord Sumner at 848. The principle should not be applied to manufacture an ambiguity where one did not exist: MacGillivray, op.cit. at [11-035], citing *McGeown* v *Direct Travel Insurance* [2003] EWCA Civ 1606, [2004] Lloyd's Rep IR 599 per Auld LJ at [13]; see also *Laidlaw* v *John M Monteath & Co* 1979 SLT 78, per Lord Allanbridge at 80 - 81. The principle was only of use as a last resort in a case of real

ambiguity, such as where two meanings were equally open. In *R* v *Personal Investment Authority Ombudsman* [2002] Lloyd's Rep IR 41, Langley J said at: [43]

> "the first task is to seek to construe the relevant words using the normal canons of construction and only where that fails may the maxim assist. Moreover ambiguity is not the same as lack of clarity. Nor can the maxim be used to create the ambiguity it is then employed to resolve".

[80] The application of section 69 did not involve the court beginning by identifying an interpretation of a contractual term that was most favourable to a consumer and then applying it. Rather, the court had to undertake the normal exercise of contractual interpretation. It was only where, having carried out that exercise, there were two competing interpretations that were both objectively reasonable, that the interpretation most favourable to a consumer had to prevail. All issues of interpretation of the questions on the proposal form fell to be considered with regard to that approach to section 69.

[81] The pursuer relied upon section 69 to support the proposition that where the word "including" appeared in the proposal form, it could signify either a closed list or an open list. It was argued that as those were competing interpretations, the court should apply section 69 and find that the use of the word "including" in the proposal form was to indicate a closed list and that Mr Cowie was accordingly only required to answer positively where the condition from which he had suffered had been listed after the word "including". However, there were not two objectively reasonable competing interpretations of the word "including" on the proposal form. As was stated in *Department of Finance* v *Quinn* [2019] NICA 41, [2021] NI 1 at [25], the word "includes" was potentially ambiguous. Its meaning would depend on its context, which would include the purpose of its use. It could be used to enlarge or extend a natural meaning; to clarify or resolve any doubt or for emphasis; or to confine by providing an exhaustive definition of the meaning of the preceding words.

Reference was also made to *R* v *Income Tax Special Commissioners ex part National Union of Railwaymen* [1967] 1 WLR 263. The court required to consider the context in which the word "including" had been used before it could determine whether there were two objectively reasonable interpretations. Viewing the words in the relevant question from the perspective of the reasonable consumer, there was only one reasonably available meaning. It would be wrong to focus only on the word "including", without considering the remainder of the sentence within which it sat. When the entirety of the question was considered, the important part of the sentence was "any disorder" along with "including". "Any" should be construed widely and so should be understood to embrace all forms of disorder of the "digestive system, liver, stomach, oesophagus, pancreas, colon or bowel". That was consistent with the ordinary use of "any" and with the approach taken in *Coltman* v *Bibby Tankers Ltd (The Derbyshire)* [1988] AC 276 at 299, [1987] 3 WLR 1181, per Lord Oliver of Aylmerton at 1186 – 1187. In that context, it was clear that the purpose of the word "including" in the proposal question was to provide non-exhaustive examples of the types of condition that might be disorders of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel (i.e. within an open list). To find that it created an exhaustive list of the only conditions that were being asked about required a strained interpretation that ignored the context of the sentence. If the word "including" was intended to create an exhaustive list, it would render the first part of the sentence redundant. An interpretation that the word "including" created a closed list would also render the word "any" redundant. There would be no reason to ask about "any disorder" if the only disorders that were being asked about were the five listed conditions following the word "including". The effect of such an interpretation would also have the effect of excluding any other disorders

of the organs in question. So, for example, it would create the effect of excluding serious and potentially fatal conditions such as liver cirrhosis.

[82] The pursuer further sought to apply the maxim *expressio unius est exclusio alterius* to support her interpretation of the word "including". The maxim applied: "where particular cases are provided for by a contract, without any general or inclusive words": Gloag, Law of Contract (1929) at 404 – 405. In the absence of general or inclusive words, the maxim applied to create a presumption that similar cases not expressly provided for were excluded: *Farrans (Construction) Limited* v *Dunfermline District Council* 1988 SC 120 at 125, 1988 SLT 466 at 469, per Lord Justice Clerk Ross. However, the maxim did not operate where there were general or inclusive words (e.g. "any" or "including"). Inclusive definitions necessarily implied that there were matters covered by the word defined that were not included in the definition: *The Derbyshire* [1988] AC 285D – G per Lloyd LJ. In the face of inclusive words being used, to argue that because one disorder was not specifically included it was impliedly excluded was fallacious, and to stand the maxim on its head. It followed that Mr Cowie was obliged to make a disclosure if within the 5 years preceding his proposal, he had had "any disorder of the … liver" and, separately, "any disorder of the … oesophagus".

[83] A "disorder" was defined by the Cambridge Dictionary as: "an illness of the mind or body", and by the Oxford English Dictionary as an: "Absence or undoing of order or regular arrangement; confusion; confused state or condition". The use of "disorder" did not give rise to any ambiguity. A reasonable consumer would understand "disorder" to describe an illness or abnormality in relation to an aspect of their health. It was not a technical medical term. It was a word which should be understood broadly, as encompassing both an abnormality which was a result of a diagnosed disease or condition, and an identified abnormality, the cause of which was undiagnosed. Mr Cowie was obliged to report any

aspect of his health which he knew to be abnormal, or not in proper order, such that it constituted a "disorder", irrespective of whether he had received a formal diagnosis.

[84] In the second of the proposal questions relied upon, Mr Cowie was required to answer whether any blood tests, scans or biopsies which he had undergone in the last 2 years were "…part of a routine 'well person' check…". Those words did not give rise to any ambiguity. A reasonable consumer would understand those words to mean a check to ascertain the general state of a person's health in the absence of a specific, known disorder, rather than an investigation into a specific, identified disorder.

[85] The reference in the second question in the proposal form set out above to the words "Apart from any condition you have already told us about, have you had any of the following in the last 5 years" could only, objectively and reasonably, refer to an applicant's earlier answers on the form. That question came after eleven detailed questions about an applicant's heath that asked for disclosure of conditions such as (for example) cancer, heart disease or diabetes. It was not a reference to any other historical applications made by an applicant. Reading it as a reference to historical applications would be unfair to consumers as it would require them to cast back their mind to forms they might have completed on multiple occasions, many years ago. In any event, Mr Cowie's previous applications did not disclose the conditions founded upon in this action by Vitality. There was no reference at all to abnormal liver function tests, or to any disorder of the liver, in those earlier applications. In an application in 2010 he had disclosed that he had had a procedure in 1997 to tighten his oesophageal sphincter. That, however, was not relevant in determining whether he ought to have disclosed the fact that he had received treatment for Barrett's Oesophagus in the 5 years before completing the proposal form. Mr Cowie had not previously disclosed Barrett's Oesophagus or deranged liver function tests and was obliged to disclose them

given that he had suffered from them in the relevant periods prior to him completing the proposal form.

[86] The task of determining whether Mr Cowie had made misrepresentations was plainly one that was only for the court, taking account of the questions posed to him and his answers thereto, along with the medical evidence which bore upon what conditions or disorders Mr Cowie suffered from, and was aware of, during the relevant period. The court was not concerned with carrying out a review of Vitality's original decision to refuse the pursuer's claim. What had happened then, and what might or might not be the best evidence of what had happened then, were matters of little or no relevance. As Rix LJ put it in *Drake Insurance Plc (in provisional liquidation)* v *Provident Insurance Plc* [2003] EWCA Civ 1834, [2004] QB 601, [2004] 2 WLR 530 at [74], "When account has to be taken of a non-disclosure, the issue moves from the world of actual fact into the world of hypothesis." In principle, it might be relevant to consider any change in the grounds relied upon since the original decision, if that change cast doubt on whether there was merit in the new position taken. However, that consideration did not arise on the facts here. In its original letter denying the claim dated 27 February 2017, Vitality had relied upon the non-disclosure by Mr Cowie of his liver function tests and Barrett's Oesophagus, which it continued to rely upon. A follow-up letter of 27 February 2017 mentioned two further grounds, which were not now founded upon. It was for the court to determine whether any misrepresentation was made and whether it met the definition of 'qualifying misrepresentation' under the 2012 Act, rather than to engage in a process of considering whether Vitality's original decision was properly taken and open to it.

[87] Dr McLennan was unable to recall specifically whether he discussed many of the entries in the redacted medical records with Mr Cowie. That was unsurprising given that

the records pertained to entries that were more than a decade old. However, he did explain that his general approach was to discuss treatment and test results with patients, and where a subsequent test was ordered, to discuss that with the patient. Dr Lord had explained that that was what was expected of a GP exercising reasonable skill and care.

[88] The redacted medical records demonstrated that in the 5 years prior to completing the proposal form Mr Cowie had Barrett's Oesophagus, a disorder of the digestive system and of the oesophagus. Dr Lord confirmed that that was a disorder of the digestive system, that it was a chronic condition, and that it carried with it an increased risk of cancerous change in the oesophagus. Due to the increased risk of cancerous change, some sufferers required to undergo regular endoscopy to assess their Barrett's. Mr Fullerton confirmed that it was a chronic condition of the oesophagus, caused by acid reflux from the stomach, resulting in changes to the lining of the oesophagus. It was considered a significant and pre-malignant condition. He had sent a letter dated 6 December 2010 to Mr Cowie's GP practice which referred to Mr Cowie having attended for: "Halo 90 radio frequency ablation of a small residual Barrett's Island on 30 November 2010". He stated that the procedure was probably the end of a longer course of treatment for Barrett's Oesophagus that would have previously involved a larger balloon device being inserted into Mr Cowie's oesophagus. The treatment of residual "Barrett's Island" was to treat small areas of Barrett's that remained after previous treatments. Mr Fullerton would have obtained consent from Mr Cowie for that procedure, which would have involved him explaining to Mr Cowie what Barrett's Oesophagus was, why the procedure was being carried out, the possible complications of the procedure, and the importance of follow-up. While Mr Fullerton could not specifically recall any conversation that took place on 30 November 2010, he was clear that he would have followed his standard practice which was to advise patients that the

treatment was intended to resolve the Barrett's Oesophagus, but that ongoing surveillance would be required. His advice in this case would have been that a further endoscopy would have been needed in around three months' time, which was consistent with the terms of his letter of 6 December 2010. Mr Cowie had had Barrett's, and still had it in November 2010. Mr Cowie was required to respond to the question of whether, in the last 5 years, he had "any disorder of the…oesophagus". His answer was "no".

[89] Having regard to the medical evidence, Barrett's Oesophagus was plainly a "disorder of the oesophagus". Mr Cowie knew that he had had the disorder, in particular, having regard to the treatment which he had on 30 November 2010, what he would have been told about the disorder and the treatment by Mr Fullerton, and the need for ongoing medication and follow up. That being so, he answered the proposal question incorrectly and thereby made a misrepresentation to Vitality. It was true that when he finally underwent a follow-up on 15 August 2016, it demonstrated that he no longer suffered from Barrett's. It therefore appeared that the treatment on 30 November 2010 was successful, though Mr Cowie could not have known that at the date of completing the proposal form, and in any event, whether he had recovered from the condition or disorder was irrelevant given the form of the question put to him.

[90] The redacted medical records further indicated that Mr Cowie had undergone numerous tests in relation to his liver function, and that such testing indicated that his liver function was "deranged" or "abnormal". Mr Cowie's first abnormal liver function test was on 9 March 2012. Dr McLennan confirmed that he discussed the results of this test with Mr Cowie, and that was demonstrated from an entry in the records of a telephone consultation on 16 March 2012. While he could not recall what he said to Mr Cowie, had he been advising a patient in Mr Cowie's position in 2012, he would have advised him that the

results were significant and that further investigation would be required. Following those results, Mr Cowie was referred to Dr El-Nujumi, who wrote a letter on 20 March 2012, following a consultation. That letter noted the raised enzyme levels which had been found and recommended further tests and monitoring before further investigation. That letter was sent to Dr McLennan and copied to Mr Cowie. A letter in similar terms was sent by Dr El-Nujumi to Dr McLennan on 31 March 2012, after a further review of Mr Cowie on the same date. There was, however, nothing to indicate that Mr Cowie was indeed followed up prior to 2014. Dr El-Nujumi could not remember any specific conversations with Mr Cowie, but stated that that he would have explained to him that there was an abnormality noted in the liver function tests and that this was the reason for carrying out further tests.

[91] Mr Cowie was due to have surgery for a cervical disc lesion in 2014. That was postponed on two occasions because of abnormal liver function test results. The first occasion was on 26 August 2014. The surgeon, Mr Taylor, stated that as a matter of general practice he would have told Mr Cowie that the surgery had been cancelled due to the test results. He had referred Mr Cowie to Dr Dover.

[92] The second occasion on which Mr Cowie's surgery was cancelled appears to have been 3 October 2014, based on an entry of Dr McLennan's telephone consultation with Mr Cowie of that date. Dr McLennan stated that he would have advised Mr Cowie that the fresh test results then obtained were significant and would need further investigation. He referred Mr Cowie for that further investigation, this time to Dr Datta for a specialist opinion regarding liver dysfunction. Dr McLennan stated that this would have been discussed with Mr Cowie during a telephone call on 3 October 2014. There was no evidence as to the outcome of the referral to Dr Datta. Mr Cowie had further liver function tests on 20 October 2014, the results of which were much improved, but still abnormal. Dr McLennan

confirmed in examination-in-chief that he would have advised Mr Cowie of that. An ultrasound was requested on 8 October 2014, and Dr McLennan confirmed that it was requested because of the deranged liver function tests and that this would have been communicated to Mr Cowie. The ultrasound showed no abnormality, but that did not mean that Mr Cowie could reasonably have considered that he did not have a disorder of the liver against a background of repeated deranged liver function tests. As Dr Lord explained, an ultrasound was performed to look for structural abnormalities in the liver, whereas liver function tests were for a distinct purpose, namely to detect abnormal liver function due to liver disease, which could exist even with a normal liver ultrasound scan. Dr McLennan confirmed that an ultrasound was not definitive as to dysfunction and that it did not lead to a conclusion that Mr Cowie's liver was functioning normally. The liver function tests were biochemical evidence of dysfunction. Sensitivity to alcohol was posited as a possible cause, but there was never a definitive diagnosis of a specific liver disease, at least prior to Mr Cowie completing the proposal form. In completing the proposal form, Mr Cowie required to respond to the question of whether, in the last 5 years, he had had any disorder of the liver. His answer was "no". Having regard to the medical evidence, he ought to have answered "yes". His persistently elevated liver function test results indicated that his liver was functioning abnormally and that he therefore had a disorder, as would have been clear to him as a result of what he was told regarding the extent of the abnormality, and as a result of the further investigation. It made no difference that no specific condition had been diagnosed as underlying the liver function test results; they were indicative of a disorder. The investigations which were carried out did not give Mr Cowie grounds to consider that he did not have a disorder of the liver. In all of these circumstances, by answering "no" to the question, Mr Cowie made a misrepresentation to the defender.

[93] Mr Cowie was further required in the proposal form to answer whether, within the last two years, he had undergone any investigation such as blood tests, scans or biopsies; whether the test was part of a routine 'well person' check or pregnancy; and whether the result was normal. He answered "yes" to all of those questions. On the basis of the understanding of those questions which should be attributed to the reasonable consumer, Mr Cowie's liver function tests could on no view have been part of a routine 'well person' check. They were undertaken on multiple occasions in order specifically to investigate the functioning of his liver. On no view could the results have been considered to be normal; on the contrary, Mr Cowie was specifically advised that they were abnormal. It was irrelevant that no specific condition had been diagnosed as underlying the test results. The question required the disclosure of the existence of abnormal tests, irrespective of their cause. In these circumstances, Mr Cowie made a further misrepresentation through his answers to this group of questions.

[94] Section 3(1) of the 2022 Act provided that whether or not a consumer had taken reasonable care not to make a misrepresentation was to be determined in the light of all the relevant circumstances. It then set out examples of matters which might need to be taken into account. In terms of section 3(2)(c), how clear, and how specific, the insurer's questions were was of relevance. The questions in issue were clear and unambiguous. Each of them admitted of only one reasonable interpretation. A reasonable consumer would have understood that he required to disclose whether he had had "any disorder of the…oesophagus", or "any disorder of the…liver" in the previous 5 years. He would equally have understood the requirement to disclose abnormal liver function tests which were not taken in the context of a "routine 'well person' check". The fact that the questions

were clear and specific was, in itself, a weighty factor pointing to the conclusion that Mr Cowie did not take reasonable care not to make the misrepresentations.

[95] Section 3(2)(b) provided that in determining whether a consumer had taken reasonable care not to make a misrepresentation, account could be taken of any relevant explanatory material authorised by the insurer. In this connection, the plan summary stated, under the heading "Making a full disclosure":

> "When you take out your plan, you have a responsibility to give us the information we ask for. That's because we rely on this information to assess your risk and work out your premiums. If any of the information you give us is incomplete, incorrect or untrue, it's likely that we'll reduce the value of any claims you make. In some circumstances we may not pay your claim at all. We may also cancel your plan altogether. So, if you realise that you haven't made a full disclosure to us, please let us know as soon as you can. Then we can help you get a valid insurance contract back in place."

[96] The Plan Provisions stated:

> "We may cancel your plan if you:
>
> *Make any untrue statements to us
>
> *Fail to disclose any material facts relevant to your plan or a claim
>
> *Act fraudulently in any way".

[97] A Confirmation Schedule was sent to Mr Cowie by way of letter dated 13 November 2015. The letter stated:

> "Your Plan has been set up using the details shown on the attached Confirmation Schedule in Section 1. This reflects the information sent to us electronically by your Financial Advisor. This Confirmation Schedule forms part of the basis of the agreement between you and VitalityLife for the provision of the VitalityLife Essentials Plan, so you must check this document for accuracy and completeness
> …
> If you need to advise us of any changes or errors, please complete Section 2 at the end of this Schedule and return this to us by fax, email or in the enclosed pre-paid envelope".

[98] Thus, the explanatory material provided to him advised Mr Cowie: (i) of the importance of giving complete and correct information in response to the questions posed; (ii) of the potential consequences of not providing complete and correct information; (iii) that the Confirmation Schedule which formed part of the agreement between him and Vitality reflected the information provided, via his financial advisor, to Vitality as part of the Proposal Form; and (iv) of the need to check it for accuracy and completeness and to advise Vitality of changes or errors.

[99] Mr Cowie was, further, given opportunities to qualify or particularise his response. In the letter of 13 November 2015, he was asked to check the Confirmation Schedule (which contained the full set of questions asked alongside his responses), and advise Vitality of whether it contained any changes or errors. As Mr Downes had stated, had Mr Cowie for example disclosed his Barrett's Oesophagus or liver function test results, he would have automatically been provided with a free text box to allow him to provide the relevant and available details.

[100] The court should also have regard (in terms of section 3(2)(e)) that Mr Cowie was assisted in completing the proposal form by a professional advisor. Paul Reynolds acted for Mr Cowie. He had no actual recollection of his video meetings with Mr Cowie. Nevertheless, he explained that his standard practice would have been to confirm when completing the proposal form that Mr Cowie required to answer all of the questions correctly as even small discrepancies could lead to the policy being null and void. He would have gone through each of the questions with Mr Cowie and would have made it clear that he should raise any queries that he had. He would have also contacted Mr Cowie to confirm that he had received the Confirmation Schedule, to advise that he should check it to ensure that all of the information was correct and, to the extent that any of it was not, that he should

notify Mr Reynolds or Vitality. In such circumstances, Mr Cowie did not take reasonable care not to make a misrepresentation to Vitality. Given the clear and specific questions put to him, and his knowledge of his disorders including his abnormal liver function test results, the misrepresentations were clear and obvious. That was underlined by the explanatory material provided by Vitality and the fact that Mr Cowie had an agent. For these reasons, individually and cumulatively, Mr Cowie did not take reasonable care not to make the misrepresentations identified, applying the standard of a reasonable consumer in terms of section 3(3).

[101] In terms of section 3(4), the court was entitled to take into account any particular characteristics or circumstances of Mr Cowie. Vitality was made aware that Mr Cowie was a solicitor at the point he applied for life insurance. The court would be entitled to consider whether Mr Cowie took reasonable care by reference to the subjective modification that he was a solicitor. It could reasonably be assumed that if there was any ambiguity in the questions posed, then a solicitor would understand them in the way proposed by Vitality. Equally, it could reasonably be assumed that a solicitor would be aware of the need to provide complete and accurate information in response to the questions. Thus, if there was any doubt as to whether Mr Cowie exercised reasonable care, then the court would be entitled to take into account his occupation and how that would assist him in responding to the questions. However, a want of reasonable care had in any event been demonstrated without taking account of Mr Cowie's occupation.

[102] In order to establish that the relevant misrepresentations were qualifying misrepresentations for the purposes of the 2012 Act, Vitality required further to establish, in terms of section 4(1)(b), that without the misrepresentations it would not have entered into the contract at all, or would only have done so on different terms. It offered to prove that it

would not have entered into the contract at all. At the time of the original claim under the policy, Vitality's Fergus Bescoby undertook a retrospective underwriting exercise to determine what it would have done had Mr Cowie not misrepresented his conditions. The same exercise was carried out by Ashley Paddock of Hannover Re as Vitality's reinsurer. On the appeal against the initial refusal of the claim, the same exercise was carried out by Neil Hartigan of Vitality and also by Theresa Taylor of Hannover Re. Each of those individuals was carrying out a retrospective exercise having regard to whether cover would have been offered at the original date of inception, in November 2015. Each of them carried out the exercise having regard to the full, unredacted medical records. At proof, Vitality led evidence from John Downes and Andrea Gregory, who had carried out the same retrospective underwriting review but had had regard only to the redacted medical records.. In terms of section 4(1)(b), Vitality needed to show that without the misrepresentations, it would not have entered into the contract at all. That inevitably involved looking retrospectively to what it would have done but for the misrepresentations, at the time of the proposal in November 2015. Its approach as to what it would have done in 2015, founded on Mr Downes' retrospective underwriting undertaken in 2025, was not materially different to the approach that it took in 2017. The evidence of Mr Downes and Mrs Gregory was no less than valuable than if Vitality had led Mr Bescoby and Mr Paddock and had asked them to review what their position would have been had they had only the redacted medical records. What was important was the substance of the evidence.

[103] Mr Downes spoke to the general process an underwriter and insurer would follow in deciding whether to offer life insurance. He pointed out that most applications were accepted through an automated process known as straight through processing ("STP"), which did not require manual underwriting. It was only where the automated system was

unable to accept an application that it was referred to a human underwriter, either to accept the risk or to obtain further information such as a GP report or the results of a medical examination. He explained that where digestive disorders were disclosed (including Barrett's Oesophagus), Vitality would always have asked for further medical evidence. Similarly, where a liver disorder or abnormal liver tests were disclosed, it would always have asked for further information, including the results of any liver function tests, given the relative underwriting guidelines. Such cases would always be dealt with by manual underwriting (i.e. by a human underwriter). An underwriter would assess the medical evidence obtained by reference to an underwriting manual. Such manuals were generally produced by reinsurance companies, were evidence-based and provided recommendations as to whether cover could be offered and at what premium. The evidence of Mr Downes and Mrs Gregory was based on the application of the underwriting guidelines relevant to elevated liver enzymes and Barrett's Oesophagus. Those guidelines were produced by Hannover Re, were provided to Vitality, were also followed by Hannover Re's underwriters, and were in force and used at the time of Mr Cowie's proposal. As Ms Gregory explained, the purpose of the guidelines, which were based on statistics representative of the insured population, was to assess whether a risk was too great to insure or could not be quantified, to ensure that Vitality charged the correct premium, and to ensure that all people in a given insurance pool were treated fairly and paid the correct premium for the risk that they brought. In short, they ensured consistency for the insurer, reinsurer and consumer.

[104] Mr Downes had dealt with the application of the guidelines to Mr Cowie's liver function tests results. The results dated 20 October 2014 were taken as the lowest of Mr Cowie's abnormal results and, therefore, those most favourable to him. Applying those guidelines, those results would have been given Rating Class H. That was the highest (or

most risky) rating, usually resulting in a proposal being declined, or at least to a referral to Hannover Re. Ms Gregory described what Hannover Re's position would have been to such results, stating that the raw figures would have given a rating class of F, but that as the test values had been persistently elevated, Mr Cowie's class would have moved up two levels and would have attracted Rating Class H, meaning that ordinarily cover would have been declined. Thus, had Mr Cowie disclosed either that: (a) he had a disorder of the liver; or (b) that he had undergone liver function tests that were not part of a routine well person check, and the results of which were not normal, Vitality would have obtained the results of those tests. Thereafter, it could be demonstrated objectively by reference to the underwriting guidance that applied at the relevant time that Vitality would have declined to offer life insurance to Mr Cowie.

[105] Mr Downes had also dealt with Vitality's underwriting guidelines relevant to Barrett's Oesophagus, and explained that where an applicant had not undergone surveillance for his Barrett's Oesophagus for more than two years, his application would be declined. He pointed out that Mr Cowie had been expected to undergo a follow up endoscopy to confirm full squamous re-epithelization of the oesophagus after his treatment for Barrett's. The fact that there had been no such follow up by the date of the proposal would have resulted in the application for cover being declined. That position was entirely corroborated by Mrs Gregory's evidence. She noted the importance under the guidelines of Barrett's being followed up, irrespective of which category it fell into under the guideline. Thus, had Mr Cowie disclosed his Barrett's Oesophagus, then Vitality would not have offered cover, given that there had been no follow up of the condition since November 2010. Later records suggested that Mr Cowie may not have been suffering from any residual Barrett's as at November 2015, but that was beside the point.

[106] Both Mr Downes and Mrs Gregory confirmed that disclosure of either the liver function test results or the Barrett's Oesophagus would have been sufficient for cover to be declined, but that the multiple grounds of refusal would have reinforced the decision. Vitality's evidence that it would not have entered into the contract was compelling. The retrospective underwriting evidence was based on the applicable guidelines in force at the time Mr Cowie had applied for cover, and not merely on an underwriter exercising his or her own judgment with the benefit of hindsight. The guidelines were intended to provide consistency in relation to decisions as to whether to provide cover. They were readily understandable, as was the evidence as to how they would have been applied taking account of the redacted medical records. They provided an objective benchmark by which to assess whether cover would have been provided. The evidence of Mr Downes and Mrs Gregory was complimentary, reflecting the fact that the guidelines were drafted by Hannover Re, shared with Vitality and used by both. The input of Hannover Re as reinsurer provided a cross check to the evidence as to what decision Vitality would have taken. The evidence of Mr Downes and Mrs Gregory was consistent with the position taken at the time that the claim was originally considered, when Mr Bescoby concluded that cover would not have been offered based on "the history of deranged LFTs with questionable alcohol intake, along with the Barrett's which was not under correct surveillance". There had been no change in that position, which was unsurprising where underwriting decisions were based on objective guidelines. Neither Mr Downes nor Mrs Gregory was cross-examined on the critical point of whether cover would have been offered but for the misrepresentations, having regard to the guidelines. The UK Supreme Court had recently provided guidance on the effect of a failure to cross-examine a witness on a material point in *TUI UK Ltd* v *Griffiths* [2023] UKSC 48, [2025] AC 374, [2023] 3 WLR 1204. It had been stated at [42] and [43] that in

general, a party was required to challenge in cross-examination the evidence of any witness of the opposing party if he wished to submit to the court that the evidence should not be accepted on that point, and that that was a matter of fairness of legal proceedings as a whole, and was not confined to allegations of bad faith or aspersions against a witness's character. The question of whether cover would have been offered was the critical aspect of the evidence of both Mr Downes and Mrs Gregory. Any challenge made to their evidence that Vitality would not have underwritten the life insurance policy with Mr Cowie had the relevant misrepresentation not been made, or that the underwriting guidelines had been applied correctly, should not be accepted by the court, on the basis that they were not cross-examined on those particular points.

[107] Vitality had established that without the misrepresentations it would not have entered into the contract at all, in terms of section 4(1)(b) of the 2012 Act. It followed that Mr Cowie had made "qualifying misrepresentations" in respect of which it had a remedy in terms of section 4(2).

[108] Vitality's primary position was that the qualifying misrepresentations were deliberate or reckless in terms of section 5(2) of the 2012 Act. On the evidence, it was open to the court to draw that inference. However, its fallback position was that even if the court did not consider that the threshold for reckless or deliberate qualifying misrepresentations had been met, they were at least careless in terms of section 5(3). Vitality recognised that Mr Cowie was dead and that the pursuer was unable to respond directly to the allegations of deliberate or reckless misrepresentation. The outcome on this issue, further, made no difference to the remedy available to it. There was a two-part test to determining whether a misrepresentation was deliberate or reckless. First, the court had to consider whether Mr Cowie knew that an answer was untrue or misleading, or did not care whether it was

untrue or misleading – section 5(2)(a). Second, the court had to consider whether Mr Cowie knew that the matter to which the misrepresentation related was relevant to Vitality, or did not care whether it was relevant – section 5(2)(b). If the court concluded that the questions posed to Mr Cowie were indeed clear and specific, then section 5(5) was engaged, and it was to be presumed that he knew that the subject matter of the question was important to Vitality. The fact that he answered a clear and specific question incorrectly, in the knowledge of the importance of the subject matter, and in the absence of any possible explanation being advanced, was in itself indicative of the incorrect answer having been deliberate. That was consistent with the approach of the court in *Ageas Insurance Ltd* at [74], and *Tesco Underwriting Ltd* at [12]. The one material distinction between, on the one hand, deliberate and reckless misrepresentations and, on the other hand, careless misrepresentations (assuming that the insurer would not have entered into the contract at all) was that where a misrepresentation was careless, an insurer was required to return the premiums paid in terms of paragraph 5 of schedule 1 of the 2012 Act (as distinct from paragraph 2 in relation to deliberate or reckless or misrepresentations). As Miss Tsebe had confirmed, the premiums had already been returned. Therefore, Vitality was entitled to refuse to meet the claim on the basis of a careless misrepresentation.

[109] The extent to which a continuing duty of good faith beyond the formation of the contract (potentially owed by the insurer or the insured, at least prior to the 2012 Act) had been recognised in various jurisdictions. In England, it had been said that the principle that insurance contracts are contracts of the utmost good faith created post-contractual duties. The duty of good faith could broadly be seen as a duty supporting the implication of contractual terms in the insurance context when required to achieve the goal of fair dealing between the parties: MacGillivray, loc.cit. at 16-171; see also *Manifest Shipping Co* v *Uni-*

Polaris Insurance Co [2001] UKHL 1, [2003] 1 AC 469, [2001] 2 WLR 170 at [52]. As MacGillivray noted, there had been few times when the courts had held that the duty applied post-contractually: 16-171. Such a duty might apply to the insurer or insured. For example, where the insurer had a right to information by virtue of an express or an implied term, there might be a duty of good faith on the insured to give such information: *K/S Merc-Scandia XXXXII* v *Certain Lloyd's Underwriters and Others, The Mercandian Continent* [2001] EWCA Civ 1275, [2001] 2 Lloyd's Rep 563 at 571. It had been recognised that the duty might apply to an insurer; if a liability insurer exercised its right to conduct the insured's defence to a claim made by a third party; the insurer was required then to act in good faith with regard to the interests of the insured: *The Mercandian Continent* at 572. The limits to which such a duty had been recognised were seen in *Insurance Corp of the Channel Islands Ltd* v *McHugh* [1997] LRLR 94, in which Mance J rejected the contention that insurers were subject to an implied term obliging them to negotiate and pay sums due with reasonable diligence and due expedition, such a term being convenient but not necessary and not the unexpressed will of the parties. It had been held that a breach of the duty of good faith did not sound in damages and that the only remedy open to the insured was to rescind the policy and recover the premium: *Banque Financiere de la Cite SA (formerly Banque Keyser Ullmann SA)* v *Westgate Insurance Co (formerly Hodge General & Mercantile Co Ltd* [1991] 2 AC 249 at 280, [1990] 3 WLR 364 at 380; *Manifest Shipping Co* at [49]. It had been recognised that the remedy of avoidance was unlikely to be of benefit to the insured in relation to something that had occurred after the contract had been entered into: *Manifest Shipping Co* at [57].

[110] In Scotland, in *Fargnoli* v *GA Bonus plc* 1997 SCLR 12, at 30 – 31, it was said *obiter* that it followed from the mutuality of the obligation of good faith on the insured that an insurer had similarly rigorous duties, which would extend to dealing with claims. The court

considered it open to question whether an insurer would be in good faith in delaying an admission of liability, advancing spurious defences to a claim, putting an insured to proof on that which the insurer knew to be true, or delaying settlement of claims which he would, objectively, be obliged to admit to be valid before a court, and that it might be conceived that the insurer would be in repudiatory breach so that the contract would be voidable at the instance of the insured, rather than void *ab initio*. In New Zealand, in *Young* v *Tower Insurance* [2016] NZHC 2956 and *Kilduff* v *Tower Insurance* [2018] NZHC 704, Geldane J. held that a duty of good faith on the part of the insurer was implied in every insurance contract, given that the duty of good faith "must flow both ways". The duty required the insurer, as a minimum, to (a) disclose all material information that he knew or ought to have known, including during and after the making of a claim; (b) act reasonably, fairly and transparently, including during and after the making of a claim; and (c) process the claim in a reasonable time – *Young* at [157] – [163] and *Kilduff* at [107]. It was held that breach of the duty might sound in damages, albeit only nominal sums had been awarded. In *Whiten* v *Pilot Insurance Company* [2002] 1 RCS 595, the Supreme Court of Canada recognised that insurers were under a contractual duty of good faith. However, little by way of principle could be taken from the case, which was primarily concerned with whether the appeal court below had been right to overturn a jury award of punitive damages, against a background of the insurers having made unfounded allegations of arson. No authority had been identified in support of the propositions that there were specific duties, based on good faith, not to rely on additional bases upon which to claim avoidance of the policy beyond those initially relied upon, or to identify the particular questions and answers which were said to amount to non-disclosure. In *Cuthbertson* v *Friends' Provident Life Office* [2006] CSOH 74, 2006 SLT 567, 2006 SCLR 697 it was argued that, in the absence of new material or information,

an insurer could not competently add to its initial grounds of avoidance. It was ultimately held that where additional grounds were founded upon, that would go to the weight or reliability of any evidence that the additional grounds might be material to the insurer. Vitality took no issue with that approach, but it was not applicable as it was relying on the same grounds to establish a qualifying misrepresentation as it did when it initially declined the claim made on the policy. There was no proper ground upon which to hold that an insurer could not add to its initial grounds of avoidance. Since the introduction of the 2012 Act, contracts falling within the scope of the Act were no longer contracts of the utmost good faith. The previous duty of utmost good faith on the consumer had been replaced with the duty to take reasonable care not to make a misrepresentation to the insurer. Given that any post-contract duty of good faith imposed on insurers came about as a result of the mutuality of obligations, it followed that a general duty of good faith could no longer form the background to the implication of specific terms. That did not mean that there was no scope to imply terms into the contract, but it did mean that the implication of any terms contended for should be considered in its own right, unaided by an overarching, mutual duty of good faith. There was no warrant for implying the terms contended for in order to achieve fair dealing between the parties.

[111] Different reasons might exist as to why an insurer added to the grounds initially relied upon. For example, it might be that existing material was considered in a different way at a different time, perhaps by a different employee, who placed different emphasis on it. It might be that the insurer had simply overlooked certain material. In either situation, the addition of new grounds would not necessarily be based on a lack of good faith. If new grounds justified, even potentially, a defence against the claim for the insurer, then it was not obvious why fair dealing would require the imposition of a blanket duty that would

prevent it from advancing such a defence, irrespective of the reasons why it was not previously advanced.

[112] In *Drake*, Rix LJ at [69] and [70] had said:

> "[69] … In principle … I would have thought that a party which seeks to terminate a contract, whether under an express clause, or whether by way of rescission for misrepresentation or avoidance in insurance for non-disclosure, or whether for breach of condition, or by way of acceptance of a repudiation, must make good his ground for bringing the contract to an end. That does not mean to say that he is limited to the ground which he advances at the time of termination, for it has often been said that if a party has a good ground for termination, then it does not matter whether he gives it or any ground at all at the time of termination. That is of course subject to termination under an express power or option in a contract, in which case the clause may well define what has to be said or done for the valid invocation of the clause, and also subject to any case of estoppel. Generally speaking, however, subject to the rules of pleading and the just case management of proceedings, a party may justify a termination of a contract, if he can, by any means which do in fact justify it. In terminating, however, he takes the risk that he can justify bringing the contract to an end. That does not mean that the termination is only effective if sanctioned by the court. If the termination is justified at the time it occurs, then it operates validly and effectively from that time — however long a dispute about it may take to resolve. But if there is a dispute, and if at trial the party which purported to terminate cannot justify his termination, and if the court finds that the contract was not validly terminated but repudiated by the party which claimed to be entitled to terminate, then the consequences of what has latterly been shown to be an invalid termination lie at the risk of the terminating party.
>
> [70] If this is so generally, why should the insurer's right to avoid a contract of insurance not similarly depend on the true facts of the case? Since the avoidance is a form of rescission from inception, the critical facts will be those in existence at the time of contract."

[113] Further, the letter sent by Vitality to Dr McLennan dated 27 February 2017had intimated its position on what had not been disclosed. At that point Vitality relied on four points of non-disclosure, two of which it continued to rely on. There was no suggestion of any prejudice having been caused to the pursuer at any stage arising out of what was complained of. The duties contended for were not required in order to achieve fair dealing between the parties.

[114] There was no established basis upon which to conclude that there was any obligation to ask the surviving spouse about why questions had been answered in a particular way before declining a claim. Although Pill LJ had said obiter in *Drake* at [177] that a failure to make any enquiry of the insured before taking the drastic step of avoiding the policy was a breach by the insurer of the duty of good faith, Rix LJ in the same case at [145] had observed that, although there was much to be said for such a conclusion, it was difficult to know where to draw the line, and that there was, so far as his Lordship was aware, no authority for the proposition that an insurer owed the insured a duty to take reasonable care to make appropriate enquiries before avoiding the policy. The remaining judge, Clarke LJ, had not dealt with the question.

[115] Even if the duties in question did fall to be implied into the contract, the remedy sought could not flow from the alleged breaches. The pursuer did not seek avoidance of the contract, or even damages, but on the contrary sought the contract's enforcement and payment of the sum said to be due thereunder. She claimed that, as a result of the breach of an implied term, Vitality was prevented from exercising a right available to it under statute. There was no basis for suggesting that breach of an implied term could deny Vitality its statutory rights. As the dispute was now the subject of these proceedings, the parties' rights and relationship were governed by the rules of procedure rather than by a continuing duty of good faith: *Manifest Shipping Co* at [73] – [78].

[116] In summary, the medical evidence demonstrated that when he completed the application for life insurance, Mr Cowie was aware that he was suffering from Barrett's Oesophagus and a disorder of the liver. The evidence also demonstrated that Mr Cowie had undergone and was aware of having undergone liver function tests which showed his liver function as abnormal or deranged. The questions posed to him by Vitality were sufficiently

clear, and he failed to take reasonable care when answering them. Those misrepresentations were either deliberate or reckless, or careless. The unchallenged evidence before the court was that but for those misrepresentations, Vitality would not have entered into a contract of life insurance with Mr Cowie. Accordingly, the pursuer's claim had to fail.

Submissions for the Pursuer

[117] On behalf of the pursuer, senior counsel submitted that this was an action for payment, being for performance of an insurance company's primary obligation under an insurance contract with the pursuer and her deceased husband. The fundamental facts were a matter of admission before the court, namely, that: (1) the parties entered into a contract for life insurance; (2) one of the insured parties, Mr Cowie, died during the currency of the insurance period; and (3) his widow, the pursuer, consequently sought payment from the insurer of the sum assured under the policy on her late husband's life. Accordingly, the pursuer's case was made out, unless and until Vitality established a relevant defence by sufficient, credible and reliable evidence. It sought to do so by claiming that the proposal form which formed the basis for the parties' consumer insurance contract contained misrepresentations by Mr Cowie; that those misrepresentations were made by him in breach of his statutory duty as a consumer to take reasonable care not to do so; and that without such misrepresentations, it would not have entered into the contract. It was only if each of those claims was made out on the evidence that the court could find that Vitality's decision in 2017 to avoid the contract, refuse the claim and return the premiums paid was lawful, such as to afford it a relevant defence to the action. It had failed to make out any of those claims. It was not in a position to defend the decision actually taken in 2017, because that decision was founded on information which its employees had extracted from medical

records which was irrelevant and unrelated to the actual cause of Mr Cowie's death and which should not have been in its possession in the first place. It had sought to circumvent this problem by giving up trying to justify the actual decision which was taken in 2017 and instead seeking to persuade the court of the lawfulness of a decision which was never in fact taken by it. It posited an imaginary situation, namely, that Dr McLennan had only ever sent it what it had asked him for, namely such of Mr Cowie's medical records as disclosed material relating to or contributing to his cause of death in the 5-year period before he completed the proposal form on 13 November 2015, and had had its witnesses speak hypothetically to a decision which might have been made on the basis of those documents. The witnesses it had chosen to that end were not those involved in the actual decision in 2017, but were selected as still being in its employ (or that of Hannover Re) and so tied and beholden to these insurers in terms of their own career protection and progression. Those witnesses (Mr Downes, Mrs Gregory and Miss Tsebe) all said that they would have refused the claim, although not necessarily on the same grounds or for the same reasons as the actual 2017 decision-makers. They denied any direct collusion in the others' statements, but given striking similarities amongst what they said, that – if true – suggested the involvement of a common author in the drafting of the statements. A further problem was that Dr McLennan's evidence did not cover what information he actually would have provided to Vitality had he been asked at the time of the policy proposal to furnish it with a medical report (whether targeted or not) on the disclosures which it was now said Mr Cowie should have made. Ultimately, Vitality had presented no evidence concerning, and no defence of the lawfulness of, the decision in fact made by it in 2017 to refuse to pay out on the claim and to repudiate the contract. Further, the evidence of Mr Downes was about matters of which he had no direct knowledge. It was not the best evidence of those matters. It was,

rather, a wholly reconstructed narrative based on the files which Vitality's legal department had selected and provided to him, full of speculation and assertion as to what the decision-makers in 2017 would have thought and done. No adequate explanation as to why the actual decision-makers had not been called was given. Similarly, Mrs Gregory's evidence was based upon her own review of the Hannover Re files. It confused what should have happened in the treatment of the claim with what would have happened. It made claims about medical disorders without Mrs Gregory possessing any relevant medical qualification. It was also a reconstructed narrative suggested and promoted to her by Vitality's legal department and was wholly unreliable. It was this sort of situation which had led the commercial courts in England and Wales to be encouraged not to place reliance on lawyer-generated witness statements, but instead to focus on what the contemporaneous internal documentation of a relevant decision-maker actually said or did not say: *Gestmin SGPS SA* v *Credit Suisse (UK) Ltd & Another* [2013] EWHC 3560 (Comm), [2020] 1 CLC 428 per Leggatt J at [22]; cf. *Jones* v *Zurich* per HHJ Pelling at [4].

[118] The 2012 Act had not affected the law of insurance in Scotland as much as it had that of England and Wales. Here, questions of the materiality of any non-disclosure in policies of life insurance had always been judged by reference to the criterion of the reasonable insured person, not that of the reasonable insurer. Further, in relation to the question of whether an insurer had been induced to enter into a policy as a result of a misrepresentation, the law in effect remained as set out in *Assicurazioni Generali SpA* v *Arab Insurance Group* [2002] EWCA Civ 1642, [2003] 2 CLC 242, per Clarke LJ at [62]; in particular, the insurer had to prove on the balance of probabilities that he was induced to enter into the contract by a material non-disclosure or misrepresentation; there was no presumption of law that an insurer was induced to enter in the contract by a material non-disclosure or misrepresentation; the

insurer had to show that the non-disclosure or misrepresentation was an effective cause of his entering into the contract on the terms on which he did, in other words that but for the relevant non-disclosure or misrepresentation, he would not have entered into the contract on those terms, but did not have to show that it was the sole effective cause of his doing so.

[119] The operation of the 2012 Act had to be assessed against the background of the common law of the respective jurisdictions in which it now operated. It was not a statute that fell to be regarded as occupying the entire field of law with which it dealt. All that the 2012 Act did was list and re-state remedies available to insurers, without changing their nature. Reference was made to *R (Child Poverty Action Group)* v *Secretary of State for Work and Pensions* [2010] UKSC 54, [2011] 2 AC 15, [2011] 2 WLR 1, per Lord Dyson JSC at [27] – [34]; the extent to which a statute occupied the field of law with which it concerned itself it was always a question of construction of the particular statute under examination. The question was whether, looked at as a whole, a common law remedy would be incompatible with the statutory scheme and therefore could not have been intended by co-exist with it. The court should not be too ready to find that a common law remedy had been displaced by a statutory one, not least because it was always open to Parliament to make the position clear by stating explicitly whether the statute was intended to be exhaustive. The mere fact that there were some differences between the common law and the statutory positions was unlikely in itself to be sufficient to exclude the continued operation of the former.

[120] In *Singularis Holdings Limited* v *PricewaterhouseCoopers* [2014] UKPC 36, [2015] AC 1675, [2015] 2 WLR 971, Lord Sumption at [28] observed:

> "The existence of a statutory power covering part of the same ground may impliedly exclude a common law power covering the whole of it. But it does not necessarily do so. An implied exclusion of non-statutory remedies arises only where the statutory scheme can be said to occupy the field. This will normally be the case if the subsistence of the common law power would undermine the operation of the

> statutory one, usually by circumventing limitations or exceptions to the statutory power which are an integral part of the underlying legislative policy …"

[121] The only question in the proposal form to which Mr Cowie's answer was founded upon by Vitality's decision-makers in 2017 was:

> "Your health in the last 5 years":
>
> Apart from any condition you have already told us about, have you had any of the following in the last 5 years: … any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel, including Gastric ulcer, Hepatitis, Pancreatitis, Colitis or Crohn's disease?"

[122] Mr Cowie was under no obligation to disclose anything which was not the subject of a question. A misrepresentation could only arise out of an answer to a specific question. In order to make a judgment as to whether or not there had been any misrepresentation in response to this question, it was necessary to analyse the wording of the question carefully in order to understand what was actually being asked. Only once that had been decided could one consider whether any response to it did or did not constitute a misrepresentation. On a plain reading of the wording "apart from any condition you have already told us about", the question specifically excluded from its ambit information about "any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel" which Mr Cowie had already told the insurer about. In responses to a medical examination report form dated 19 April 2010, taken in relation to an application for an earlier policy, Mr Cowie answered positively the question "Have you ever suffered from any disease or disorder of the digestive system, ulcers, colitis or change in bowel habits". When it came to answering the questions in the form in issue in November 2015, he would have known that Vitality had previously been told, specifically under reference to further explanation of that answer, about his having gastric reflux (for which he had been prescribed the drug Losec) and separately oesophagitis ascribed to a tightening oesophageal sphincter (and that he had

undergone surgical intervention in the form of laparoscopic Nissen fundoplication in respect of this). He would also have known that, in full knowledge of these conditions, Vitality had opened a life assurance policy with him on standard terms with a start date of 21 April 2010. The question about information previously supplied could not be regarded as restricted to information already supplied in the 2015 form, because where that was what was being referred to, the form made it clear by stating "Apart from any condition you have already told us about in this form …". In assessing the claim, Vitality's relevant employees had all called up and referred to the medical information they already held from previous applications for policies by Mr Cowie. It appeared to be the case that, by the time of the 2015 application, Vitalityhad decided to introduce automatic underwriting which did not allow for any routine cross-checking by the computerised system for any medical or other information already held by it on any individual applicant. But that was Vitality's choice and not something for which Mr Cowie bore any responsibility.

[123] Section 3(4) of the 2012 Act enjoined the court, when determining in the light of all the relevant circumstances whether or not a consumer had taken reasonable care not to make a misrepresentation, to take into account any particular characteristics or circumstances of the actual consumer of which the insurer was, or ought to have been aware. Vitality and Mr Cowie in this case were both aware when he was filling in this form that it already held information about him. The pursuer had pointed this out to it when correspondence about the rejection of the claim was being exchanged, but Miss Tsebe had confirmed that Vitality's employees were consciously instructed by higher management not to address the points raised by the pursuer when responding to her, apparently because she was being helped in making those points and because Mr Cowie had been a lawyer. Such a policy of deceptive evasiveness on the part of Vitality constituted a breach of its duties of

utmost good faith *qua* insurer to act at all times when dealing with the claim on the policy in a manner which was reasonable, fair and transparent. In sum, a reasonable consumer exercising reasonable care in November 2015 who had, in April 2010, already previously advised the insurer that he had suffered from "any disease or disorder of the digestive system" and had undergone a medical examination and had a policy approved by the insurer on standard rates thereafter, would form the view that it was not interested in any duplication of information already held. A reasonable consumer exercising reasonable care would reasonably assume in these circumstances that, if the insurer had wanted him to provide further more up-to-date information about "any disorder of the digestive system" he might have had in the last 5 years, it would contact him once it had received his application and seek such further information as it might require. In these circumstances, given Vitality's prior knowledge of Mr Cowie's health, it had not shown that the answer to the question in issue involved a misrepresentation in breach of the duty set out in section 2(2) of the 2012 Act.

[124] The next issue with the question in issue concerned the words "Any disorder of the digestive system". As the pursuer had also pointed out to Vitality in her correspondence with it, Mr Cowie could not be said to have had, in the 5 years prior to filling in the form on 13 November 2015, any "disorder" of the digestive system but had merely suffered historically from infrequent bouts of acid reflux which had resolved before the relevant period following surgery in 1997. Vitality had also deliberately ignored this point in its response for no good reason, thus demonstrating a culture of dealing with the claim in a manner which contravened its continuing duties to deal with claims with utmost good faith. The forms issued by or on behalf of Vitality used the different expressions "disorder" and "disease". A reasonable consumer might understand that the insurer was meaning different

things and seeking to find out different information by the use of such different words. As was noted in *Kennedy* v *Smith*, 1975 SC 266 at 277 – 278, 1976 SLT 110 at 116 per Lord President Emslie:

> "[I]n *Anderson v. Fitzgerald*, 4 HLC 484, Lord St Leonards said this:— 'A policy ought to be so framed, that he who runs can read. It ought to be framed with such deliberate care, that no form of expression by which, on the one hand, the party assured can be caught, or by which, on the other, the company can be cheated, shall be found upon the face of it.' The same sentiment has repeatedly been expressed by judges ever since and for example Lord Wright in *Provincial Insurance Co Ltd* v *Morgan*, 1933 AC 240 put it thus— 'For myself I think it is a matter of great regret that the printed forms which insurance companies prepare and offer for acceptance and signature by the insuring public should not state in clear and unambiguous terms the events upon the happening of which the insuring company will escape liability under the policy. The present case is a conspicuous example of an attempt to escape liability by placing upon words a meaning which, if intended by the insurance company, should have been put before the proposers in words admitting of no possible doubt.' I quote one further example. It comes from Lord Greene MR in *Woolfall & Rimmer Ltd* v *Moyle*, 1942 1 KB 66 and is in these terms— 'If underwriters wish to limit by some qualification a risk which, *prima facie*, they are undertaking in plain terms, they should make it perfectly clear what that qualification is. They should, with the aid of competent advice, make up their minds as to the qualifications they wish to impose and should express their intention in language appropriate for achieving the result desired. There is no justification for underwriters who are carrying on a widespread business and making use of printed forms, either failing to make up their minds what they mean, or, if they have made up their minds what they mean, failing to express it in suitable language. Any competent draftsman could carry out the intention which [counsel] imputes to the document, and, if that was really intended, it ought to have been done.'

[125] Dr Lord in his cross examination had not demurred from the suggestion put to him that the words "disorder" and "disease" were sometimes used interchangeably, but that there were clear differences between them; a disorder was a group of symptoms that disrupted normal body functions but did not have a known cause, while a disease was a medical condition with an identifiable cause. The medical evidence was that the cause of Barrett's Oesophagus was known. It was not described either by Dr El-Nujumi or by Mr Fullerton as either a disease or a disorder. Mr Fullerton had described it as a "complication", which sometimes occurred in persons who were prone to, or had suffered

over the years from, chronic gastric acid reflux. It was a complication because, even although itself asymptomatic in some cases, cells affected by Barrett's Oesophagus might mutate and develop into oesophageal cancer. In all the circumstances Vitality had not shown that in denying any "disorder" of the digestive system, Mr Cowie had made any misrepresentation in breach of his section 2(2) duty.

[126] Further, the question which Vitality's claims assessors and underwriters relied upon in 2017 made no express mention of Barrett's Oesophagus or Barrett's Island, or dyspepsia or irritable bowel syndrome. Given that there were apparently in place on 13 November 2015, within Vitality, specific Decision Pathway Rules for their claims assessors and separately Underwriting Guidelines for their underwriters in respect of Barrett's Oesophagus respectively, one might reasonably have expected it to have included a question specifically about this condition. Vitality had lodged specific Decision Pathway Rules in force as at 13 November 2015 for their claims assessors (but no Underwriting Guidelines for their underwriters) in respect of Dyspepsia/Acid in Stomach/Heart Burn/heartburn /Indigestion. No specific questions were asked about those matters either. No Decision Pathway Rules or Underwriting Guidelines had been provided in relation to Irritable Bowel Syndrome, making that difficult to treat as something which Vitality considered important enough to affect its acceptance of proposal for life assurance. It followed that Vitality was claiming that the question was to be understood as implicitly asking about those conditions. The common law allowed for the possibility of terms being implied into contracts. The manner in which terms might be implied into contracts was settled in *Marks & Spencer Plc* v *BNP Paribas Securities Services Trust Co (Jersey) Ltd* [2015] UKSC 72, [2016] AC 742, [2015] 3 WLR 1843, reaffirming the traditional test of necessity, and not merely reasonableness or fairness. The conditions for establishing necessary implication

were strict, and essentially grammatical. As Lord Hobhouse noted in *R (Morgan Grenfell)* v *Special Commissioners of Income Tax* [2002] UKHL 21, [2003] 1 AC 563, [2002] 2 WLR 1299 at [45], necessary implication was to be distinguished from "reasonable implication":

> "It is accepted that the statute does not contain any express words that abrogate the taxpayer's common law right to rely upon legal professional privilege. The question therefore becomes whether there is a necessary implication to that effect. A necessary implication is not the same as a reasonable implication. A necessary implication is one which necessarily follows from the express provisions of the statute construed in their context. It distinguishes between what it would have been sensible or reasonable for Parliament to have included or what Parliament would, if it had thought about it, probably have included and what it is clear that the express language of the statute shows that the statute must have included. A necessary implication is a matter of express language and logic not interpretation."

[127] The conditions required for it to be found to be a necessary implication that the question under examination was to be understood as including any of Barrett's Oesophagus, Barrett's Islands, dyspepsia or Irritable Bowel Syndrome were not present. It was neither necessary to give the insurance contract business efficacy nor was it a reading-in that "every reasonable man on the one part would desire for his own protection to stipulate for the condition, and that no reasonable man on the other would refuse to accede to".

[128] The next issue was what "including" meant in the question. It was necessary in that connection to consider the wording of the question as a whole, and to note specifically that it had the word "including" followed by a list of specific matters it is asking about. Using the word "including" followed by a list of discrete named disorders added another level of complexity. "Including" used in this way was a word which could bear more than one meaning. It might indicate a closed list, which is to say that it would indicate to a reasonable consumer that the only disorders which the insurer was interested in knowing about were those and only those expressly set out in the list. That "closed list" interpretation of "including" was the basis for the legal maxim *expressio unius est exclusio alterius* – i.e. if one

chose expressly to list particular instances of a condition, one was to be taken to be understood as excluding any other (even like or similar conditions) not expressly mentioned. The word could also be used simply to introduce an open list of illustrative examples, but if that was the intended meaning then lawyers habitually added "including, without prejudice to the foregoing generality …" or "including, but not restricted to …" because without the addition of such phrases the word "including" could certainly mean "including and restricted to". Reference was made to *Caledonia North Sea* v *London Bridge Engineering Ltd* 2000 SLT 1123 per Lord Sutherland at 1174 and Lord Coulsfield at 1193; *Dilworth* v *Commissioner of Stamps* [1899] AC 99, per Lord Watson at 105 – 106; *Commissioners of Customs and Excise* v *Savoy Hotel Ltd* [1966] 1 WLR 948 per Sachs J at 954; *R* v *Income Tax Special Commissioners ex part National Union of Railwaymen* [1967] 1 WLR 263; *Church* v *HM Advocate* 1995 SLT 604; *National Asset Management Agency* v *Commissioner for Environmental Information* [2015] IESC 51, [2015] 1 IR 626; and *Department of Finance* v *Quinn* [2019] NICA 41. The first problem for Vitality in its assertion that the meaning of the ambiguous word "including" which favoured their interest was to be preferred was that the circumstances of this case concerned a consumer contract which was covered by the provisions of the Consumer Rights Act 2015. Section 69(1) of the 2015 Act provided as follows:

> "69. Contract terms that may have different meanings
>
> (1) If a term in a consumer contract, or a consumer notice, could have different meanings, the meaning that is most favourable to the consumer is to prevail."

[129] The proposal form fell within the definition of a "consumer notice" contained in subsections 61(7) and 61(8) of the 2015 Act, and in any event concerned the terms upon which a consumer insurance contract was concluded. Accordingly, where a term in it could have different meanings, the meaning that was most favourable to the consumer had to

prevail. That was a statutory consumer protection provision which was distinct from (and did not displace or repeal) the common law protections already afforded to individuals taking out insurance contracts by the *contra proferentem* principle of interpretation. Section 69(1) of the 2015 Act created an additional hurdle for the Vitality to overcome, involving as it did a consumer notice and a consumer contract. In the present case the meaning of "including" in the questions in the proposal that was most favourable to Mr Cowie *qua* consumer was that it set out instances forming a closed list, rather than simply providing examples of a broader open category. On a reading of the question compliant with section 69(1), the answer "No" by Mr Cowie did not constitute his making a misrepresentation in breach of his duty set out in Section 2(2) of the 2012 Act.

[130] The second problem for Vitality in its assertion that the meaning of the ambiguous term "including" which favoured its interest was to be preferred was that the case involved a proposal form for an insurance contract, to which the common law principle of *contra proferentem* interpretation applied. The courts in Scotland (and elsewhere) had been especially diligent in applying this principle against insurance companies seeking to deny their liabilities under insurance contracts which they had entered into with individuals who were not acting in the course of their own business. The common law doctrine of *contra proferentem* interpretation was described relative to the proposer's obligations of disclosure in *Life Association of Scotland* v *Foster* (1873) 11 M 351 by Lord President Inglis at 358 as follows:

> "[I]t is further to be kept in mind that such obligations fall to be construed strictly *contra proferentem*. This rule, founded on plain justice, is quite settled in practice. Insurance companies have the framing of their contracts in their own hands. They may make such conditions as they please, but they are bound so to express them as to leave no room for ambiguity."

[131] Reference was also made to *Craig* v *Imperial Union Accident Assurance Co* (1894) 1 SLT 646 per Lord Kincairney at 647 and to *Condogianis* v *Guardian Royal Insurance Co* [1921] 2 AC 125 per Lord Shaw of Dunfermline at 130. In *R & R Developments* v *Axa Insurance* [2009] EWHC 2429 (Ch), [2010] Lloyd's Rep IR 52, the court stated at [34] that:

> "Whilst obviously there is no limit on what question insurers may ask, where the scope of the intended questions is as wide as these insurers contend, they must ask them clearly and explicitly: no court is going to assist insurers with a benevolent construction of questions which (if they were indeed what was intended) were asked in a muddled and confusing manner."

[132] The pursuer was not relying on the *contra proferentem* principle to create or invent ambiguity where none existed. Vitality's own witnesses differed amongst themselves and were unclear about what aspects of the proposal form meant, especially the phrase "apart from any condition you have already told us about" and about the distinctions between a "disease", a "disorder" and a "condition". It was wholly appropriate in such circumstances for the court to invoke the *contra proferentem* principle in approaching the proper interpretation of the question which Vitality purported to rely upon in its decision in 2017 to refuse the claim and repudiate the contract, namely the question concerning and only concerning disorders of the digestive system. In *Ristorante* v *Zurich*, (a case which did not involve a consumer insurance contract) the *contra proferentem* principle was described per Snowden J as follows at [35] – [36].

> "[35] When the court is interpreting questions posed by insurers rather than a negotiated contract term, a different approach applies under which any genuine ambiguity is resolved in favour of the applicant. Thus, if faced with two rival constructions, both of which are objectively reasonable, the insurer will not be entitled to impugn as a misrepresentation of fact an answer given by the policy holder if that answer was true having regard to a construction which it was objectively reasonable to give to the question: see MacGillivray at [16-026]: 'If there is genuine ambiguity in a question put to an applicant by insurers in a proposal form or elsewhere, the latter cannot rely upon the answer as a misrepresentation of fact if that answer is true having regard to the construction which a reasonable man might put upon the question.'

> [36] The same point is illustrated by the remarks of MacKinnon J in *Revell* v *London General Insurance Co Ltd* (1934) 50 Ll L Rep 114 at 116: 'I think Mr Samuels is right when he says – indeed, it is elementary – that if there is an ambiguity in this question so that upon one view of the reasonable meaning which is conveyed to the reasonable reader of it the answer was not false, the company cannot say that on the other meaning of the words the answer was untrue so as to invalidate the policy.'"

[133] If, contrary to what had already been submitted, the court were to find that there had indeed been a misrepresentation by Mr Cowie in responding "No" to the question under discussion, then under the 2012 Act the question which would then arise for determination was whether or not Vitality had satisfied the court that the misrepresentation was made by Mr Cowie in breach of his statutory duty as a consumer to take reasonable care not to make a misrepresentation to the insurer. The pursuer submitted that that question should be answered negatively. It was the retrospective underwriting decision of Mr Bescoby on 17 February 2017 which had been the basis for Vitality's decision to advise the pursuer that it was refusing to pay out on her claim under the policy and was repudiating the contract and returning the premiums paid to date. It did not then advance any claim that Mr Cowie had failed in his statutory duty as a consumer to take reasonable care not to make a misrepresentation to the insurer and indeed had failed to specify just what question was said to have been wrongly answered.

[134] Its decision appeared to have been made on the basis of a misunderstanding or misrepresentation of the law to the effect that Mr Cowie had a duty proactively to disclose or volunteer all and any information which the insurer might consider relevant to its entering into this contract, an attempted restatement of the common law duties associated with the legal doctrine of *uberrimae fidei*, which no longer had any application to an individual consumer seeking insurance in the UK. It was clear from Vitality's internal files that the only alleged misrepresentation upon which it in fact relied in refusing this claim in

2017 was the answer to the question regarding any disorders of the digestive system. It assumed that a positive answer to that question would have led to the provision of a GP report from which the deranged liver function tests and the unsurveilled Barrett's would have emerged. There was, however, no evidence as to what such a report would in fact have revealed. Vitality had presented no relevant defence in relation to the lawfulness of the decision that was actually taken in 2017. It was already aware at the time of the November 2015 policy application, from two previous insurance policy applications by Mr Cowie, of his history of digestive system problems, with investigations and treatment, and had nonetheless previously offered him full life cover on standard rates in the knowledge of that history. Against that background, it was entirely unclear on what basis it might be suggested that there was any misrepresentation by Mr Cowie in relation to that matter when he applied for the cover in November 2015. If Vitality had wanted more up-to-date information on this matter from him to supplement and add to what it already knew before offering him cover and concluding the contract it could have asked for it.

[135] It was clear from Dr McLennan's evidence that there were no GP records for Mr Cowie prior to 12 November 2015 which referred to intracerebral haemorrhage, coagulopathy or liver cirrhosis. Although the medical records referred to abnormal liver function tests carried out in 2014, those results were wholly unrelated to his diagnosis of cirrhosis in 2016. An ultrasound on the liver which was carried out in 2014 showed no evidence of cirrhosis, and the initial deranged readings on liver function subsequently resolved back to a normal range without any treatment or intervention. Vitality was aware of this when it declined the claim. The fact that the liver function tests resolved down towards normal levels and the ultrasound showed no liver damage led the treating physicians at the time in 2014 to advise Mr Cowie's other doctors that the test results may

have been attributable to a passing and now resolved viral illness which had caused temporary liver inflammation, rather than indicative of there being any underlying disease or disorder of a less than healthy liver. Again, Vitality was aware of this. More specifically on the issue of Mr Cowie's alcohol consumption, the medical consensus in 2014 was that if and insofar as alcohol might be implicated in the liver function test readings highlighted, that was not because of excessive alcohol consumption but rather because, in Mr Cowie's case, his liver appeared to have an acute sensitivity to alcohol consumption of any amount. Vitality was again aware of this.

[136] In *Hutchison* v *National Loan Fund Life Assurance Society* (1845) 7 D 467 Lord President Boyle observed at 470, 474 – 476:

> "If I thought the view pressed by the Insurance Company was the law, I should say there was an end to all life insurance in time to come ….The doctrine pressed by the Insurance Company just amounts to this: that when a person dies a post mortem examination is warranted, and if anything should be found that indicate, an incipient or latent disease, though there were never any symptoms, and there is no insinuation of fraud or gross negligence, there is a breach of the warrandice, which voids the insurance. I can arrive at no such conclusion. Such a doctrine is not deducible from the strongest of the authorities. If a person is not guilty of any negligence in acquiring knowledge of his own condition - if this is not established, there is no breach of any warranty. It appears to me to be extravagant to maintain that an insurance may be voided upon an inquisitorial investigation into latent evils in constitution of the party, who has no indication of disease at the time of the insurance;-upon a latent defect in the constitution, which, though not the cause of death, might have been."

[137] In *Life Association of Scotland* v *Foster* (1873) 11 M 351, Lord Deas said at 366:

> "I cannot entertain a doubt that it is one reason amongst others why many prudent people insure their lives for the benefit of their families, that there may be undeveloped diseases lurking in their system, or congenital peculiarities, unknown and unsuspected, and yet that the result often is that they live to pay premiums which, if saved and accumulated, would greatly exceed the amount assured and payable at death. Most people would pause, I think, in effecting a life assurance if informed in plain terms, that however candid their statements, it could not, by possibility, be determined, till they were dead and dissected, whether their families would be entitled to anything under the policy, or whether, on the contrary, all the money paid for it in the shape of premiums would be forfeited. Many, I think,

> would decline altogether to enter into the proposed contract, and, if this would be so were such an explanation given of its nature, I cannot think that assurance companies, by wrapping up the matter in generalities, or using language which is not clear and unequivocal, ought to be allowed to prevent the applicant from considering, with his eyes open whether he will enter into such a contract or not."

[138] The evidence of Mr. Cowie's cirrhosis in 2016 (after the contract was entered into) was revealed and confirmed by a CT scan of his thorax, abdomen and pelvis carried out on 22 September 2016 and separately by ultrasound of his abdomen carried out on 27 September 2016. It was this liver cirrhosis which was listed as a presumed underlying cause of his death by having decreased his blood's ability to clot (because of low platelet levels) following his brain haemorrhage in late October 2016. Once again, Vitality was aware of all this. The aetiology of the underlying liver cirrhosis which was referred to in his death certificate was never established during his lifetime. A number of possible factors were mentioned in the records, including alcohol, non-alcoholic fatty liver disease and viral illness. The possibility of liver cancer was not ruled out on the basis of the 2016 scan. None of that was known to, or predicted by, his doctors in 2014. It was reasonably to be inferred that at the material time Mr Cowie understood his liver function test results to have normalised and to have been a temporary spike only because of a sensitivity to alcohol, rather than to any underlying liver disease disorder or pathology. Accordingly, answering "no" to the question in issue did not in all the relevant circumstances constitute breach of Mr Cowie's statutory duty to take reasonable care not to make a misrepresentation to the insurer.

[139] On 30 November 2010 Mr Cowie had attended Mr Fullerton for an endoscopy which resulted in the ablation of a small residual Barrett's Island on 30 November 2010. That was 17 days short of 5 years dating back from 13 November 2015. The letter sent by Mr Fullerton recording the ablation did not appear to have been sent or copied to Mr Cowie.

Mr Fullerton's evidence was that the ablation apparently performed on Mr Cowie on 30 November 2010 was carried out as part of the routine follow-up three months after initial treatment, and its purpose was to check on the success of an initial larger scale balloon radio frequency ablation treatment in late August or early September 2010. Mr Cowie would have consented prior to the procedure both to the endoscopy and, if any residual Barrett's was found during this procedure, to its further ablation. The endoscopy would have been carried out under either general anaesthetic or heavy sedation. He might have been told of the further ablation after awakening from the sedation/anaesthetic used in procedure, but the main message which was given to and received by him was that the procedures he had undergone in 2010 had resulted in the complete eradication of the Barret's Oesophagus. Having regard to the central question with which the court had to engage – what did Mr Cowie know at the time of completing the proposal form – and bearing in mind Vitality's choice to ask binary questions without any room for nuance – it was clear that Mr Cowie understood his Barrett's to have been successfully treated and no longer to be present. It was reasonable for him to believe that. Accordingly answering "no" to the insurer's question did not in all the relevant circumstances constitute a breach of his statutory duty under the 2012 Act.

[140] In any event, Vitality required to satisfy the court that but for a misrepresentation by Mr Cowie, it would not have entered into the contract. It had led no evidence from any of the original decision-makers on this point. Its files relating to the refusal of the claim in 2017 indicated that if there had been no misrepresentation in relation to the question about gastro-intestinal and digestive issues, Vitality would have requested a targeted GP report on, and only on, this issue. The terms of just what this notional report would have been were nowhere specified; it was simply assumed that such a report would have alerted

Vitality to the history of deranged liver function and the unsurveilled Barrett's. Vitality had had the opportunity at the proof to lead evidence about what this notional report would be likely to have contained, but chose not to do so. In any event its employees were not even applying the correct legal test on the issue of what might constitute a "qualifying misrepresentation". The 2017 file entries showed no reference to the requirements of the 2012 Act. Instead, it was clear that the decision to refuse the claim and repudiate the contract was made on the basis of an alleged breach by Mr Cowie of a duty of non-disclosure. Section 2(4) of the 2012 Act provided that "The duty set out in subsection (2) replaces any duty relating to disclosure or representations by a consumer to an insurer which existed in the same circumstances before this Act applied." Vitality had not even attempted to adduce any evidence that had the original decision-makers applied the law as it in fact stood, then the decision would have been that the terms offered for the life cover in this case should be retrospectively withdrawn. If Mr Cowie had made any misrepresentation, Vitality had no remedy open to it because it had failed to produce any evidence showing that any such misrepresentation was indeed a "qualifying misrepresentation" as required in terms of section 4 of the 2012 Act.

[141] It was axiomatic that the court would not allow itself and its procedures to be used in any manner which enabled any litigant before it to benefit from its own unlawful acts, as a matter of public policy which applies equally to defenders as to pursuers. Thus, the court could sustain the defence allowed for under the 2012 Act only if satisfied that Vitality had come to the court, and prosecuted its defence, "with clean hands". Within the insurance law context, that meant that the insurer had acted at all times in accordance with its duties of utmost good faith. In *Strive Shipping Corp & Anor* v *Hellenic Mutual War Risks Association*

(Bermuda) Ltd ('The Grecia Express') [2002] EWHC 203 (Comm), [2003] 1 CLC 401 at 474C-D, 480E, Colman J said:

> "The court's jurisdiction to avoid for misrepresentation or non-disclosure therefore cannot be exercised without regard to whether the insurer has acted consistently with his duty of the utmost good faith. If he has failed to do so, the court must decide whether such failure should disentitle him to avoidance of the policy. … Having regard to the equitable origin of the jurisdiction to avoid a policy for breach by the assured of the duty of the utmost good faith, the court should not be inhibited from giving effect by appropriate orders to the insurers' countervailing duty of the utmost good faith to the assured. The breach of that duty by the insurers would be so unconscionable as to disentitle the insurers from invoking the equitable jurisdiction of the court to avoid the contract on the grounds of non-disclosure by the assured."

[142] Vitality had not come to the court with clean hands, or having complied with its duties of utmost good faith *qua* insurer. It had become plain in the course of the proof that it had, from the outset of receiving the claim, behaved in a manner which was wholly incompatible with, and in contravention of, its common law duties of utmost good faith to deal with the claim on the policy fairly and transparently, and at all times to act reasonably, fairly and transparently in relation to the pursuer during and after her lodging of this claim. Not only that, but it did not even follow its own supposed internal procedures, which were said to conform to standard industry practice. It had, contrary to its own pre-2019 "claims philosophy", sought medical information about Mr Cowie after the claim was made with no reason to believe that there had been misrepresentation. Likewise, it had acted on the basis of information sent to it which it had not requested, and had not sought the release of that information specifically or asked about the reasons for any apparent non-disclosure before making a decision about what to do with the claim. Its witnesses were unable to explain any of that.

[143] In *Drake Insurance plc* v *Provident Insurance plc* [2003] EWCA Civ 1834, [2004] QB 601 Pill LJ said at [177]:

> "[A] failure to make any enquiry of the insured before taking the drastic step of avoiding the policy was in my judgment a breach by the insurer of the duty of good faith. …[T]he duty of good faith required them at least to tell the insured what they had in mind and give him an opportunity to update them …. If more than lip service is to be paid to the principle that an insurer shall show the utmost good faith, the principle in my judgment required that enquiry to be made before the 'wholly one−sided' remedy of avoidance was exercised.."

[144] A further breach by Vitality of its common law duties of utmost good faith was established by the manner in which it dealt with the pursuer's appeal against its original decision to refuse the claim. It had specifically decided not to respond to the points that the pursuer had raised, preferring to leave the grounds for its decision vague, and further had made false claims to her that the appeal had been referred to a Claims Review Committee including a medical officer and a legal adviser. No such persons were involved in considering the appeal. The same employee, Maureen Richards, was behind the initial decision to refuse the claim and also to refuse the appeal, despite it having been claimed that the review had been independent of the initial decision-making process. Vitality had been in breach of contract as at the date of its purported repudiation of the insurance contract in 2017. The rights of the parties were fixed at that point and was not now open to Vitality, consistently with its duties of utmost good faith, to attempt at proof to found on different bases for its decision than those upon which had founded at the point at which it advised the pursuer of the unilateral ending of their contract. In *American Paint Service* v *Home Ins Co of New York* 246 F2d 91 (3d Cir. 1957) the United States Court of Appeals for the Third Circuit noted at 94:

> "If the insurer denies liability and compels the insured to bring suit, the rights of the parties are fixed as of that time for it is assumed that the insurer, in good faith, then has sound reasons based upon the terms of the policy for denying the claim of the insured. To permit the insurer to await the testimony at trial to create a further ground for escape from its contractual obligation is inconsistent with the function the trial normally serves. It is at the trial that the insurer must display, not manufacture, its case."

[145] In *Fargnoli*, Lord Penrose noted at 31B:

> "[I]t follows from the mutuality of the obligation of utmost good faith that an insurer has similarly rigorous duties in dealing with claims. It must be open to question whether an insurer would be in good faith in delaying an admission of liability, or in advancing spurious defences to a claim, or to put the insured to proof of what the insurer knows is true, or in delaying settlement of claims which he would, objectively, be obliged to admit before a court to be valid. Since one is concerned with mutual obligations, it is difficult to see why breach of such a duty by an insurer should have consequences different from those which properly follow a breach by the insured."

[146] Various other claims of misrepresentation made in Vitality's pleadings were, it seemed, no longer being relied upon by it. Nonetheless, it was a breach of its duty of utmost good faith for it to have stated them in the first place. It was in these circumstances unable to rely upon and seek any of the remedies which Schedule 1 to the 2012 Act otherwise provided to insurers who relevantly, and in accordance with their overriding duties of utmost good faith owed to those making claims on an insurance contract, identified and found on qualifying misrepresentations.

[147] Vitality was still relying on Mr Cowie's positive responses to the following series of questions as amounting to a qualifying representation:

> "Apart from anything you have already told us about in this form within the last 2 years have you undergone any investigation such as blood tests, scans or biopsies? If so for what condition (or suspected condition)"
>
> " … was the test part of a routine 'well person' check or pregnancy"; and
>
> "… was the result normal"

[148] However, it was not open to Vitality to seek to defend the lawfulness of its decision on the claim on any grounds other than those in fact founded upon by its decision makers in February 2017. That was a requirement of the duties of utmost good faith which it owed to the pursuer.

[149] In any event there had been no misrepresentation, because there was no reference in any of the questions in the proposal form to liver function tests, and so Mr Cowie could not properly be expected to mention or volunteer having had such tests, particularly against a background that he been told by his doctors in 2014 that his liver function numbers spontaneously improved without medical intervention, that the recorded variation in these numbers could be ascribed to his particular sensitivity to alcohol and/or viral illness, and that there was no sign on examination of any underlying liver disease. Vitality had provided no definition or explanation of what was to be considered "a routine 'well person' check"; the 2014 liver function tests and ultrasound could properly be described as such within the context of normal medical practice. There was no evidence about whether or not Mr Cowie underwent any form of well-person check in the two-year period immediately prior to filling in the proposal form in November 2015. Vitality simply assumed that he had not. It could have asked the pursuer before making its decision to refuse this claim, but did not. There was no support for the evidence of Mr Downes that when, filling in the proposal form, "yes" answers would have permitted additional information to be included or further specified by way of a drop box which would then appear. Mr Reynolds had said that the form only allowed for binary responses. Even if there had been a qualifying misrepresentation, Vitality had not established that it would not have entered into the contract but for any misrepresentation. If it had sought further information about the proposal, and had determined there to be an increased risk of particular illnesses, it might at most have excluded certain illnesses from cover. It would not have refused all cover if acting reasonably. Given that the cause of the Mr Cowie's death was entirely unrelated to any of the matters on which it sought to rely, the obligation to make payment under the policy of insurance would, therefore, have remained unchanged.

[150] The defender had listed a variety, and ever-changing list, of witnesses. It had determined not to call as witnesses any of the individuals who were actually responsible for making the 2017 decision at issue in the case – whether in February 2017 to refuse the claim, or in December 2017 to turn down the appeal. No proper or adequate explanation had been given for that. It had selected only existing employees to speak to the internal processes of itself and Hannover Re, and its legal department had drafted the witness statements presented to the court under reference only to a pre-selected package of documents from the information available to it. What those individuals spoke to was not their own original, spontaneous, unmediated and untainted evidence. It was in large and crucial measure not credible nor reliable.

Decision

[151] As already noted, certain issues initially ventilated at the preliminary proof made a reappearance at the substantive hearing. Counsel for Mrs Cowie sought to take one of the rationales for Vitality's undertaking – that Dr McLennan had in his earlier statement identified specific elements of the records as not relevant to Mr Cowie's death – and to generalise it into a deemed undertaking by Vitality not to rely on documents which Dr McLennan at any point might opine were not relevant to the causes of death. That was not what was undertaken, and as my decision at the conclusion of the preliminary proof was that the medical records as a whole were admissible, the suggestion that the undertaking should be extended at the hand of the court falls to be rejected.

[152] In advance of and in the course of the substantive proof, further, it became apparent that Mrs Cowie wished to maintain objections to evidence being adduced from the medical witnesses who had not provided witness statements (being Mr Fullerton, Dr El-Nujumi and

Mr Taylor) which concerned their discussions with Mr Cowie in the various consultations they had respectively had with him on the basis of general medical confidentiality and more specifically because it was maintained that the disclosure of such material was not strictly necessary for the purposes of the litigation. These objections were noted and reserved, but in the event were not expressly insisted upon in submission at the close of the proof, perhaps because none of those witnesses could in fact remember any such discussions and had to surmise what might have happened from the terms of the records which I had already decided were admissible. To the extent that any residual objection remains in respect of the evidence of these witnesses, I formally repel it, for essentially the same reasons as underlay my decision that the records as a whole were admissible; by applying for a policy of life insurance, Mr Cowie put his medical history in issue insofar as it touched upon the truth or accuracy of his answers to the questions which were posed of him in the relative proposal form.

[153] Similar objections were made to certain elements of the further witness statement provided by Dr McLennan; indeed, some pressure had been put on him by the pursuer's agents not to provide any such statement at all. This naturally was a cause of some concern to him, and I allowed counsel representing him to be present in court when he was giving evidence and to make any appropriate representations both in writing before the proof commenced and orally at its conclusion. However, like the other medical witnesses, Dr McLennan could recall little or nothing of materiality beyond what was suggested by the records already deemed admissible and, to the extent that any objection ultimately remained to his evidence, it falls to be repelled for the reason already stated.

[154] Counsel for the pursuer also strenuously put to Dr McLennan, and even more so to the witnesses from Vitality and Hannover Re, that the content of their witness statements

had been unduly influenced by agents who had assisted in their composition. As to Dr McLennan, I consider that the mistakes which were undoubtedly made in the preparation of his statement for the preliminary proof had not been repeated at this stage of proceedings. His later statement appeared to me to have been very carefully and circumspectly drafted and at no point did he feel constrained to depart from its terms. It became apparent in the course of the cross-examination of the Vitality and Hannover Re witnesses that there must have been a substantial degree of assistance from agents representing Vitality in their composition, despite the initial reluctance of the witnesses in question to accept that. The statements contained some striking similarity in phraseology which could not sensibly be ascribed to coincidence. There is, however, nothing inherently wrong with witnesses receiving an element of direction from agents as to what their statements should cover or how it should be structured, so long as any influence or direction does not extend to the substance of what is said. Nothing of the latter appeared to me to have been made out in the present case. I have commented on other occasions about the somewhat haphazard and precipitous mode by which the use of witness statements as a substitute for oral evidence in chief came to be introduced into the practice of the court, with a consequent lack of planned and effective regulation, and about the desirability of clear and practical guidelines being set down by the appropriate regulatory bodies as to what is and is not proper practice in their composition. At least until that point is reached, an element of judicial wariness will inevitably remain priced into their treatment as representing the spontaneous and unadulterated recollection of the witness, and objectively supportive evidence will be at a premium, as has been recognised in England and Wales. Beyond that, nothing was established in the circumstances of the present case to warrant the criticised statements being treated as more especially unreliable.

[155] As to the witness evidence itself, I was not particularly impressed by Mr Reynolds, who is technically a defender to the action. He seemed somewhat alarmed by the prospect of being involved in a dispute about liability arising out of a policy he had arranged, and appeared to have an acute awareness of where his interests might lie. He would either not listen to certain questions asked of him or, worse, listen and then try to reframe them into something more comfortable for him to answer. I do not place any weight on his evidence and, insofar as the involvement of an agent in the conclusion of the policy in question is a matter which may be taken into account in terms of section 3(2)(e) of the 2012 Act in determining the question of whether reasonable care was taken not to make a misrepresentation to the insurer, am not inclined to treat his involvement as adding to the evaluation exercise which the court has to undertake in this connection.

[156] As to the medical witnesses, they were trying to do their best to assist the court about matters of which they understandably had little or no actual recollection. It is fair to say that Mr Taylor did not appear to be trying particularly hard in that connection, and was noticeably more casual and suggestible in his evidence than were the others. It is unfortunate that Dr Dover, to whom he referred Mr Cowie after the first cancellation of the planned neck operation, did not give evidence. He might well have been able to cast more light on just what was going on with Mr Cowie's liver at that time, but in the event did not appear.

[157] The correct approach to a case, like this one, governed by the provisions of the 2012 Act, is the tripartite one identified by HHJ Pelling in *Jones* v *Zurich*. In this case, a fourth stage is required, to determine whether Vitality breached any duty of utmost good faith incumbent upon it in its handling of the claim, and, if so what if any consequences that may have on what would otherwise have been the parties' rights and obligations.

Proper construction of the proposal form

[158] The first stage of the exercise is to determine objectively, and taking account of the requirements of section 69 of the Consumer Rights Act 2015, just what the questions posed in the proposal form meant. That is to say, what would a reasonable person in the position of the proposer understand them to be asking? This is not an exercise of seeking to imply into the terms of the proposal form some matter which they do not, on a proper construction, comprehend. It is simply concerned with determining the true meaning of what they set out. The answer to that enquiry will enable a determination to be made as to whether the answer given to a particular question was objectively wrong, i.e., at odds with the true facts, and thus constituted a misrepresentation.

[159] The first question relied upon by Vitality as having given rise to a misrepresentation by Mr Cowie was in the following terms:

> "Your health in the last 5 years
>
> Apart from any condition you have already told us about, have you had any of the following in the last 5 years: …
>
> Any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel, including Gastric ulcer, hepatitis, Pancreatitis, Colitis or Crohn's disease"

[160] Three issues of interpretation attend that question for present purposes. Firstly, does the expression "Apart from any condition you have already told us about" refer to conditions already disclosed in the proposal form, or to conditions about which Vitality had at any previous point been informed by Mr Cowie, even in connection with different policies? Secondly, what ought the word "disorder" be regarded as comprehending? Thirdly, does the word "including" limit what the question is asking about to the disorders then specifically set out?

[161] Dealing with the first of those matters, I accept the submission that, for section 69 of the 2015 Act to operate, there must be (at least) two available rival constructions, both or all of which are available constructions of the words under consideration. I would not go so far as to say that some ambiguity must persist after the normal canons of construction have been worked through; the process of construction seeks to determine the true legal meaning to be accorded to the text under construction, and in doing so to resolve any ambiguity. It follows that there must be a stopping point for consideration of the application of section 69 before the process of construction is otherwise complete if that section is to have any room at all in which to operate. That point is where, after the application of those elements of the process of construction designed to indicate available meanings has resulted in there remaining more than one such meaning which might commend itself to a reasonable man. In such circumstances, section 69 operates to select, as the meaning to be accorded in law to the text under consideration, that which is most favourable to the consumer. In that sense section 69 has become part of the legal process of construction in the cases to which it applies, rather than something sitting outside that process as a last resort to be applied only when the normal canons of construction struggle to resolve ambiguity. It was not disputed in the present case that the proposal form was a document to which section 69 might apply.

[162] The competing constructions of the phrase "apart from any condition you have already told us about" in the context already noted are, firstly, that the previously-supplied information which is referred to is information supplied in the preceding parts of the proposal form itself (the question in issue coming after a number of other questions dealing with various health conditions which might to some degree at least overlap with the conditions now specifically asked about) or alternatively that what is being referred to is information provided at some (presumably any) earlier stage in dealings between the

proposer and the insurer or indeed some entity falling to be regarded as equivalent to it in the conduct of the same business. Had the process of construction required to operate outwith the sphere of influence of section 69, the final choice as between those alternatives would have been a narrow one, since cogent arguments could have been (and were) made in favour of each. However, there appears to me to be no question that both constructions are available ones or, to put it in a slightly different way, that a reasonable man might well have been left in material doubt as to which was the correct one. That is precisely the territory in which section 69 finds its hunting ground, and the question thus becomes which construction would be most favourable to the consumer. Issues might arise as to which construction of any word or phrase under examination would as a matter of generality be more or less favourable to consumers as a whole, but section 69 appears to me to direct attention to the specific case rather than to pose any more abstract question, and in this context it is clearly more favourable to the consumer to allow any previous information supplied by him to be taken into account than to restrict consideration only to what was entered in the specific proposal form which led to the conclusion of the contract in issue. This first question of construction thus falls to be resolved as contended for by the pursuer. The practical implications of that will shortly be examined.

[163] The next construction question requiring resolution in connection with the first question relied upon by Vitality is the meaning of the word "disorder". Although a quite elaborate argument was presented as to the precise distinctions between the concepts of "disorder", "disease" and "condition", primarily from a medical viewpoint, the true question is not what any witness or witnesses in the proof considered the word might mean, but rather what the court considers it would mean to an ordinary person in the position of those to whom the proposal form was directed, i.e.members of the general public seeking

life assurance. That is a broad and relatively diverse group of persons, and it would be wrong to suppose that its members would be likely to approach the question posed in an over-exacting manner or to ponder long (or at all) on where the dividing line fell to be drawn amongst a disease, a disorder or a condition. Rather, a reasonable reader of the form would consider that what he or she was being asked about was simply whether anything had been dysfunctional, not in order or simply "wrong" with the specified organs or system during the period in question, regardless of whether the cause of that was known or unknown. I can see no circumstances in which such a reader would be left in any reasonable doubt about what was being asked by the question and thus what the answer ought to be in his or her individual circumstances. There is no room for the operation of section 69 of the 2015 Act in this instance.

[164] The final question of construction attending the first question in the proposal form relied upon by Vitality is whether the word "including" which introduces the list of specific conditions being enquired about leaves the category of conditions properly to be regarded as the subject of enquiry open, or else renders it comprehensive and closed. The suggestion that "including" is a word capable of introducing ambiguity into a phrase in which it is deployed scarcely required the citation of the volume of relative authority with which I was favoured. Few words in the English language are, devoid of context, only ever capable of conveying one definitive meaning. In the present case, however, the context in which the word appears ("Any disorder … including X, Y or Z") indicates clearly that the list of specific conditions is left as an open one. No reasonable person reading that phrase could be left in any material doubt that the specified conditions were cited as examples only of the wider set of disorders about which the question was being asked. Again, section 69 has no room for operation in such circumstances. Nor does the maxim *expressio unius est exclusio*

alterius apply; for the reasons explained by Lloyd LJ in *The Derbyshire* at [1988] AC 285D – E, the application of that maxim to what is in its terms plainly a non-exclusive list is fallacious. Accordingly, the use of the word "including" in the question under examination does not excuse any failure to disclose a "disorder" not specifically listed in the question if it otherwise constitutes a disorder of the organs or system mentioned in the sense already discussed.

[165] Turning to the second question relied upon by Vitality, it will be recalled that it is in the following terms:

> "Apart from anything you have already told us about in this form within the last 2 years have you undergone any investigation such as blood tests, scans or biopsies? If so for what condition (or suspected condition)"
>
> " … was the test part of a routine 'well person' check or pregnancy"; and
>
> "… was the result normal"

[166] This question raises fewer issues of construction. The extent of the exemption from further mention of matters already disclosed to the insurer is made explicit. The use of "such as" rather than "including" equally makes it clear that "investigation" is wider than the blood tests, scans or biopsies specifically mentioned, leaving only the meanings of "a routine well person check" and, possibly, "normal" as potential sources of controversy. The former question was one of the many aspects of the case which were fought well, if not always wisely, but I can see no real reason for doubt that in the mind of the reasonable reader of the proposal form that what is thereby being referred to is a health check undertaken other than in the context of signs or symptoms suggesting the existence of some condition or other, as opposed to something done in response to a concern based on such a sign or symptom which had manifested itself, with a view to clarifying its cause. It is not clear to me that the addition of the word "routine" succeeds in in what was presumably an

attempt to add to the clarity of the phrase, since some "well person" checks might arguably not be described as such (for example, checks undertaken before taking up some particular occupation or embarking on travel to areas without developed healthcare, or – as here – in advance of a planned operative procedure). For reasons to be explained, however, it is unnecessary in the circumstances of the present case to go into this particular matter further.

[167] Similar observations apply to the question of what might be regarded as a "normal" result of a test. In certain cases there may be scope for argument about whether any particular test result, especially when taken on a single occasion, falls to be regarded as "normal" or not, but any such issue would fall to be determined on the basis of the medical evidence made available to the court and against the criterion that a "normal" result is one which would not give a competent and careful medical practitioner any cause for concern, nor suggest to him or her a need for further investigations. Again, however, the facts of the present case give rise to no such delicate issue.

[168] Reference was made in argument to the *contra proferentem* principle of construction in connection with the proper meaning to be ascribed to various aspects of the proposal form. A detailed discussion of the potential application of that principle to the form would raise many questions, not least whether the principle still actually operates, or whether it survives only in the vestigial form of a presumption against the tacit surrender of rights which the common law would otherwise afford to a party to contractual relations created in certain types of circumstance. However, it is very difficult to see how the *contra proferentem* principle, in whatever form it may now exist, could sensibly operate as part of the exercise of construction of texts to which section 69 of the 2015 Act is applicable. In my view the statutory provisions fall to be seen, in relation to such texts, as coming in place of the operation of the common law principle. Further, had the common law principle been

applied to the issues raised by the proposal form in the present case, the result of the exercise of construction would in every instance have been the same as that produced by the application of the statutory provision. It is accordingly unnecessary to say more about the nature and incidents of the common law principle in order to deal with the issues of construction raised by the proposal form.

Existence of misrepresentations

[169] One is thus in a position to determine, against the background of the proper construction of the proposal form, whether the answers provided by Mr Cowie in November 2015 represented misrepresentations by him. Although in the course of the argument before me the distinction between the existence of a misrepresentation and the question of whether a statement was or was not made with the reasonable care required by the 2012 Act was not always clearly brought out, it is appropriate – if clarity of thought and analysis is to be maintained – to appreciate that whether or not a misrepresentation was made is simply a matter of determining whether the answer provided to a question in the proposal form did or did not correspond with the objective truth about the matter with which the question, properly construed, was concerned. If a misrepresentation was made, questions about the circumstances in which that occurred, the possible reasons for it, how far the answer deviated from the truth and similar such matters, may go to the issue of whether the standard of care demanded by the 2012 Act was or was not met, but do not alter the character of the answer as a misrepresentation.

[170] The first alleged misrepresentation complained of by Vitality is that Mr Cowie ought to have disclosed his Barrett's Oesophagus in response to the question of whether he had, in the 5 years leading up to the completion of the proposal form on 13 November 2015, and

apart from any condition he had previously disclosed, had any disorder of the oesophagus. I have already held that that question was not confined to the specific conditions further mentioned in the question. It was argued that Barrett's did not qualify as a disorder of the oesophagus within the meaning of the question in the proposal form. That argument is entirely unsustainable. As Mr Fullerton explained, Barrett's is a chronic condition involving abnormal metaplastic changes in the nature of the cells of the epithelium lining the oesophagus which, if untreated, may become dysplastic such changes and ultimately frank cancer. That amply qualifies the condition as a disorder within the meaning of the relative question. Turning to the matter of whether information provided to Vitality other than by way of the answers given in the proposal form under examination may be taken into account in determining the existence of any misrepresentation, I have already held that such other information may be taken into account on the proper construction of the form. However, Mr Cowie had never previously disclosed to Vitality or its predecessor in business that he suffered from Barrett's Oesophagus. In an application for life cover made by him in 2010 to that predecessor, he had disclosed that he suffered from acid reflux and oesophagitis and had been or was being treated for those conditions, neither of which falls to be regarded as in any way equivalent for present (or indeed any) purposes to the distinct condition separately categorised as Barrett's. Thus, although the previous disclosures exemption in the proposal form falls to be construed as contended for by the pursuer, it did not remove any requirement otherwise incumbent on Mr Cowie to disclose in 2015 that he had suffered from Barrett's in the previous 5-year period. I note in passing, lest it be thought that any implication arises that Mr Cowie ought to have disclosed his Barrett's in the 2010 application, that the evidence before me, although it shows that he was being treated for Barrett's in late 2010, does not enable any conclusion to be drawn that he was or ought to

have been aware that he was suffering from it when he completed the application made in the spring of that year.

[171] The evidence does, however, leave no room for doubt that, on 30 November 2010, and thus within the 5-year period enquired about by the proposal form, Mr Cowie was treated by Mr Fullerton for residual elements of Barrett's which then existed in his oesophagus and which had survived an earlier treatment that had occurred outwith that period. It is incontrovertible that his denial in response to the relative question that he had had a disorder of the oesophagus within that period was objectively untrue and thus constituted a misrepresentation on his part.

[172] It is next contended by Vitality that Mr Cowie's denial that he had suffered from a disorder of the liver within the relevant period was also a misrepresentation. The evidence of Dr El-Nujumi establishes that the results of liver function tests carried out on Mr Cowie in 2012 were abnormal. That episode, however, petered out without a diagnosis of any particular liver disorder having been made. The scheduled neck operation to be carried out by Mr Taylor in the autumn of 2014 was then cancelled because liver function tests carried out on the day of the surgery were again obviously abnormal. Repeated tests carried out thereafter in the period through to the latter part of October 2014 continued to produce abnormal results, albeit they were moving towards a more normal level and were (according to Dr McLennan, at least) not specific to any particular clinical scenario. Although referrals for further investigation were made (to Dr Dover and Dr Datta), again no particular diagnosis was arrived at, at least so far as the evidence before me demonstrated. There can be no doubt that at these points Mr Cowie's liver was functioning in a way other than one would expect a normal liver faced with no particular insult to be functioning. There was an issue of a nebulous kind which was manifesting itself over time in the test results. The

difficulty for Vitality lies in bridging the gap between that conclusion and the conclusion necessary for its purposes that the liver itself was in a state of disorder. That is not simply a question of the failure of any of the witnesses to identify just quite what state of disorder may have been involved; it is a matter of the need to distinguish between the test results as indicating the reaction of a liver functioning normally in reaction to the provocation of external factors to which it might have been exceptionally sensitive or as indicating the existence of some inherent disorder of the organ itself. The evidence led before me failed to establish on the balance of probabilities that Mr Cowie was suffering from a disorder of the liver in the sense already discussed during the period in issue. That he denied in his answers to the questions in the proposal form that he had suffered from any such disorder accordingly did not constitute a misrepresentation.

[173] Vitality finally relies on Mr Cowie's positive responses to the questions as to whether he had undergone any investigation within the two years before completing the proposal form, whether that was part of a routine "well person" check, and that the result was normal, as constituting a further misrepresentation, again relying on his history of abnormal liver function test results. For the purposes of this question, the episode spoken to by Dr El-Nujumi in 2012 lies outwith the relevant time period and falls to be left out of account. It might be argued that the initial liver function test done in advance of the planned operation in autumn 2014 was part of a routine "well person" check, since it was not done with a view to investigating any sign or symptom but rather as a matter of course to check Mr Cowie's fitness for the procedure, but the results were clearly abnormal. The follow-up tests done in the period to the end of October 2014 were on no view routine "well person" checks, and their results were unarguably abnormal, albeit to a lesser extent. In these circumstances,

Mr Cowie's answers to these aspects of this series of questions did not objectively correspond to the truth and constituted misrepresentations for present purposes.

Lack of reasonable care

[174] It is next necessary to determine whether, in making the misrepresentations identified, Mr Cowie failed in his duty under section 2(2) of the 2012 Act to take reasonable care not to make a misrepresentation to Vitality. It will be recalled that that is, in terms of section 3(1) of the Act, to be determined in the light of all the relevant circumstances, with examples of various matters that "may need to be taken into account" set out in section 3(2). The standard of care is that to be expected of a reasonable consumer, subject to any particular characteristics or circumstances of the actual consumer of which the insurer was or ought to have been aware, and to the fact that a misrepresentation made dishonestly falls always to be taken as showing a lack of reasonable care.

[175] I do not find certain aspects of section 3 of the 2012 Act particularly easy to understand or apply. One would hope that, in any determination of whether reasonable care had been taken in any particular situation, a court would take into account all relevant circumstances (i.e. all circumstances capable of informing the answer to the question) without any statutory injunction so to do. A non-exhaustive list of things that may be taken into account may be useful, but the phrase that certain (unidentified) aspects of any case may "need" to be taken into account suggests that the exercise is not to be regarded as one for the unlimited exercise of judicial discretion, while not indicating where the lines of the limits may fall to be drawn. The generally objective standard postulated by section 3(3) is significantly undermined by the "characteristics or circumstances" of the actual consumer concerned having to be taken into account if the insurer subjectively knew of them or

objectively should have known of them, transforming the test where such knowledge exists or is deemed to exist into what it would have been reasonable for the particular consumer with such known characteristics or in such known circumstances to have done rather than what it would have been reasonable for a consumer in general to have done. Finally, if dishonesty attended the making of the representations in question, then nothing else in the exercise which would otherwise require to be undertaken matters, since an automatic conclusion of lack of reasonable care falls to be drawn in such circumstances.

[176] Doing my best to carry out the envisaged exercise, I consider firstly the type of consumer insurance contract in question and its target market, as indicated in section 3(2)(a). Life assurance is evidently a type of contract whereby the parties enter into what may well transpire to be a long-term arrangement based on information initially provided, rather than one renewed on a periodic basis with the opportunity for the risk being undertaken to be re-assessed on the basis of new information provided on that basis. It is an arrangement likely to be of considerable importance to the consumer and (because of the sums potentially at stake) also to the insurer. Against that background, it would be clear to a reasonable person considering taking out such insurance that the state of health of the person whose life is being insured at the stage of proposal would be important and that the preparedness of the insurer to accept the risk, and on what terms, would be likely to depend on its ability accurately to assess the current and likely future state of that health. To that extent the kind of insurance in question may properly be regarded as heightening somewhat the degree of care which a reasonable person would expect to attend the completion of the proposal form. The target market for such insurance is wide and not particularly specific, extending as it does to those seeking security for their dependents in the event of their death as well as those seeking the insurance as a product for use as part of their wider financial purposes,

and I do not consider that this aspect of matters contributes materially to the decision that requires to be made.

[177] Turning to any relevant explanatory material or publicity produced or authorised by the insurer, reliance was placed in submission on various materials emphasising the importance of answering the questions asked in the proposal form correctly and accurately. I am not sure that that is quite the sort of publication at which section 3(2)(b) is directed, as opposed to material designed to suggest to the public that obtaining or making a successful claim on the insurance in question is simple and easy, of which there was none in the present case, and again I do not consider that the material to which my attention was drawn is of particular relevance to determining just what the relevant standard of care requires in this case.

[178] The next matter to be taken into account is how clear, and how specific, the insurer's questions were. Now that section 69 of the 2015 Act has also entered the field, it seems likely that (as was in part the situation in this case) any substantial lack of clarity in the questions posed will already have operated to the benefit of the consumer in the determination of what the proposal form was actually asking, and thus whether there was any misrepresentation in the first place, leaving the scope for further reconsideration of essentially the same question at the stage of deciding whether reasonable care was exercised decidedly limited. In any event, other than the matter of the extent of exemption from repetition of material previously disclosed which has already been discussed and resolved in Mr Cowie's favour, the questions at issue in this case were, as they ought to have been, and for the reasons already set out, amply clear and specific, in the sense that they would have left no room for material doubt in the mind of their reasonable reader as to what exactly was being asked about. This consideration accordingly also does not affect the

determination of whether the standard of care was or was not met in the circumstances of the present case.

[179] Next for consideration, in terms of section 3(2)(e), is the question of whether or not an agent was acting for the consumer. In the present case, Mr Reynolds was acting as Mr Cowie's agent, but appears to have had no appreciable input, for better or worse, into the completion of the proposal form, so this again is a feature of the case which makes no difference to the assessment of whether reasonable care was used in the exercise of completing the form.

[180] Finally amongst the specific matters for possible consideration in this context. Vitality was aware at the relevant time that Mr Cowie was a lawyer, although it does not appear that it knew any more than that about what exactly his job entailed. It was suggested to me that his known status as a lawyer was relevant in terms of section 3(4) of the Act, either as a relevant circumstance attending his completion of the form or as a relevant characteristic possessed by him. This argument appears to be predicated on the assumption that a lawyer ought to have been (and, it seems, that Mr Cowie therefore was or at least ought to be treated as having been) more aware of the need for correctness and accuracy in the completion of the proposal form than consumers in general. I am not persuaded that that is the sort of circumstance or characteristic at which section 3(4) is aimed. The submission proceeds upon the basis that Mr Cowie's actions should be scrutinised more closely than those of the average consumer because of assumed attributes that he may or may not actually have had. An assumption that lawyers are more careful and precise in their personal business dealings than the general run of consumers is not one that would necessarily be vindicated by experience. Further, if the questions asked in the proposal form were clear and specific (as they were), and the importance of answering them correctly and

fully ought to have been obvious to a consumer of ordinary intelligence and exercising ordinary care (as it should) then some additional requirement incumbent upon a lawyer would be superfluous in practice as well as dubious in principle. I give no weight to Mr Cowie's profession in determining whether or not he exercised the appropriate degree of care in completing the proposal form. The only particular matter out of those specifically listed in the Act as being of potential significance is the nature of the insurance in question, which – for the reasons I have already stated – I regard as heightening to a limited degree the standard of care to be expected of the reasonable consumer.

[181] I turn from matters of generality to the specific known circumstances of the two misrepresentations which I have found established, and address firstly the denial of any disorder of the oesophagus. In a case which involves a claim on a policy of life assurance where the proposer is also the life assured and therefore deceased by the time the validity of the claim falls to be adjudicated upon, there is likely to be a penury of direct evidence on what was in the mind of the consumer when the proposal form was filled in. Mrs Cowie, in her appeal against Vitality's initial refusal of the claim, made certain assertions in writing about what Mr Cowie did and did not know from time to time about his Barrett's, but she chose not to give evidence at the proof and thus those assertions remained untested and are capable of bearing little or no weight on their own. Dr McLennan was not able to say that he had ever discussed the subject of Barrett's with Mr Cowie, and the most direct evidence on the subject came from Mr Fullerton. Although he could not remember any actual interaction with Mr Cowie, it is not disputed that ablation of residual elements of Barrett's from Mr Cowie's oesophagus, after earlier and more substantial treatment, took place at his hands on 30 November 2010. It was not known before the endoscopy process which included that ablation was begun whether or not any such residual elements would be found, but it was

Mr Fullerton's evidence that the possibility that they might be found would have been explained to Mr Cowie and that he would have given informed consent in advance to the ablation which in the event took place. Mr Fullerton also stated that it would have been his normal practice, after such a procedure had been undergone and the patient had sufficiently recovered, to tell him that residual elements of Barrett's had been found and removed. I accept that evidence and can see no reason to doubt that that the prospect of finding such elements and the process that would be gone through in that event would have been discussed with Mr Cowie before the endoscopy on 30 November 2010 commenced, and that the fact that residual elements of Barrett's had been found and removed would have been explained to him afterwards. That fixes Mr Cowie with the knowledge as at 30 November 2010 that, on that date, he had had Barrett's. I equally see no reason to doubt that he would have been aware from what had been explained to him in the context of the treatment he had undergone, if not otherwise, that that was a disorder of the oesophagus in the relevant sense.

[182] A rather more difficult question is whether a reasonable consumer would, as at 13 November 2015, the date upon which the proposal form was completed, recall that he had had Barrett's as at the end of November 2010 rather than, for example, as at the end of September or October 2010, dates which would have been outwith the 5-year period being enquired about. The recollection of entirely reasonable people about quite how far in the past something happened to them, even something relatively important, can be notoriously inaccurate. This consideration makes it relatively easy, in the context of the misrepresentation concerning Barrett's, to conclude that no dishonesty on the part of Mr Cowie has been established. Put short, a mistake concerning a period of less than three weeks as to exactly when an ablation procedure undertaken about 5 years previously was

undergone is a mistake which an honest person could easily make. The narrower question is whether it is a mistake which a reasonable consumer completing a proposal form for life assurance could have made. Not without some hesitation, I conclude that it is not. Such a person would have well appreciated, as I have set out above, that it was important to consider the questions being asked and, if unsure about the correct and accurate answer, to check the facts about the subject of the question before answering. Such a person would not have guessed about the date upon which he had last undergone ablation, would not have regarded the previous disclosure of different (if potentially related) digestive issues as sufficient, and would not have assumed that his subjective understanding (if he had one) that his Barrett's had been cured and that there had in the meantime been no recurrence of relative signs or symptoms in the intervening period meant that the matter was not of significance and could be glossed over. Rather, he would have read and understood the question posed and provided himself with the information needed to answer it accurately. It follows that Mr Cowie failed to exercise the standard of care required of him by the Act in responding as he did to the question on the proposal form about disorders of the oesophagus which had affected him the 5-year period leading up to his completion of the form.

[183] I turn to the second established misrepresentation, namely that concerning the results of the liver function tests which he had undergone in the two-year period leading up to the completion of the form. The episode of concern in this regard had occurred just over a year before that point. Dr McLennan and Mr Taylor were clear that they would have informed Mr Cowie that those results were not normal and required further investigation, which each sought to arrange. Mr Cowie could have been in no doubt that he had had, within the period being enquired about, investigations which were not part of a routine

"well person" check and the results of which were abnormal. The relatively recent point at which he had been made aware of the abnormal nature of the results is not conducive to any conclusion that he may have been mistaken about whether or not that had occurred within the relevant period. The only points which can, on the evidence before me, be stated in his favour are the facts that he was also aware, before filling in the form, that the abnormal readings had resolved without treatment, that no specific condition which had caused them had been identified, and that a liver ultrasound had returned an unremarkable result. None of that would, in my opinion, have led a reasonable consumer to fail to appreciate that what was being asked about in the proposal form was simply the nature of results returned in the period under examination, rather than whether any underlying condition had been discovered or diagnosed, and that the insurer itself would wish to determine the significance of those results. Such a consumer would accordingly have disclosed that the results in question were abnormal and let the insurer decide what, if any, consequence for an offer of cover flowed from them. I find that Mr Cowie also failed to exercise the standard of care required of him by the Act in responding as he did to the questions on the proposal form about abnormal test results in the two-year period leading up to his completion of the form. It is, indeed, quite difficult in the circumstances to escape a conclusion that his answer to that question was dishonest, even bearing in mind a natural reluctance to make such a finding against a man who is perforce unable to defend himself and provide an explanation consistent with honesty which is not otherwise available from the known facts. However, given that such a finding is unnecessary in light of my conclusion that the answer was in any event given without the exercise of the required standard of care, and bearing in mind the consideration to which I have just adverted, I refrain from making it.

[184] I conclude that each of the two misrepresentations which I have found established was made without that standard of care required of Mr Cowie by the 2012 Act and were accordingly qualifying misrepresentations for the purposes of the Act.

What would Vitality have done in the absence of the qualifying misrepresentations?

[185] A great deal of effort was expended at the proof in examining what had actually happened in 2017 when the claim made by the pursuer on the policy was intimated and declined, and her appeal against that declinature was rejected. Those events happened on the basis of an assessment of all the medical records which Vitality had obtained, unlawfully, from Dr McLennan. Once Vitality decided in the course of these proceedings that it would not seek to rely on all of that documentation, the witnesses Tsebe, Downes and Gregory undertook a further exercise based only on the records which Vitality had decided that it was appropriate for it to rely on, each concluding by slightly different routes that the claim made in 2017 ought to have been declined on account of the misrepresentations which Vitality considered that Mr Cowie should have made. That process was equally subject to close scrutiny and criticism in the course of the proof. All of that rather misses the point. The question which now falls to be answered, in terms of section 4(1)(b) of the 2012 Act, is whether Vitality has shown that, without the qualifying misrepresentations which I have identified, it would not have entered into the insurance contract at all (the possibility of its entering into the contract only on different terms not arising in this case, since that is not what Vitality offers to prove that it would have done). The entire proper focus now for the section 4(1)(b) issue is thus on what Vitality would have done had Mr Cowie stated in the proposal form in 2015 that he had suffered from a disorder of the oesophagus within the preceding 5-year period and/or what it would have done had he disclosed that he had

undergone investigations with abnormal results in the preceding two-year period: cf. Rix LJ in *Drake* at [74]. What happened incidentally to the claim made in 2017 being declined and the refusal of the appeal therefrom, and what the witnesses whose evidence was adduced at proof thought about whether that claim ought to have been declined then, or what the applicable law was, when they reviewed the matter on the basis of the restricted medical evidence is of no direct relevance to the resolution of that issue. Equally, the fact that the matters which were the subject of misrepresentation in 2015 were not connected to Mr Cowie's cause of death is not relevant to the questions which arise under the 2012 Act; the issue is simply what effect the misrepresentations made in 2015 would have had on Vitality's willingness then to accept the risks inherent in insuring his life.

[186] What Vitality would have done had the qualifying misrepresentations not been made to it in 2015 is necessarily a hypothetical question. All that the witnesses could meaningfully do in that connection – and what was done – was to point to the underwriting guidelines then in force within Vitality and Hannover Re as an indication of what ought to have happened. In relation to Barrett's, those guidelines indicated that for metaplasia affecting an area of less than 8 centimetres in length, without any dysplasia or malignancy, when there had been no regular surveillance and the last surveillance had been over two years previously, an application for life cover should be declined. In relation to elevated liver enzymes, the guidelines indicated that an AST level of more than four times the normal level would in itself have resulted in the application for life cover being rated in class "H", meaning that it would have been referred to Hannover Re and usually declined. The ratio of AST to ALT was 1.82, which ought to have resulted in the application moving up one rating class, but for the fact that class "H" was already the highest (i.e. most risky) class. If

evidence had been provided that ALT and AST levels had been persistently elevated, a theoretical raising by two classes ought also to have occurred.

[187] Other matters (including whether the guidelines would in fact have been followed) must necessarily be a matter of inference. It is, for example, not known how Mr Cowie would have reacted had he been asked to provide further information about his Barrett's or his abnormal liver function tests, and in particular whether he would have authorised the disclosure of medical information to Vitality and, if so, to what extent. It is equally unclear just what information or opinions Dr McLennan or other relevant practitioners might have made available to Vitality if authorised to do so. However, an insurer has always been able to make out a case that it was induced to enter into an insurance contract on the basis of inference from background facts; see, e.g., *Assicurazioni Generali SpA* per Clarke LJ at [62].

[188] The burden of the evidence which was led on the question of the effect of the misrepresentations on Vitality, particularly from Mr Downes, was that a disclosure that Mr Cowie had suffered from Barrett's within the relevant period would have been met with a request for medical evidence, and the fact that he had not for more than two years in the meantime undergone monitoring for the condition would have led to Vitality refusing to take on the risk which that situation posed. Ms Gregory confirmed that from the point of view of Hannover Re. On the issue of the abnormal liver function test results, the essence of the evidence of Mr Downes was that the disclosure of the results which had been returned, and the fact that their cause remained unknown, would have resulted in the refusal (or at least postponement) of cover. Disclosure of both the Barrett's and the abnormal test results would have made the refusal of cover even more emphatic. Although Mr Downes and Mrs Gregory were cross-examined extensively, their evidence on these matters was not challenged, at least beyond the general assertion put to them that they were saying what

their employers wanted them to say rather than giving an accurate account of what had happened in the course of their dealings with the dispute. The fact that the oral evidence was backed by reference to the relevant guidelines operative in 2015, coupled with the lack of specific cross-examination, results in a relatively easy conclusion that Vitality's position that it would not have offered Mr Cowie cover on any terms but for the identified qualifying misrepresentations made to it by Mr Cowie, has been made out on a balance of probabilities, even if the precise mechanism by which that conclusion would have been reached cannot be definitively ascertained.

[189] I deal now with whether the qualifying misrepresentations which I have identified fall to be categorised as either deliberate or reckless, or else careless, within the meaning of section 5 of the 2012 Act. It will be recalled that the burden of proof lies on an insurer to establish that a qualifying misrepresentation falls for the purposes of the Act to be regarded as deliberate or reckless if the consumer knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and either knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer, it being presumed that the consumer had the knowledge of a reasonable consumer, and that he knew that a matter about which the insurer asked a clear and specific question was so relevant. No attempt to rebut those presumptions was made in the present case. Any qualifying misrepresentation which is not shown to meet that definition falls to be regarded as careless in nature.

[190] The decision as between deliberate and reckless misrepresentation on the one hand, and careless on the other, is of no practical consequence in this case, since the only difference concerns whether Vitality would be obliged to return the premiums paid under the policy if both misrepresentations were merely careless, which it has in any event already done.

There is also the consideration, which I have already mentioned, that any evidence which Mr Cowie might have been able to provide going to the distinction between the kinds of misrepresentation if still in life has not been heard. Much of the material relevant to this issue has been canvassed in the context of whether the misrepresentations were dishonest for the purposes of the section 2 duty of care. For essentially the same reasons as were mentioned in that context, I do not consider that the qualifying misrepresentation about a disorder of the oesophagus has been shown to have been deliberate or reckless; the lapse of time between Mr Cowie's treatment for Barrett's and his completion of the proposal form would not support any such conclusion. That misrepresentation accordingly falls to be treated as careless for the purposes of section 5. In relation to the qualifying misrepresentation about the liver function test results, the relative question asked in the proposal form was clear and specific, so Mr Cowie is presumed to have known that the matter to which this representation related was relevant to the insurer. If he had considered carefully his answer to the question, he would have appreciated that that answer was untrue or misleading. Whether he gave any such consideration to his answer is a question which the available evidence leaves unanswered. The most favourable inference that can be drawn from the known circumstances, and that which I draw as a matter of fact, is that he did not carefully consider his answer. That falls a little (if only a little) short of supporting a conclusion that his answer was deliberately untrue or misleading, that he was reckless as to whether or not it was untrue or misleading, or that he did not care whether it was untrue or misleading or not. By something of a hairsbreadth, then, I conclude that Vitality has not established on the balance of probabilities that this misrepresentation was deliberate or reckless either, and it too falls to be regarded as merely careless.

Impact of any breach of a duty of utmost good faith

[191] There remains for discussion the rather vexed questions of whether Vitality owed Mrs Cowie a duty of utmost good faith in dealing with her claim and her appeal, if so whether it breached that duty, and if it was in breach, what consequences, if any, that has for its entitlement to the remedy for Mr Cowie's qualifying misrepresentations to which the 2012 Act would otherwise entitle it.

[192] The primary objects of the 2012 Act were to define in the law of consumer insurance contracts the nature of the duty incumbent on a consumer in making representations to the insurer (see section 2(4)), and to set out the remedies which an insurer has if that duty is breached (section 4). Concentrating for now on those aspects of the Act which address matters of duty, it does not purport to affect any other duties incumbent on either party to the contract. It follows that any duty of utmost good faith incumbent on the insurer by way of the pre-existing law remains incumbent on it. The next question that requires to be answered is whether a duty of utmost good faith may extend to the insurer's treatment of a claim made under the policy. Since that is an aspect of the relationship which arises out of the contract between the parties, I see no reason in principle why it should not. However, by the point at which a claim is made under the policy, there is at least the potential for disagreement between insurer and insured as to whether liability has been incurred or not. The insurer is entitled to maintain a position that it is not so liable, and to take reasonable steps to guard its position, just as any party to an incipient dispute might do, so long what it does is not done with malicious or dishonest intent. A duty of good faith, even of utmost good faith, falls short of imposing on the insurer some sort of generalised quasi-fiduciary duty to preserve and advance the interests of the insured in preference to its own. Carelessness, disorganisation or other sub-optimal discharge of its administrative functions

are not in themselves necessarily redolent of a breach of the duty of utmost good faith owed by an insurer. A close examination of what was done and in what context, why it was done, and how significant it was to the essence of the relationship between the parties is required in order to determine whether or not some action or inaction on the part of the insurer which is complained of amounts to a breach of its good faith duty.

[193] In dealing, in particular, with Mrs Cowie's appeal against the initial refusal of her claim, Vitality fell well short of the administrative standards to be expected of a competent insurer. It made various statements to her about the mechanics of how her appeal had been processed which were not true. It made a conscious decision not to engage with many of the points which she had made in writing in support of her appeal. It decided to avoid the contract without finally putting to Mrs Cowie for her comment the reasons why it proposed to do so. These actions do it no credit. It is necessary to bear in mind, however, that it was apparent by the time that these things were done that there was little or no common ground between the parties on the question of the validity of the claim. Vitality had formed the view, for no very good reason, that Mrs Cowie was likely to be troublesome and considered that she wished to argue a position based in part at least on the lack of connection between the alleged misrepresentations and the cause of Mr Cowie's death which it considered (correctly) to be irrelevant to its liability under the policy. None of that remotely justified it in corresponding with her using template letters which did not accurately detail the procedure that had been used in dealing with her appeal, or in ignoring the points which she wished to have addressed – an approach calculated to lead to infuriation rather than reconciliation. Counsel for the pursuer submitted that Vitality, in its dealings with Mrs Cowie, had engaged in a "policy of deceptive evasiveness". It was certainly evasive, to an extent at least, and it said things that were not true. However, I have not been able to

find in the evidence any proper basis for a suggestion that Vitality did what it did in an attempt to suppress what it regarded as a good claim, or that it set out to, or did, assess the claim or the appeal in a substantively unfair manner which would have gone to the heart of the parties' relationship. In such circumstances, while I entirely accept that its conduct was reprehensible in a wider sense, I do not consider that what it did amounted to any material breach of its good faith duties.

[194] In relation to the suggestion that Vitality had changed its position on why it was entitled to avoid the contract as between the point in 2017 when it purported to do so, and the point by which it was defending the litigation, and that that change of position amounted to a further breach of its duty of utmost good faith, the observations made by Rix LJ in *Drake* at [69] – [70] have already been noted. I consider that those observations equally represent the law of Scotland, and that the remarks in *American Paint Service* to which my attention was drawn do not. It is of course true that a change of position might be the product of bad faith on the part of the insurer, as for example if it were demonstrated that it had no genuine belief in the validity of the new position and was simply adopting it to string out proceedings and put financial pressure on its opponent, although demonstration of such a state of affairs would be very difficult where, as here, the insurer was represented by responsible agents and counsel. In the present case, nothing of the sort is made out. Indeed, I find it difficult to see that the essence of Vitality's position on why it was entitled to avoid the contract has materially changed since 2017. In its letter to Dr McLennan dated 27 February 2017 first intimating its rejection of the claim, Vitality noted the following:

> "Mr Cowie did not disclose the following when he applied for plan on 12 November 2015:
>
> - Long history of disorders of the digestive system with investigations and treatment

- Abnormal liver function tests
- Postponement of neck surgery following abnormal liver function results on two occasions
- Barrett's oesophagitis

Had we been aware of the above conditions on application, our underwriter would have requested for the General Practitioner's Report; this in turn would have alerted us on deranged liver functions with questionable alcohol intake; along with the Barrett's which was not under correct surveillance.

Had Mr Cowie disclosed this information to us, his application for Life Cover would have been declined."

[195] In this action, Vitality has made out a positive case of misrepresentation based on Mr Cowie's denials that he had suffered from any disorder of the oesophagus in the 5-year period leading up to the completion of the proposal form, whereas in fact he had suffered from Barrett's within that period, and on his assertion that the results of such investigations as he had undergone in the two-year period leading to that point were normal, whereas in fact the results of liver function tests he had undergone in that period were far from normal. At most, it might be said that its case has undergone some refinement and contraction since first advanced, but any suggestion that it is radically different, certainly to the extent that its statement demonstrates a lack of good faith on the part of Vitality, is insupportable.

[196] Given that I have held that Vitality was not in breach of any duty of utmost good faith incumbent on it, the question of what remedy might have been afforded had the contrary conclusion been reached does not arise. The question of available remedies for breach by an insurer of such a duty is complex, not least because some controversy surrounds the precise genesis of the duty. A detailed analysis of the English authorities on the source of the duty was undertaken by Slade LJ at the Court of Appeal stage in the *Banque Keyser Ullmann* litigation [1990] 1 QB 665 at 777 – 781, [1989] 3 WLR 25 at 85 – 89, rejecting the suggestions that it arose as an implied term of the insurance contract or out of the law of

tort, and preferring the analysis that it was an aspect of the jurisdiction of the courts of equity. Given the somewhat limited extent to which equity may grant certain forms of relief, particularly damages, that conclusion may lead to the result that a wrongful act cannot be visited with an effective remedy – a factor which much influenced Steyn J (as he then was) at first instance in the same case. The alternative analysis, that the duty of utmost good faith may be seen as arising out of an implied term of the insurance contract, has gained some traction, but while it may be a plausible explanation in the more blatant cases of breach of the duty in question, it may be difficult to regard some of the ways in which the duty may arguably be breached as capable of being explained by the current theory which justifies the implication of terms into a contract, as exemplified in *Marks & Spencer* v *BNP Paribas*. It may be, then, that some instances of what is compendiously called a breach of the duty of utmost good faith in an insurance contract do represent breaches of an implied term of the contract while others are recognised as such by the operation of more general legal principles. It may, indeed, be the case that those are simply different ways of expressing the same concept.

[197] It is, however, not necessary to resolve these interesting issues for present purposes. That is for two main reasons. Firstly, the type of conduct said to amount to breaches of the duty in this case would, if it did constitute such breaches, not qualify as so serious in nature as to justify the relief sought by the pursuer, which is to disqualify Vitality from availing itself of the remedy provided to it by the 2012 Act in respect of Mr Cowie's misrepresentations. Adapting the words used in the pre-Act era by Colman J in *The Grecia Express* already cited, they were not so unconscionable – did not so go to the heart of the parties' relationship – as somehow to disentitle Vitality in equity from invoking the statutory remedy. If the implied contract term analysis is used, they do not amount to a

breach of contract apt to disentitle Vitality from invoking that remedy while maintaining the other aspects of the contract enforceable by the pursuer; indeed, it is quite difficult to see how the contractual analysis could, either by way of the doctrines of mutuality of obligation or repudiatory breach, ever lead to that outcome, and it has throughout been quite clear that the remedy sought by the pursuer is enforcement of the contract, not damages for its breach or wrongful repudiation.

[198] Secondly, even if the actions complained of were breaches of the duty of utmost good faith sufficient to prevent Vitality from exercising a common law remedy otherwise available to it, we are no longer in the realm of common law remedies. Rather, section 4 of the 2012 Act provides an express statutory remedy for breach of the duty created by section 2. In the passages from the *Child Poverty Action Group* case already cited, Lord Dyson JSC observed that when a special statutory remedy was provided, a displacement of the pre-existing common law did not require to arise expressly or as a matter of necessary implication save where fundamental rights or a basic tenet of the common law were affected. Outwith that territory, a reasonable implication might suffice. In the present case, no question of fundamental rights or basic principles of the common law arise. Parliament could have stipulated that the remedy it was providing by way of section 4 was to be available if, and only if, the insurer's own conduct had not been such as to disqualify it in equity or otherwise from enjoying it. Such a stipulation would undoubtedly have added a great deal of complication and uncertainty to what was intended to be a clarifying legislative reform, and it is easy to see why that choice was not made. However, for the court to hold that the availability of the statutory remedy is, even in theory, subject to some such condition would be to make the stipulation which Parliament could have made and did not. It would undermine the plain wording of the Act and represent an unwarranted judicial

interference with the policy choice implicit in it. Those considerations provide ample grounds for declining to recognise the potential for any continuing common law brake on the statutory remedy which has now been provided to deal with such misrepresentations as have been found to exist in this case.

Conclusion

[199] Vitality has discharged the burden of demonstrating that Mr Cowie breached the duty incumbent on him to take reasonable care not to make misrepresentations to it before the consumer insurance contract between them was entered into. It has further shown that without those misrepresentations (which were careless within the meaning of the 2012 Act), it would not have entered into that contract at all. It is thus entitled to, and has, avoided the contract and refused the claim made under it, having returned the premiums paid, all in terms of paragraph 5 to the first Schedule to the Act.

Disposal

[200] For the foregoing reasons, I shall sustain Vitality's fourth plea-in-law, repel the pursuer's pleas, and grant decree of absolvitor.