Neutral Citation Number: [2024] EWCA Civ 1026

Case Nos: CA-2023-1474, CA-2023-1479, CA-2023-1755, CA-2023-1769, CA-2023-1774, CA-2023-1777, CA-2023-1800

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
BUSINESS AND PROPERTY COURTS OF ENGLAND AND WALES
KING'S BENCH DIVISION
COMMERCIAL COURT
Mr Justice Jacobs
[2023] EWHC 1481 (Comm)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 06/09/2024

Before:

LORD JUSTICE MALES
LORD JUSTICE POPPLEWELL
and
LADY JUSTICE ANDREWS

- -

BETWEEN:

CA-2023-001474

LONDON INTERNATIONAL EXHIBITION CENTRE PLC	**Respondent /Claimant**

- and -

1) ALLIANZ INSURANCE PLC **2) AVIVA INSURANCE LIMITED** **3) ZURICH INSURRANCE COMPANY LTD** **4) CHUBB EUROPEAN GROUP SE**	**Appellants/ Defendants**

AND BETWEEN:

CA-2023-1777
CA-2023-001800

1) HAIRLAB LIMITED **2) MUSCLEWORKS LIMITED** **3) BODYLINES FITNESS LIMITED**	**Respondents/ Claimants**

-and-

AGEAS INSURANCE LIMITED

Appellant/ Defendant

AND BETWEEN:

CA-2023-001755

MAYFAIR BANQUETING LIMITED — **Respondent/ Claimant**

-and-

AXA INSURANCE UK PLC — **Appellant/ Defendant**

AND BETWEEN:

CA-2023-1479
CA-2023-1774

1) KAIZEN CUISINE LTD (t/a Kaizen Cuisine)
2) MY TIME FINE FAIR LTD (t/a My Time)
3) UMBERTO'S RESTAURANT LTD (t/a Umbertos) — **Respondents/ Claimants**

-and-

HDI GLOBAL SE-UK BRANCH — **Appellant/ Defendant**

AND BETWEEN:

CA-2023-1769

WHY NOT BAR AND LOUNGE LIMITED — **Respondent/ Claimant**

-and-

1) WEST BAY INSURANCE PLC (formerly ZENITH INSURANCE PLC)
2) QIC EUROPE LIMITED — **Appellants/ Defendants**

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Appeal CA-2023-1474
Gavin Kealey KC & Keir Howie (instructed by **Clyde & Co LLP**) for the **Appellant Insurers**

Adam Kramer KC & William Day (instructed by **Stewarts Law**) for the **Respondent Policyholders**

Appeals CA-2023-1777 & CA-2023-1800
Aidan Christie KC & Anna Hoffmann (instructed by **Keoghs LLP**) for the **Appellant Insurer**
Jeffrey Gruder KC & Mubarak Waseem (instructed by **Barings Law**) for the **Respondent Policyholders**

Appeal CA-2023-1755
Michael Davie KC & Martyn Naylor (instructed by **DAC Beachcroft Claims Ltd**) for the **Appellant Insurer**
Neil Fawcett (instructed by **Gunner Cooke**) for the **Respondent Policyholder**

Appeal CA-2023-1479 & CA-2023-1774
Keir Howie (instructed by **Clyde & Co**) for the **Appellant Insurer**
Jeffrey Gruder KC & Mubarak Waseem (instructed by **Barings Law**) for the **Respondent Policyholders**

Appeal CA-2023-1769
Aidan Christie KC & Sushma Ananda (instructed by **DWF Law**) for the **Appellant Insurer**
Richard Chapman KC & David Hoffman (instructed by **Hugh James**) for the **Respondent Policyholder**

Hearing dates: 18, 19, 20 & 21 June 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 6 September 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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LORD JUSTICE MALES, LORD JUSTICE POPPLEWELL & LADY JUSTICE ANDREWS:

A. INTRODUCTION

1. These appeals are from the decision of Mr Justice Jacobs determining preliminary issues in six expedited test cases.[1] The claims are for business interruption ('BI') losses allegedly suffered by a number of different policyholders as a result of Covid-19. Although the wordings of the policies differ, they have in common that they provide cover for disease occurring (or in some cases manifesting itself or being suffered) 'at the premises' of the policyholder.

2. In this respect they may be contrasted with the policies considered by the Supreme Court in *Financial Conduct Authority v Arch Insurance (UK) Ltd* [2021] UKSC 1, [2021] AC 649, which provided cover for disease occurring within a specified radius of the policyholder's premises. That case decided what a policyholder with a radius clause has to prove in order to recover BI losses suffered as a result of the closure of its premises by government action in response to Covid-19.

3. The present appeals raise the same question of causation in the case of 'at the premises' clauses, together with a number of other issues which arise in individual cases.

The policyholders

4. The lead case in the court below and on appeal was the claim by London International Exhibition Centre Plc ('ExCeL'). The claimant in that action owns and operates a large and well-known exhibition and venue space in east London, commonly known as the ExCeL Centre. The policy was led by Royal & Sun Alliance Insurance Plc ('RSA'), and a following market comprising five other well-known insurers, but RSA has not appealed from the judge's decision and one of the following insurers has settled the claim. The appellants in this appeal are the four remaining members of the following market.

5. All of the other claimants in these actions are small or relatively small businesses, operating from a single premises. The *Hairlab* action claimants are a hairdresser in Basingstoke and two London gyms; the *Mayfair* action claimant operates a London nightclub; the *Kaizen* action claimants are two small restaurants in Winchester and Hornchurch and a café in London; and the *Why Not Bar* action claimant operates a bar and nightclub in Aberystwyth.

The insuring clauses

6. In each case we are concerned with cover for BI losses which does not depend on physical damage to the premises. In the *ExCeL Centre* action, the relevant policy wording ('the RSA Infectious Disease Extension') is as follows:

> '**Infectious Diseases – Extension**

[1] One of those actions, *PizzaExpress v Liberty Mutual*, has settled and is not before us. In another, the *ExCeL* case, only some of the insurers have appealed.

> The word Damage is extended to include closure of the Premises or part thereof on the order or advice of any local or governmental authority as a result of an outbreak or occurrence at the Premises of
>
> A) Any human contagious or infectious disease other than Acquired Immune Deficiency Syndrome (AIDS) or any AIDS related condition, an outbreak of which is required by law or stipulated by the governmental authority to be notified
>
> B) Food or drink poisoning
>
> C) Vermin or pests
>
> D) Defective sanitation
>
> Provided that
>
> 1) the Maximum Indemnity Period is limited to three months and shall apply from the date from which the closure order is enforced
>
> 2) the Company shall not be liable under this Extension for more than the limit stated below in respect of any one loss
>
> Limit £15,000,000'

7. The clause covers losses caused by 'closure of the Premises' resulting from an outbreak or occurrence of notifiable diseases 'at the Premises'. It is, therefore, what was described in the Supreme Court at [4] as a 'hybrid' clause, which may be contrasted with a 'pure' disease clause where the occurrence of disease at the premises is itself the insured peril.

8. The equivalent clauses in the other policies are broadly similar, but with some differences. They are as follows:

Hairlab

> '**Notifiable Diseases, Poisoning, Defective Drains and Murder or Suicide**
>
> The **Company** will indemnify the **Insured** in respect of loss resulting from the interruption or interference with the **Business** in consequence of
>
> a i any occurrence of a Notifiable Disease (as defined below) at the **Premises** or attributable to food or drink supplied from the **Premises**
>
> ii any discovery of an organism at the **Premises** likely to result in the occurrence of a Notifiable Disease (as defined below)

b the discovery of vermin or pests at the **Premises** which causes restrictions on the use of the **Premises** on the order or advice of the Local Authority

c any accident causing defects in the drains or other sanitary arrangements in the **Premises** which causes restrictions on the use of the **Premises** on the order or advice of the Local Authority

d any occurrence of murder or suicide at the Premises.'

Mayfair

'**Murder, suicide and infectious diseases extension 2006**

Section B (Loss of Profits) is extended to include losses arising from the closure of the Premises by a competent authority due to an human notifiable infectious disease or food poisoning suffered by any visitor or employee or by defective sanitation vermin or pests at the Premises as specified in the schedule or by murder or suicide occurring at the Premises.'

Kaizen

'The liability of the **Insurer** includes loss as insured by this Section resulting from interruption or interference with the **Business** in consequence of

1) Premises Closure or Restrictions

a) closure or restrictions placed on the **Premises** on the advice of or with the approval of the Medical Officer of Health for the Public Authority as a result of a **Notifiable Human Disease** occurring at the **Premises**

b) closure of the whole or part of the Premises by order of the Public Authority consequent upon injury or illness closure of the whole or part of the Premises by order of the Public Authority consequent upon sustained by any person caused by or traceable to foreign or injurious matter in food or drink sold from the **Premises** by the **Insured**

c) closure of the whole or part of the Premises by order of the Public Authority consequent upon vermin and pests at the **Premises**

d) closure of the whole or part of the Premises by order of the Public Authority consequent upon closure of the whole or part of the Premises [*sic*.] by order of the Public Authority consequent upon defects in the drains and other sanitation at the Premises

> e) closure of the whole or part of the Premises by order of the Public Authority consequent upon consequent upon murder or suicide occurring at the **Premises**
>
> subject to an aggregate maximum of £50,000 in any one Period of Insurance'

Why Not Bar

> 'The insurance is extended to include business interruption loss as insured in this Section in consequence of …
>
> A) closure or restrictions placed on the Premises on the advice or with the approval of the Medical Officer of Health of the Public Authority as a result of a notifiable human disease manifesting itself at the Premises.
>
> B) closure or restrictions placed on the Premises due to Injury or illness sustained by any customer or Employee arising from or traceable to foreign or injurious matter in food or drink sold from the Premises
>
> C) closing of the whole or part of the Premises by order of the Public Authority for the area in which the Premises are situate consequent upon defects in the drains and other sanitary arrangements at the Premises.
>
> D) closure or restrictions placed on the Premises due to murder or suicide occurring at the Premises.
>
> E) loss destruction or damage caused by any of the Covers to property in the vicinity of the Premises which prevents or hinders the use of the Premises or access thereto whether the Premises or Your property therein shall be damaged or not but excluding Damage which prevents or hinders the supply of electricity gas water or telecommunications services
>
> provided that Our liability, after the application of all other terms and conditions of the Policy, shall not exceed the sum insured by this insurance or £1,000,000 whichever is the less.'

9. As can be seen, so far as the disease cover is concerned, the *Mayfair*, *Kaizen* and *Why Not Bar* clauses are also hybrid clauses, while the *Hairlab* clause is a pure disease clause. In each case disease cover is contained in a clause which also provides cover for other perils such as closure due to vermin infestation, defective drains and murder or suicide at the premises.

The causation issue in outline

10. It was either agreed or assumed for the purposes of the preliminary issues that in each case the policyholder would be able to prove that at least one person with Covid-19 was

present at the policyholder's premises between the date when Covid-19 became a notifiable disease and the closure of the premises as a result of government action.[2] On that basis, although the preliminary issues in the different actions were expressed in different terms, the effect of the judge's decision was that the necessary causal link between the occurrence of the disease and the BI losses suffered as a result of the closure of the premises was satisfied. As the judge expressed the issue and his answer in the *ExCeL* case:

> 'For the purposes of the Infectious Diseases Extension, in order to show that loss resulting from interruption of or interference with the Claimant's business at the Premises was proximately caused by closure of the Premises or part thereof on the order or advice of any local or governmental authority as a result of an occurrence of COVID-19 at the Premises, is it sufficient to prove that the order or advice was made or continued in response to cases of COVID-19 which included at least one case of COVID-19 at the Premises which had occurred by the date of the order or advice?
>
> Yes: it is sufficient so to prove.'

11. The insurers challenge this conclusion, although they differ in their approaches. The parties helpfully produced an agreed list of issues for the appeal, which identifies the positions adopted by the various parties:

> '**Common Causation Issues**
>
> 1. What are the causation requirements for the 'at the premises' (**ATP**) disease/hybrid cover in each appeal on the correct construction of each policy? In particular, in order to show that loss resulting from interruption of or interference with each insured's business at the premises was caused by closure or restrictions of the insured premises or other government measure caused by an occurrence or manifestation or suffering of COVID-19 at the insured premises:
>
>   (1) Is it sufficient to prove that the relevant measure was made or continued in response to cases of COVID-19 which included at least one case of COVID-19 at the insured premises?
>
>   (*As found by the Judge and argued by all insureds*)
>
>   (2) Is it necessary to prove that the occurrence or manifestation of COVID-19 at the insured premises was a distinct effective cause of the relevant measure, in the sense of it being the fact of disease having occurred or

[2] There is a separate issue, considered in Section E below, whether it is sufficient for the policyholder to prove the occurrence of Covid-19 at the premises before it became a notifiable disease.

manifested at the Premises to which the authority was responding in ordering or advising that the Premises be closed?

(*As contended by the insurers in* ExCeL *and* Kaizen *as their primary case, and the insurers in* Hairlab *and* Why Not *as their alternative case*)

(3) Is it necessary to prove that the occurrence or manifestation of disease at the Premises was a 'but for' cause or a necessary and/or sufficient cause of the relevant measure?

(*As contended by the insurers in* Hairlab *and* Why Not *as their primary case, and the insurers in* ExCeL *and* Kaizen *as their alternative case*)

(4) Is it necessary to prove that the occurrence or manifestation of disease at the Premises was reported to or otherwise known about by the authority prior to the order or advice for closure etc. of the Premises?

(*As contended by all insurers*)

(5) Is it necessary to prove that the occurrence of COVID-19 at the premises was something the government had information about and was taken into account by the government prior to the date of government action?

(*As contended by the insurer in* Mayfair).

The other issues

12. In addition to these common causation issues, a number of other issues arise which the parties expressed as follows:

'**Notifiability (*Hairlab* and *Kaizen* only)**

2. Do occurrences of COVID-19 at the premises before it became a notifiable disease (i.e. prior to 5th March 2020 at 6.15pm) qualify as relevant occurrences for the purposes of the ATP disease/hybrid cover in *Hairlab* and *Kaizen*?

Medical Officer of Health (*Kaizen* and *Why Not* only)

3. What is the proper construction of the words "*the Medical Officer of Health for* [or *of*] *the Public Authority*" and does that phrase encompass the Chief Medical Officer / Deputy Chief Medical Officer or other relevant medical officer at the Welsh and/or UK governments and/or closures or restrictions imposed by the Welsh and/or UK governments?

Knowledge (*Kaizen* and *Why Not* only)

4. Regardless of the causation requirements of the relevant ATP extensions, is it necessary to prove that the occurrence or manifestation of disease at the Premises was reported to or otherwise known by the Medical Officer of Health of/for the Public Authority prior to their giving advice or approval for closure or restrictions being placed on the Premises?

Other (*Mayfair* only)

5. What is the proper construction of the words "*suffered by any visitor or employee*" in the *Mayfair* Disease Clause? More particularly, is the *Mayfair* Disease Clause an 'occurrence' wording or a 'manifestation' wording?

6. What are the causation requirements of the ATP disease cover in *Mayfair* and do the words "*disease suffered by any visitor or employee … at the Premises*" mean it is necessary to prove that COVID-19 suffered by any visitor or employee at the premises was something the government had information about and was taken into account by the government prior to the date of government action leading to closure of the premises?

(*As contended by the insurer in* Mayfair).

B. FACTUAL BACKGROUND

13. The preliminary issues were tried on the basis of agreed and assumed facts which went into considerable detail. The facts agreed were not identical in all the actions, but in practice were to essentially the same effect and, not surprisingly, to the same effect as the facts agreed and assumed in the *FCA v Arch* case. The judge set out a full account of the factual background in his judgment to which reference can be made as necessary, together with the summary of the facts at [6] to [35] of the Supreme Court judgment. In oral submissions, however, very little reference was made to the detailed facts, either in this court or in the court below. For the purposes of these appeals, the following short summary will suffice.

14. The broad consensus amongst epidemiologists is that the rate of initial importations of SARS-CoV-2 into the UK in either late 2019 or early 2020 was low, and then rose rapidly in February and early March 2020. The first reported case of infection with SARS-CoV-2 arrived in the UK on 23rd January 2020 from Hubei province in China. The first recorded case of Covid-19 in the UK was announced on 31st January 2020.

15. Covid-19 was made a notifiable disease in Scotland on 22nd February 2020, in England on 5th March 2020, and in Wales on 6th March 2020.

16. As at 9th March 2020, the total number of reported cases of Covid-19 in the UK was 649. However, it was recognised that the true number of cases greatly exceeded the number reported. On 10th March 2020, at the fourteenth SAGE meeting about Covid-19, it was discussed that 'the UK likely has thousands of cases – as many as 5,000 to

10,000', but with further data to be collected and input into models. In contrast, the total number of reported cases at this date was only 914. On 12th March 2020, the total number of reported cases of Covid-19 in the UK was 1,801. On 13th March 2020, SAGE met again and revised its previous modelling of the spread of the disease. It considered that:

> 'Owing to a 5-7 day lag in data provision for modelling, SAGE now believes there are more cases in the UK than SAGE previously expected at this point, and we may therefore be further ahead on the epidemic curve.'

17. On 16th March 2020, the Prime Minister instructed the country to 'stop non-essential contact with others and stop all unnecessary travel' and to avoid 'pubs, clubs, theatres and other such social venues', adding that the government would 'no longer be supporting mass gatherings'. The minutes of the SAGE meeting from this date recorded that it was 'possible that there are 5,000-10,000 new cases per day in the UK', far above the daily rate of cases being diagnosed and reported.

18. On 20th March 2020, the Prime Minister reiterated his previous advice and announced the closure of social venues.

19. On 21st March 2020, the Health Protection (Coronavirus, Business Closure) (England) Regulations 2020 were made by the Secretary of State for Health and Social Care pursuant to powers under the Public Health (Control of Disease) Act 1984. These provided for the closure of certain businesses.

20. On 23rd March 2020, the Prime Minister announced the first UK-wide lockdown, giving the public 'a very simple instruction – you must stay at home', with people 'only … allowed to leave their home for … very limited purposes', such as shopping for necessities. The Prime Minister confirmed that the government would close all shops selling non-essential goods and stop all gatherings and social events.

21. On 26th March 2020 the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 were made by the Secretary of State for Health and Social Care pursuant to powers under the 1984 Act. These revoked most of the previous Regulations and introduced a more expansive regime for business closures.

22. For the purposes of the *ExCeL* action, the parties assumed that the Centre was, or would have been, closed by virtue of one or more of the 20th March instructions and/or the Regulations which followed. (It was in fact taken over as a 'Nightingale' hospital to provide the NHS with capacity for an additional 4,000 hospital beds in London).

23. The agreed and assumed facts in the *ExCeL* action addressed the position up until the assumed closure of the Centre in March 2020, since ExCeL's claim arose from the lockdown that occurred at that time. The agreed and assumed facts in other cases addressed the position thereafter, as there were arguments at an earlier stage of the proceedings arising from the sequence of lockdowns in the UK, interrupted by periods when restrictions were at least partially lifted, with different types of business being affected in different ways. However, these arguments fell away at the hearing in the court below and it is unnecessary to describe these further events.

24. For the purpose of these appeals the important facts which arise from this summary are that it was known that the true number of cases of Covid-19, whatever it was, far exceeded the number of reported cases; that the disease was known to be spreading rapidly; and that in England at least it had spread by the time of the government action to almost every part of the country, with no reason to think that the position was different in Scotland or Wales.

C. THE COMMON CAUSATION ISSUES

FCA v Arch

25. As already noted, in *FCA v Arch* the Supreme Court was concerned with radius clauses which provided cover for BI losses resulting from the occurrence of a notifiable disease within a specified distance from the insured premises. In most cases, the specified distance was 25 miles, but in some cases the radius specified was only one mile (see at [94]) and we were told that an example of a radius clause with a radius of only 250 metres was also in evidence before Mr Justice Jacobs. The Supreme Court's analysis did not differ according to the length of the radius.

26. So far as relevant to the present appeals, two broad issues arose for decision. The first concerned the nature of the insured peril under the radius clauses at issue. There is no equivalent issue in the present appeals. The second concerned the nature of the required causal link between the insured peril and the BI losses suffered by the policyholder.

27. As to the first issue, the Supreme Court disagreed with the conclusion of the Divisional Court [2020] EWHC 2448 (Comm), [2020] Lloyd's Rep IR 527. It held that each case of illness from Covid-19 sustained by an individual was a separate occurrence of a notifiable disease; and that each such case within the specified radius was an insured peril (or in the case of hybrid clauses, that each such case within the specified radius satisfied the disease element of the clause). As to the second issue, the Supreme Court held that each of the individual cases of Covid-19 which had occurred by the date of any government action was a separate and equally effective cause of that action and of the public's response to it. Accordingly, in order to recover under a radius clause, it was sufficient for the policyholder to prove that a case of Covid-19 had occurred within the radius before the relevant restriction was introduced.

28. In brief outline, the Supreme Court's reasoning was that the parties to the radius clauses in issue did not intend the 'but for' test of causation to apply:

> '192. We return to the disease clauses in the present case. We agree with Mr Kealey's submission on behalf of MS Amlin that the right question to ask is: did the insured peril cause the business interruption losses sustained by the policyholder within the meaning of the causal requirements specified in the policy? Taking MSA 1 as an example, the question is whether the interruption of the business carried on by the policyholder at the insured premises occurred "following" illness sustained by any person resulting from COVID-19 within a radius of 25 miles of the premises. In particular, it is necessary to ask: would the causal requirement imposed by the word "following" be satisfied by showing that one or more cases of illness from COVID-19

had occurred within the specified radius before national restrictions which caused interruption of the insured business were imposed on the basis of those and all other cases of COVID-19 that had occurred by that date?

193. The FCA submits that the causal requirement would be met in such circumstances, applying the alternative analysis of the court below that each individual case of illness from COVID-19 was an equally effective cause of the government measures and consequent business interruption. The insurers contend that a "but for" test should be applied or, alternatively, if that contention is rejected, that a single case of disease or a relatively small number of cases of disease occurring within the specified radius is not sufficient to satisfy the causal connection required by the policy.

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

195. We do not consider it reasonable to attribute to the parties an intention that in such circumstances the question whether business interruption losses were caused by cases of a notifiable disease occurring within the radius is to be answered by asking whether or to what extent, but for those cases of disease, business interruption loss would have been suffered as a result of cases of disease occurring outside the radius. Not only would this potentially give rise to intractable counterfactual questions but, more fundamentally, it seems to us contrary to the commercial intent of the clause to treat uninsured cases of a notifiable disease occurring <u>outside</u> the territorial scope of the cover as depriving the policyholder of an indemnity in respect of interruption also caused by cases of disease which the policy is expressed to

> cover. We agree with the FCA's central argument in relation to the radius provisions that the parties could not reasonably be supposed to have intended that cases of disease outside the radius could be set up as a countervailing cause which displaces the causal impact of the disease inside the radius.
>
> 196. This conclusion is reinforced by the other matter to which the court below attached particular importance in interpreting the disease clauses. This is the fact that the relevant wordings do not confine cover to a situation where the interruption of the business has resulted only from cases of a notifiable disease within the radius, as opposed to other cases elsewhere. As leading counsel for the FCA, Mr Edelman, pointed out, to apply a "but for" test in a situation where cases of disease inside and outside the radius are concurrent causes of business interruption loss would give the insurer similar protection to that which it would have had if loss caused by any occurrence of a notifiable disease outside the specified radius had been expressly excluded from cover. If the insurers had wished to impose such an exclusion, it was incumbent on them to include it in the terms of the policy.
>
> 197. We accordingly reject the insurers' contention that the occurrence of one or more cases of COVID-19 within the specified radius cannot be a cause of business interruption loss if the loss would not have been suffered but for those cases because the same interruption of the business would have occurred anyway as a result of other cases of COVID-19 elsewhere in the country.

29. The Supreme Court went on to reject also what was described as 'the weighing approach', according to which there would be cover under any given policy if all cases of disease falling within the scope of the policy, taken together, had an equal or similar causal impact when compared with the aggregate impact of all cases of disease not covered by the policy.

30. Finally, the Supreme Court stated its overall conclusion as to the causal link required in the case of a pure or hybrid disease clause covering the occurrence of Covid-19 within a specified radius in the following terms:

> '212. We conclude that, on the proper interpretation of the disease clauses, in order to show that loss from interruption of the insured business was proximately caused by one or more occurrences of illness resulting from COVID-19, it is sufficient to prove that the interruption was a result of Government action taken in response to cases of disease which included at least one case of COVID-19 within the geographical area covered by the clause. The basis for this conclusion is the analysis of the court below, which in our opinion is correct, that each of the individual cases of illness resulting from COVID-19 which had occurred by the date of any Government action was a separate and equally

> effective cause of that action (and of the response of the public to it). Our conclusion does not depend on the particular terminology used in the clause to describe the required causal connection between the loss and the insured peril and applies equally whether the term used is "following" or some other formula such as "arising from" or "as a result of". It is a conclusion about the legal effect of the insurance contracts as they apply to the facts of this case.'

The judgment

31. The judgment of Mr Justice Jacobs dealt comprehensively with the causation issues between [157] and [251]. At [171] he identified 'the critical question' as being 'whether the causation reasoning of the Supreme Court in relation to the various "radius" clauses considered in the test case can properly be applied to "at the premises" clauses', applying the principles of construction identified by the Supreme Court at [47] and [77]. In circumstances where the Supreme Court had considered the question of causation in the context of the Covid-19 pandemic, in circumstances not materially different from the present cases, and on the basis of agreed facts which were incorporated into the agreed facts in the present cases, he accepted at [174] the policyholders' submission that he was not 'dealing with the question of construction with a blank slate, by applying the iterative process of construction … as though the Supreme Court decision did not exist'. He therefore defined the question for decision as being:

> '176. … Whether the logic and rationale of the Supreme Court's decision in relation to radius clauses should be applied to the "at the premises" wordings.'

32. The judge's answer to this question was that the logic and rationale of the Supreme Court decision did apply: as a matter of the policy wording, 'at the premises' wording was 'no different in substance to the arguments based upon the coverage being for occurrences within the radius in the FCA test case' (see at [183]); and the existence of a radius, which might be very small, did not amount to a fundamental difference leading to a different test of causation (see at [202]). Rather, the critical features of the Supreme Court's reasoning were (1) the nature of the notifiable diseases covered (see at [195] to [199]); (2) the fact that the function of the radius (which might even be as short as 10 metres) in a radius clause was simply to define the geographical area in which the insured peril must occur (see at [200] to [206]); (3) the fact that the relevant wordings did not confine cover to a situation where the interruption of the business resulted only from cases of disease within the radius (see at [207] to [209]); and (4) the need for a test of causation which was clear and simple to apply (see at [210]). The judge considered that these features applied equally in the context of an 'at the premises' clause (see at [211]).

33. In the remaining part of this section of his judgment, the judge dealt with and rejected the insurers' arguments in support of a different test of causation. These included the 'but for' test and the 'distinct cause' test, both of which the judge rejected on the ground that they could not stand with the reasoning of the Supreme Court in *FCA v Arch*. The judge also rejected an argument based on a supposed equivalence between the 'Lower Tier Local Authority areas' about which the government had data when it made its decision to impose restrictions and the geographic areas represented by circles with a

radius of 25 miles from various insured premises, which would have no application in the case of 'at the premises' clauses.

34. He stated his conclusions as follows:

> '248. Accordingly, I consider that the Supreme Court analysis applies on the causation argument, and that none of the insurers' arguments in support of the contrary conclusion are persuasive.
>
> 249. This seems to me to be an appropriate result, since any other conclusion would give rise to anomalies which it would be difficult rationally to explain to a reasonable SME policyholder who read the policy. In the course of argument, I gave the example of two restaurants, next door to each other: an Italian restaurant owned by Mario, who has an ATP policy, and a Greek restaurant owned by Costas who has radius wording (say 1 mile or "vicinity"). If Mario had contracted Covid-19 in the period before lockdown, there is no dispute that Costas would be able to rely upon Mario's illness in order to claim for the business interruption loss flowing from the closure of his restaurant. This is because, applying the Supreme Court's reasoning, Mario's illness would be a concurrent cause (with many other causes) of the closure of Costas's restaurant and therefore of his loss. However, on the insurers' case, a completely different analysis would apply when Mario sought to claim for the closure of his own restaurant and the consequent losses. For although Mario's illness would be treated as one of many concurrent causes of the closure of Costas's restaurant, it would not be treated as a concurrent cause of the closure of his own restaurant. I find it difficult to see how the reasonable SME reader of Costas's policy would (on the Supreme Court's analysis) reach the conclusion that Mario's illness was a concurrent cause of Costas's loss, but that the reasonable reader of Mario's policy would reach a completely different conclusion in relation to Mario's loss. There was in my view considerable force in Mr Gruder's submission (referring to hairdressers and gym owners) that:
>
> > "if we come back to the position at the conclusion of the policy, if somebody had explained the position in simple words to a hairdresser or to the owner of the gym – if your disease at your premises in conjunction with the same disease at other premises, either in the same town or in the same borough or in the same county or in the same country, if they all together caused restrictions which caused all these businesses to close down, in my submission a business owner would say: well, why shouldn't we all recover. We are all in it together, we're all the cause, we're all the cause together".
>
> 250. My conclusion also resolves another issue raised by certain of the preliminary issues. The preliminary issues indicated that

> insurers were contending that the "at the premises" wordings required, in substance, each occurrence to have been reported to the relevant authorities and for the authorities to have acted on the basis of the knowledge so acquired. As the argument developed, however, it became clear that this was not a point which was separate from the causation argument, whether advanced on a "but for" or "distinct cause" test. The requirement for reporting and knowledge was therefore part and parcel of those causation arguments. Since I reject those arguments, and consider the Supreme Court concurrent cause test to be applicable, there is no separate point which requires resolution. In so far as a separate point was advanced, I reject it as being inconsistent with the Supreme Court decision and unsupported by any relevant wording in the clauses which I am considering.
>
> 251. Finally, in the ExCeL proceedings, Mr Kramer placed reliance upon the specific reference in the relevant policy wording to "closure … on the order or advice of any local or governmental authority as a result of an outbreak or occurrence …". The reference to "governmental authority" was, here, clearly a reference to a national government response, and not simply a local authority response. The reference to "outbreak" was wider than occurrence. Both points led to the conclusion that there would be coverage for a wide-scale response at a national level, and therefore provided reasons why the insurers' contrary argument should be rejected. I consider that there was force in these submissions, and that (in the case of ExCeL) they are further reasons for rejecting the insurers' argument. However, those policyholders who do not have equivalent wording are in no worse position: the Supreme Court's concurrent causation analysis applies whether or not these or equivalent words are present.'

The rival submissions in outline

35. So far as the causation issues common to all the appeals were concerned, the differing submissions on behalf of the insurers were presented principally by Mr Gavin Kealey KC on behalf of the ExCeL insurers following market, Mr Aidan Christie KC on behalf of the Hairlab and Why Not insurers, and by Mr Michael Davie KC on behalf of the Mayfair insurers, with other counsel adopting their submissions as appropriate. The submissions on behalf of the policyholders were presented principally by Mr Adam Kramer KC for ExCeL and Mr Jeffrey Gruder KC for Hairlab and Kaizen.

The ExCeL following market

36. Mr Kealey criticised the judge's approach, submitting that instead of starting with the Supreme Court decision and asking whether its reasoning in relation to radius clauses could be applied to 'at the premises' clauses, the judge should have applied the normal iterative approach to contractual interpretation, starting with the language of the policies and the presumed commercial intentions of the parties. The result in *FCA v*

Arch was exceptional, critically dependent on the interpretation of the radius wordings, and unlikely to reflect the parties' intentions in other cases.

37. Mr Kealey emphasised also the need to avoid hindsight, stressing the unprecedented nature of the national lockdown in 2020. He reminded us that such measures went far beyond the measures taken during previous epidemics such as the Plague of Justinian and the closure of the London theatres due to plague in the first Elizabethan age. (Other counsel made the same point by reference to the Spanish influenza pandemic at the end of the First World War). It was therefore important to approach interpretation of the policy with no preconception that it was intended to provide cover in the unprecedented and unforeseeable events which occurred.

38. Mr Kealey did not contend for a 'but for' test of causation, but submitted that there would be cover only when an occurrence of disease at the premises was a 'distinct effective cause' of the closure of the premises, in the sense of it being the fact of disease having occurred at the premises to which the government or local authority was responding in ordering or advising that the premises be closed. The fact that there was a case of disease and that it was at the premises must be what caused the authority to take this action. Mr Kealey accepted that knowledge of that occurrence on the part of the authority was not an independent requirement, but submitted that it was inherent in the requirement that the authority was responding in this way to an occurrence of disease at the premises. For this purpose, the authority needed either to know about the occurrence at the premises or to believe on reasonable grounds that there had been such an occurrence.

39. Mr Kealey submitted that this approach accommodated concurrent causation: an occurrence of disease at the premises was capable of being a proximate cause even when it combined with other occurrences outside the premises to cause the authority to intervene by ordering the closure of the premises. The distinction was between closure of a large number of premises in 'distinct reaction' to known cases of disease at each of them (in which case there would be cover) and a general response to an outbreak of disease in which the occurrence of the disease at the specific premises had no identifiable causal impact of its own (in which case there would not).

40. Mr Kealey submitted that radius and 'at the premises' clauses are materially different. A radius clause which provided cover in the event of an occurrence of disease as far away as 25 miles from the premises necessarily contemplated that such a geographically remote occurrence might have an impact on the insured premises, and therefore that the authority would be reacting to general, wide-area outbreaks of disease which need have no connection to the insured premises. An occurrence of disease up to 25 miles away would only ever have such an impact in combination with other cases (i.e. in the context of a general outbreak), to which the authority was reacting as a whole by imposing wide-area restrictions to check the spread of disease, which restrictions were not directed at any specific premises. Accordingly, for the radius clause cover to be meaningful, the concurrent causation analysis adopted by the Supreme Court was necessary.

41. In contrast, an 'at the premises' clause responds to, and is focused exclusively upon, the occurrence of disease at the specific insured location, i.e. circumstances in which the premises were closed down because the disease was there. Moreover, other perils within the insuring clause such as food or drink poisoning, vermin or pests, and

defective sanitation were inherently localised. Construing the extension clause as a whole, it contemplates the risk of authority reaction to conditions which pose a public health risk at and from the specific premises.

The Hairlab and Why Not insurers

42. Mr Christie submitted that the occurrence of disease at the premises had to be the necessary (i.e. 'but for') or sufficient cause of the interruption of the business. These terms were explained by Lord Leggatt in *R (Finch on behalf of the Weald Action Group) v Surrey County Council* [2024] UKSC 20:

> '67. Establishing that, as a matter of fact, there is a causal relationship between events X and Y, does not by itself answer the question whether, as a matter of law, X is to be regarded as a cause of Y (and Y as an effect of X). To answer that question, it is necessary to understand the purpose for which the question is being asked: see eg *Environment Agency (formerly National Rivers Authority) v Empress Car Co (Abertillery) Ltd* [1999] 2 AC 22, 29-31.
>
> 68. Depending on the context, various tests of causation may be applied, some more demanding than others. A test often used at least as a minimum requirement is whether X is a necessary condition for the occurrence of Y. This is known by lawyers as the "but for" test because one simple way of expressing it is to ask: would event Y have occurred but for the occurrence of event X? The "but for" test is generally seen as a weak test of causation because, in any given situation, many events (or states of affairs) will satisfy the "but for" test which would not usually be regarded as causes of the event under consideration: see eg *Financial Conduct Authority v Arch Insurance (UK) Ltd* [2021] UKSC 1; [2021] AC 649, para 181.
>
> 69. The strongest possible test of causation, which is seldom satisfied when questions of causation arise in law, requires the occurrence of event X to be both a necessary and sufficient condition for the occurrence of Y. If X is a sufficient cause of Y, then every time X happens Y will always follow. This is the kind of unbreakable connection that exists, for example, where laws of physics, such as Newton's laws of motion, operate.
>
> 70. An example of a test not as strong as this but much stronger than the "but for" test is the interpretation placed on pollution control legislation in the *Environment Agency* case mentioned earlier. The legislation made it an offence to cause polluting matter to enter controlled waters. Diesel oil stored in a tank in the defendant's yard had overflowed into a river but only because an outlet tap without a lock had been turned on by a person unknown. The question was whether the defendant had caused the oil to enter the river. The House of Lords held that the criterion for identifying which intervening acts and events

> negative causal connection for this purpose was whether the intervening act or event was a matter of ordinary occurrence or was something extraordinary. If, as on the facts of that case, the third party act which was the immediate cause of the pollution was a matter of ordinary occurrence, it should not be regarded as negativing the causal effect of the defendant's acts. The proper conclusion would therefore be that the defendant had caused the polluting matter to enter the river.
>
> 71. A similar test applies in insurance law where, unless the insurance policy otherwise provides, the insurer is liable only for losses "proximately" caused by a peril insured against. As explained in *Financial Conduct Authority v Arch Insurance*, paras 164-168, the term "proximate" means "real or efficient" and whether the occurrence of an insured peril was the proximate (or efficient) cause of the loss involves making a judgment as to whether it made the loss inevitable - if not, which could seldom if ever be said, in all conceivable circumstances - then in the ordinary course of events. For this purpose, human actions are not generally regarded as negativing causal connection, provided at least that those actions were not wholly unreasonable or erratic.'

43. In his written submissions Mr Christie submitted that any occurrence of disease at the premises had to be shown to be a necessary and sufficient cause of the subsequent restrictions, that is to say he argued for what Lord Leggatt described in *Finch* at [69] as 'the strongest possible test of causation', albeit one which is 'seldom satisfied'. In oral argument, however, he was prepared to accept that there would be cover 'if the occurrence of the disease at [the policyholder's] premises was a necessary or at least a sufficient cause of its loss' (our emphasis), the 'critical point' being that 'there must be a direct causal link between that occurrence and any measures taken in response to the occurrence at the premises'.

44. However, we did not understand Mr Christie to be using the term 'sufficient cause' in the sense described by Lord Leggatt in *Weald Action Group* at [69], i.e. that every time X happens, Y will always follow. Rather, his submission was that BI losses caused by the closure of the premises by a public authority would only be covered if the authority actually knew about and acted in response to the occurrence of the disease at the premises. As he put it, 'the causal requirement under the ATP clause requires a direct causal relationship between the occurrence of disease at the premises and the restrictions on the use of the premises imposed in response, in the sense that the restrictions were directed at and taken in specific response to and with knowledge of the cases at the premises.' To that extent, the difference between Mr Christie's and Mr Kealey's submissions was to some extent, as Mr Christie accepted, 'more apparent than real'. Like Mr Kealey, Mr Christie accepted that, provided this test was met, the occurrence of disease at the premises need not be the only cause of the restrictions imposed, so that the clause did not rule out a concurrent causation analysis.

45. Mr Christie also criticised the judge for having started with the decision of the Supreme Court without recognising the material differences between radius and 'at the premises' clauses, and urged the avoidance of hindsight.

The Mayfair insurers

46. Mr Davie accepted that the suffering of disease at the premises need only be a cause of the competent authority's decision to close the premises, in the sense that it made a contribution to that decision, and that the contribution need not be substantial or material; but the authority had to know about the suffering of disease at the particular premises and had to take it into account in reaching its decision. He submitted that the government did not take the (assumed and yet to be proved) presence of the disease at the Mayfair premises into account because, on the facts, the government was responding only to the reported cases of Covid-19 which numbered about 8,000, and that is what the Supreme Court meant when it referred at [212] to each of the individual cases of illness which had occurred by the date of any government action as a separate and equally effective cause of that action. In fact, he submitted, the government was not responding to the presence of Covid-19 in any particular premises at all, but merely to the fact that its presence had been reported in local authority areas throughout the country, with only very limited exceptions.

47. Mr Davie relied also on the reference in the Mayfair policy, not present in the other policies, to the disease being suffered by a visitor or employee. We deal separately with the significance or otherwise of that wording in Section G below.

The policyholders

48. Mr Kramer and Mr Gruder commended the judge's approach, including his reasoning and conclusions. They submitted that the essential feature of the Supreme Court's reasoning on the issue of causation was the nature of the notifiable diseases covered, which were highly contagious and infectious, and liable to spread widely and unpredictably so as to call for a response by local or national government which in its nature would be unlikely to depend on knowledge of the precise premises at which the disease was present; that reasoning was equally applicable to the 'at the premises' clauses and indicated that the causal link required for such clauses was no different.

49. Further, the Supreme Court had held, and it was not challenged in the present cases, that an 'occurrence' of disease did not need to have been diagnosed, or even to have been symptomatic, in order to constitute an insured peril: if that was so, it was unlikely that the parties would have stipulated for a causal link which required knowledge of the presence of the disease at the premises on the part of the relevant authority. Mr Kramer and Mr Gruder emphasised also what they submitted was a finding of fact made by the Supreme Court, which was equally applicable in the present cases, that the restrictions introduced by the government were a response to all cases of Covid-19 in the UK, whether known or unknown, and even though the government did not know where they all were.

Analysis

Some general principles

50. As the insurers in the present appeals insisted, 'at the premises' clauses are different in some respects from radius clauses. We shall have to consider to what extent, if any, those differences affect the outcome of these appeals. Nevertheless, the following aspects of the Supreme Court's reasoning are important. They represent general

principles applicable to the analysis of causation in insurance cases, which are not limited to the particular radius clauses in issue in *FCA v Arch*. They are therefore an authoritative statement of the principles which we must apply to the issue of causation in the present cases.

51. First, an insurance policy, like any other contract, must be interpreted objectively by asking what a reasonable person, with all the background knowledge which would reasonably have been available to the parties when they entered into the contract, would have understood the language of the contract to mean (*FCA v Arch* at [47]). In the case of these BI policies, as in the present cases, it was significant that the policies in issue were sold principally to small and medium-sized enterprises:

> '77. … In any event, the overriding question is how the words of the contract would be understood by a reasonable person. In the case of an insurance policy of the present kind, sold principally to SMEs, the person to whom the document should be taken to be addressed is not a pedantic lawyer who will subject the entire policy wording to a minute textual analysis (cf. *Jumbo King Ltd v Faithful Properties Ltd* (1999) 2 HKCFAR 279, para 59). It is an ordinary policyholder who, on entering into the contract, is taken to have read through the policy conscientiously in order to understand what cover they were getting.'

52. Second, the nature of the causal link required depends upon the interpretation of the policy. An insurer's liability is contractual. It is therefore open to the parties to agree what must be proved by way of causation. Although the law has developed the test of 'proximate' (or more accurately, 'efficient') cause, this is based on the presumed intention of the contracting parties and is capable of being displaced if the policy, on its proper interpretation, provides for some other connection between loss and the occurrence of an insured peril (see at [163]). In this connection the Supreme Court cited the speech of Lord Shaw of Dunfermline in *Leyland Shipping Ltd v Norwich Union Fire Insurance Society Ltd* [1918] AC 350, saying:

> '166. … By far the fullest discussion of the concept of proximate cause is contained in the speech of Lord Shaw of Dunfermline. He made it clear, first of all, that the test of causation is a matter of interpretation of the policy and that "The true and the overruling principle is to look at a contract as a whole and to ascertain what the parties to it really meant"' (see p369).

53. However, interpretation of the policy to determine the nature of the causal link which the parties intended to apply is unlikely to depend on linguistic analysis of the words of causation (e.g. 'as a result of') used in the policy. A wider enquiry is necessary in order to ascertain the parties' intentions:

> '162. Many different formulations may be found in insurance policy wordings of the required connection between the occurrence of an insured peril and the loss against which the insurer agrees to indemnify the policyholder. This may be illustrated by the variety of phrases used in the sample wordings in the present case. We noted earlier that RSA 3 uses the word

> "following" to describe the required connection between occurrence of a notifiable disease and interruption of the business. So do MSA 1 and MSA 2. In the Argenta wording the phrase used is "as a result of". In QBE 1, it is "arising from"; and in QBE 2 and QBE 3, it is "in consequence of". We do not think it profitable to search for shades of semantic difference between these phrases. Sometimes the policy language may indicate that a looser form of causal connection will suffice than would normally be required, such as use of the words "directly or indirectly caused by …": see eg *Coxe v Employers' Liability Assurance Corpn Ltd* [1916] 2 KB 629. The same may arguably be said in the present case of the word "following". But it is rare for the test of causation to turn on such nuances. Although the question whether loss has been caused by an insured peril is a question of interpretation of the policy, it is not (unlike the questions of interpretation of the disease, hybrid and prevention of access clauses considered above) a question which depends to any great extent on matters of linguistic meaning and how the words used would be understood by an ordinary member of the public. What is at issue is the legal effect of the insurance contract, as applied to a particular factual situation.'

54. The Supreme Court described the approach to be followed in this way:

> '168. The common-sense principles or standards to be applied in selecting the efficient cause of the loss are, however, capable of some analysis. It is not a matter of choosing a cause as proximate on the basis of an unguided gut feeling. The starting point for the inquiry is to identify, by interpreting the policy and considering the evidence, whether a peril covered by the policy had any causal involvement in the loss and, if so, whether a peril excluded or excepted from the scope of the cover also had any such involvement. The question whether the occurrence of such a peril was in either case the proximate (or "efficient") cause of the loss involves making a judgment as to whether it made the loss inevitable - if not, which could seldom if ever be said, in all conceivable circumstances - then in the ordinary course of events. For this purpose, human actions are not generally regarded as negativing causal connection, provided at least that the actions taken were not wholly unreasonable or erratic.'

55. Third, a loss may be caused by more than one cause, each of equal efficacy, neither (or none) of which would have caused the loss without the other(s). In such circumstances, the policyholder will generally be entitled to recover if one of those causes is an insured peril, so long as the uninsured cause is not expressly excluded. *The Miss Jay Jay* [1987] 1 Lloyd's Rep 32 illustrates this principle. There were two causes of equal or nearly equal efficiency, adverse sea conditions (which was an insured peril) and design defects (which were not, but nor were they an excluded peril). The policyholder was entitled to recover. In contrast, where there are two proximate causes of loss, of which one is an

insured peril but the other is expressly excluded from cover, the exclusion will generally prevail (see at [173] to [175]).

56. The novelty of *FCA v Arch* was the application of this analysis to a case of multiple (in fact thousands of) causes acting in combination to bring about a loss:

> '176. There is, in our view, no reason in principle why such an analysis cannot be applied to multiple causes which act in combination to bring about a loss. Thus, in the present case it obviously could not be said that any individual case of illness resulting from COVID-19, on its own, caused the UK Government to introduce restrictions which led directly to business interruption. However, as the court below found, the Government measures were taken in response to information about all the cases of COVID-19 in the country as a whole. We agree with the court below that it is realistic to analyse this situation as one in which "all the cases were equal causes of the imposition of national measures" (para 112).'

57. Fourth, the existence of these multiple causes meant that the policyholders were unable to satisfy the 'but for' test. That is to say, the government would probably have acted as it did regardless of the existence of Covid-19 within the specified radius of any individual insured premises:

> '179. … In these circumstances it is unlikely that the existence of an enclave with a radius of 25 miles in any one particular area of the country which was so far free of COVID-19 would have led to that area being excepted from the national measures or otherwise have altered the Government's response to the epidemic. That in turn means that in the vast majority of cases it would be difficult if not impossible for a policyholder to prove that, but for cases of COVID-19 within a radius of 25 miles of the insured premises, the interruption to its business would have been less.'

58. Nevertheless, although the 'but for' test must usually be satisfied if one event is to be treated in law as the cause of another (see at [181]), that is not always the case. There may be cases where a series of events combine to produce a result, but where none of the individual events was either necessary or sufficient to bring about the result by itself (see at [183]). There is no reason in principle why an insured peril which, in combination with many others, brings about a loss, should not be regarded as having caused that loss. Whether it should be so regarded depends on the interpretation of the policy:

> '190. … Whether an event which is one of very many that combine to cause loss should be regarded as a cause of the loss is not a question to which any general answer can be given. It must always depend on the context in which the question is asked. Where the context is a claim under an insurance policy, judgements of fault or responsibility are not relevant. All that matters is what risks the insurers have agreed to cover. We have

> already indicated that this is a question of contractual interpretation which must accordingly be answered by identifying (objectively) the intended effect of the policy as applied to the relevant factual situation.
>
> 191. For these reasons there is nothing in principle or in the concept of causation which precludes an insured peril that in combination with many other similar uninsured events brings about a loss with a sufficient degree of inevitability from being regarded as a cause - indeed as a proximate cause - of the loss, even if the occurrence of the insured peril is neither necessary nor sufficient to bring about the loss by itself. It seems incontrovertible that in the examples we have given there is a causal connection between the event and the loss. Whether that causal connection is sufficient to trigger the insurer's obligation to indemnify the policyholder depends on what has been agreed between them.'

The correct approach

59. Although it may ultimately make no difference to the outcome, we think there is force in the insurers' submission that the correct approach is to begin with the interpretation of the policies in issue, having regard to their language and context, rather than asking whether those clauses differ materially from the radius clauses considered in *FCA v Arch*. That is not to say that the reasoning of the Supreme Court should be ignored and no counsel suggested that it should be. But the Supreme Court was not considering 'at the premises' clauses and it is appropriate to begin by considering the features of those clauses in the policies with which we are concerned.

The nature of the insured peril

60. The nature of the insured peril will inform the nature of the causation test which the parties can be taken to have agreed. For that reason no real assistance can be derived from the other perils mentioned in the various insuring clauses, such as vermin infestation, defective drains and murder or suicide at the premises. Those are by definition different insured perils from that dealt with in the disease limb of the clauses. Once it is accepted, in accordance with the teaching of the Supreme Court, that the nature of the insured peril in question will inform the nature of the causal link required to be satisfied, the focus must be on the particular insured peril in question and on what that tells us as to the parties' intentions regarding causation.

61. All of the disease clauses in the present cases, whether pure or hybrid, include as an element of the insured peril that there should be an occurrence at the premises of a notifiable disease. In some cases that disease must be 'suffered' (*Mayfair)* or 'manifested' (*Why Not*) and we consider below whether that wording makes any difference, but on any view a disease cannot be suffered or manifested unless it also occurs.

62. The notifiable diseases referred to in the policies were the diseases listed in Schedule 1 of the Health Protection (Notification) Regulations (SI 2010/659) as amended or its Welsh equivalent. Under those regulations, a registered medical practitioner has a duty

to notify the local authority where the practitioner has reasonable grounds for suspecting that a patient has a 'notifiable disease'. Although Covid-19 was not listed (and was not even known of) at the date of the policies, the diseases which were listed included diseases such as cholera, plague, typhus, yellow fever and SARS which are capable of spreading rapidly and widely, potentially affecting and causing interruption to businesses over a wide area. Although there may be exceptions, these are in general not diseases which are likely to be confined to occurrences at a single premises. Such occurrences come not single spies but in battalions.

63. Accordingly, if the parties had applied their minds to the circumstances in which the insured premises were likely to be closed by a relevant authority as a result of an occurrence of disease at the premises, they would have contemplated that closures or restrictions imposed by the authority in such cases would be unlikely to be a response only to the occurrence of the disease at the insured premises. Rather they would be imposed in response to the outbreak as a whole over the relevant area, whether local or national. Indeed, the worse and more widespread the outbreak of the disease, the more likely it would be that such restrictions would be imposed. If the disease clauses were to have meaningful content, therefore, the parties must have intended that there would be cover in such circumstances.

64. These considerations demonstrate, in our judgment, that the parties cannot have intended a conventional 'but for' approach to causation to apply. In the circumstances in which the insured peril was likely to arise, and cover under the disease clause would be most needed, it would in general be difficult or impossible for the policyholder to prove that the restrictions would not have been imposed 'but for' the occurrence of the disease at the insured premises. Accordingly the parties must have intended that the causation requirement would be satisfied if the occurrence at the premises was one of a number of causes of the closure (or, in the case of a 'pure' disease clause, of the BI losses suffered as a result of the disease). Moreover, it would not have mattered to the parties whether the number of other causes was large or small. Indeed, the larger the number, the more likely it was that restrictions would be imposed and the cover would be needed.

65. In the case of the *ExCeL* wording this analysis is supported by the reference in the clause to 'any local or governmental authority', which expressly contemplates restrictions imposed at a national as well as local level. However, it does not depend on this, but arises simply from the nature of a notifiable disease and the circumstances in which the occurrence of such a disease is likely to lead to closure or restrictions being imposed on business premises.

66. The question then arises whether the causation requirement would only be satisfied if the relevant authority actually knew of (or as Mr Kealey submitted, had a reasonable belief as to) the occurrence of the disease at the insured premises. Again it is necessary to consider the circumstances in which closure or other restrictions would be likely to be imposed in response to occurrences of a notifiable disease. It is unrealistic to think that the authority would apply its mind to identifying the particular premises at which there had been such occurrences. It would know in the case of a serious outbreak that there had been a number of occurrences of the disease in its area (or perhaps in particular kinds of premises in its area, such as restaurants, schools or other places where people gather) and would react to those occurrences by imposing restrictions

accordingly. Identification of the particular premises at which there had been such occurrences would be an irrelevant consideration.

67. We agree with the insurers' submission that it is necessary to approach the interpretation of these policies without applying hindsight. However, we do not accept that the analysis so far undertaken involves such hindsight. It represents what the parties would have contemplated when entering into these policies as to the circumstances in which the disease clauses would apply.

68. The point can be illustrated by reference to some examples canvassed in argument. One such example was a hypothetical outbreak in Upper Street, a street in Islington where, apparently, there are many restaurants of various kinds. Suppose that there are 20 such restaurants, at all of which there have been occurrences of a notifiable disease. The relevant authority does not know that there have been occurrences at all 20 restaurants, but it knows about ten of them at one end of the street and decides that it is necessary to close all 20 as a matter of urgency without investigating the position at the other ten. Assuming all the restaurants to be insured on the same or equivalent terms, it would be surprising if the only insurers liable were those where the policyholder could prove that the authority knew about the occurrence in question. From the perspective of the policyholders at the other end of the street who were insured against losses caused by an occurrence of the disease, and whose restaurants had in fact had such an occurrence and had been closed, that would be a surprising and unjust result.

A finding of fact

69. It is more realistic in such circumstances to regard the restriction in question, whether that be the national lockdown imposed as a result of Covid-19 or a hypothetical closure of restaurants in Upper Street, as a response by the relevant authority to all cases of the disease, whether known or unknown. That was in fact the approach of the Divisional Court and the Supreme Court in *FCA v Arch*:

> '179. … As already mentioned, the court below found as a fact (at para 112 of the judgment) that the Government response was a reaction to information about all the cases of Covid-19 in the country and that the response was decided to be national because the outbreak was so widespread.'

70. The point was repeated at [212] as the factual basis for the Supreme Court's conclusion as to the interpretation of the radius disease clauses in issue:

> '212. … The basis for this conclusion is the analysis of the court below, which in our opinion is correct, that each of the individual cases of illness resulting from Covid-19 which had occurred by the date of any Government action was a separate and equally effective because of that action (and of the response of the public to it)'.

71. That is a finding of fact which must apply equally in the present cases, and one which, in our view, is self-evident from the agreed facts about the matters which SAGE and the government were taking into account in their decision-making at the relevant time. It cannot be wished away by saying that the Supreme Court meant to refer only to

reported cases and not to all cases which had occurred by the relevant time. It means that the government action was taken, not merely in response to the still relatively low number of reported cases, but in response to each and every case of Covid-19 which had so far occurred, whether or not it had been reported. These 'unknown' cases, referred to at the hearing before us as the 'known unknowns', were known to exist, even though the government did not know precisely how many such cases there were or precisely where they were.

Conclusion

72. It follows that the government's order or advice to close the ExCeL Centre was caused by what is agreed to have been an occurrence of Covid-19 at the Centre, operating in combination with all other cases of Covid-19 in the country which had occurred. The same analysis applies to the other policies. On the assumption that there were occurrences of Covid-19 at each of the policyholders' premises, those occurrences together with all other cases of Covid-19 in the country were a cause of the closure of those premises. In ordering the national lockdown, therefore, the government was responding to the fact of disease having occurred at each of these premises. This is an approach which is clear and simple to apply, in contrast with an interpretation which would require the policyholder to establish precisely what knowledge (or belief) the relevant authority had as to the existence of a disease at any given location. In our judgment it reflects the way in which the words of the contract would be understood by a reasonable person and in particular the ordinary policyholder taking out this kind of policy.

73. Accordingly, although we have preferred to base our conclusion on the language and context of the 'at the premises' clauses in issue and the presumed common intentions of the parties, rather than on how the Supreme Court interpreted the radius clauses, we agree with the conclusion and much of the reasoning of the judge on the common causation issues. Although there are differences between radius and 'at the premises' clauses, those differences do not materially affect the nature of the causal link which must be proved, save that in the case of 'at the premises' clauses the occurrence of disease must be at the premises themselves and not within a specified distance from them.

D. MEDICAL OFFICER OF HEALTH

74. The *Kaizen* and *Why Not* policies require the closure or restrictions to be placed on the premises 'on the advice or with the approval of the Medical Officer of Health for the Public Authority'. The position of medical officer of health no longer existed at the time the policies were entered into and had not done so for approaching 50 years. The post had been created and recognised by statutes since the 19th century conferring functions and powers on such a person in relation to aspects of regulation of public health at a local level. The post was abolished when its functions were transferred to area health authorities in the NHS reforms brought about by the Local Government Act 1972 and the National Health Service Reorganisation Act 1973, both of which came into effect in April 1974.

75. The insurers challenge the judge's conclusion that the Chief Medical Officer, Deputy Chief Medical Officer, and other medical officers advising government in England and Wales, fulfil the description 'Medical Officer of Health' in these policies. They contend

that the reference is to an officer of a local authority only, and is to be read as any such officer who has been designated by the local authority to perform functions previously performed by a medical officer of health as envisaged by s. 74 of the 1984 Act.

The rival submissions

76. The arguments of Mr Christie on behalf of the *Why Not* insurers can be briefly summarised as follows. 'Public Authority' means a local authority only, and 'Medical Officer of Health' means the modern day equivalent of medical officers of health in the form of local authority officers performing their former functions and responsibilities. Paragraph 6C) of the extension, which provides cover for BI loss from closure consequent upon defects in drains and other sanitary arrangements in the premises 'by order of the Public Authority *for the area in which the Premises are situate*', refers to closure by a local authority, and makes clear that Public Authority was being used in 6A) in the same sense, referring to an authority at a local area level. This is reinforced by the other closure perils identified in extension 6 which are, he submitted, local matters: sale of food and drink from the premises, defects in drains and sanitary arrangements, murder or suicide at the premises and damage to property in the vicinity of the premises. Extension 6, he submitted, including 6A), provides cover for exclusively local matters and highly localised incidents, so that any reasonable reader of the policy would regard it as being concerned exclusively with local authority responses to localised incidents and events. This is reinforced by the use of the definite article *the* Public Authority, which it was submitted is an indication that a particular type of public authority was being identified. This was said to be put beyond doubt by the reference to Medical Officer of Health which properly construed refers to the authorised officer of the local authority concerned with local questions of public health including notifiable disease: this follows from s. 74 of the 1984 Act which identifies the person to whom notification of a notifiable disease has to be made as an officer appointed for that purpose, whose responsibilities correspond to those of the former medical officers of health. Mr Christie also placed reliance on what was said by Lord Mance in his arbitration award in the dispute between various policyholders and China Taiping Insurance (UK) Ltd.

77. On behalf of the *Kaizen* insurers, Mr Keir Howie made similar points, so far as referable to the slightly different wording in that policy, which contains no equivalent to 6C) referring to the Public Authority 'for the area in which the premises are situate'; but conversely has the Public Authority requirement for all the perils covered by the extension, whereas in *Why Not's* policy it only applies to notifiable disease cover and defective. In relation to all the other perils, he submitted, the closure would almost always be by the local authority. Moreover the whole extension is focussed locally on something which occurs at the premises. Mr Howie criticised the judge for failing to identify clearly what was meant by Medical Officer of Health: his conclusion that it included the Chief Medical Officer cannot have been intended to be exhaustive, given that the cover for all the perils clearly covered local authority closures. He criticised the policyholders' argument as being in effect that Medical Officer of Health meant anyone making the closure decision, which would deprive the words of any meaning or effect. He argued that the cover would most reasonably be understood as confining 'Public Authority' to a local authority and the advice or approval as having to come from authorised local officers of local authorities who are concerned with notifiable disease in their area.

78. On behalf of the *Why Not* policyholders, Mr Richard Chapman KC submitted that public authority was a broad expression whose natural meaning was not confined to a local authority. He prayed in aid the difference between clauses 6A) and 6C) as something supporting the policyholders' construction: the fact that the expression Public Authority in 6A) was not confined to an authority for the area in which the premises were situated meant that it was intended to cover authorities with wider area jurisdiction, including national authorities; alternatively, and at the lowest, a public authority for an area in which premises are situated, for the purposes of 6A), could mean an area the size of a country. He argued that there was nothing in the other sub-paragraphs of the extension which suggested that the wide meaning of public authority should be cut down. He gave examples of how each of the perils covered by the sub-paragraphs might realistically elicit a national response; and argued that in any event each sub-paragraph involved separate perils, to which the requirement of advice or approval of a Medical Officer of Health did not attach save in the case of notifiable diseases. The nature of that peril, which was of a disease which might be highly infectious or contagious, contemplated a national response because, as the Supreme Court identified in *FCA v Arch* at [194], the parties would be presumed to have known that some notifiable diseases would be capable of spreading rapidly, widely and unpredictably, and would not be confined to the locality of the particular premises. Other parts of the policies refer to local authority or government where they wish to be specific; by contrast Public Authority is an expression of wide ambit. The policyholders could not be expected to know anything about the defunct historical role of medical officers of health, and the reference to such officers cannot cut down the plain meaning of Public Authority which encompasses national governments who could be contemplated as responding to some outbreaks of notifiable diseases.

79. On behalf of the *Kaizen* policyholders, Mr Gruder advanced similar submissions, again taking account of the differences in the wordings.

Admissible background material as an aid to construction

80. The agreed and assumed facts for the *Kaizen* dispute include the matters set out in Appendix 1 to this judgment; and those for *Why Not*, the matters set out at Appendix 2, to the very limited extent that they are additional or different. They trace the history of the appointments of Medical Officers of Health from their first appearance in Liverpool in 1846 in relation to local sanitation, to their abolition in 1974 with the introduction of the 1972 NHS reforms. The Appendices also set out the statutory basis for the exercise of some of the relevant powers and functions in relation to public health and notifiable diseases since then, at national and local level.

81. Interesting as some may find the brief summary of public health regulation going back to the 19th century set out in the Appendices, by no means all of it is admissible as an aid to construction of the clauses in the *Kaizen* and *Why Not* policies. It was accepted on behalf of the insurers that the policyholders could not reasonably be expected to have been aware of repealed legislation by which medical officers of health formerly had their functions conferred and defined. Had the policyholders applied their minds to what a Medical Officer of Health was, at the time they entered into the policies, they would have been aware that it was not something which existed (as would have been confirmed by resort to the Oxford English Dictionary which does not refer to such a term). They could not reasonably have been expected to inquire into its historical function. Nor would they have treated it as a defined term, despite its capitalisation,

because it was not so defined anywhere else in the policy or used elsewhere in the policy. The same is true of Public Authority which despite its capitalisation was not a defined term or one used with capitals elsewhere in the policies so as to assist in its meaning. The expression would therefore have been approached as an ordinary English phrase, medical officer of health for the public authority, without any defined meaning as a term of art.

82. On the other hand, current legislation in force at the date the policies were entered into is admissible as relevant background to the exercise of construction if it was reasonably available to the parties, that is to say material which it is reasonable to expect them to have discovered by inquiry even if not within their actual knowledge. We would ourselves question whether these SME policyholders, or brokers acting for them, could reasonably have been expected to be aware of all the legislation then in force referred to in the Appendices which might have some bearing on the issue, including in particular s. 74 of the 1984 Act upon which insurers placed such reliance. However the parties treated it all as admissible and we are content to do so for the purposes of the appeal.

83. Accordingly, on this basis, the relevant available background at the time the policies were entered into was the following:

i) There was no such thing as a 'Medical Officer of Health' as a defined post or position. At the time that each of the policies was entered into, there was no one in local or national government who was a medical officer of health as such.

ii) Regulation of public health generally is the responsibility of a range of different local and national bodies.

iii) In relation to public health risks generally arising at individual premises, including those related to food hygiene, environmental health, sanitation, vermin and non-notifiable infectious and contagious diseases, action would usually be undertaken by authorities at a local authority level, including through local courts, but might conceivably take place on occasion on a wider area level or a national level.

iv) What constituted a notifiable disease, and how it was to be notified, was determined at a national, not local, level by regulations made by the Secretary of State.

v) There was a wide range of notifiable diseases and causative agents listed at Schedules 1 and 2 of the 2010 Regulations which numbered over one hundred, including for example food poisoning, measles, Legionnaires disease, Ebola virus and SARS. For the purposes of the cover in these policies the category was not closed, and would include any diseases which became notifiable during their currency. The variety and range inherent in the category, and its potential extension to new diseases after inception, meant that any given outbreak of a notifiable disease might have a purely local effect within the area of a single local authority, or might have an area wide or national effect beyond the jurisdiction of any particular local authority.

vi) Restrictions or closures might be placed on premises as a result of a notifiable disease being present at them by a local authority, a local court or a national authority. Such restrictions or closures would not be limited to an exercise of powers by local authorities, in the sense of those who formerly had medical officers of health, but might be by a range of public bodies, national or local.

vii) The process of notification of notifiable diseases requires a registered medical practitioner to notify "the proper officer of the relevant local authority" where they have reasonable grounds for suspecting that a patient whom they "are attending" has a notifiable disease. In the *Hairlab* dispute it is agreed that notification by a registered medical practitioner may alternatively be given to a Health Protection Team, which is under the umbrella of the central authority of UKHSA; and that laboratories conducting a 'primary diagnostic role' also have a notification requirement which is to be made to UKHSA. In the *Why Not* dispute, it is agreed that the primary aim of notification by registered medical practitioners is to enable the proper officer of the local authority to investigate promptly and take health protection measures to prevent the further spread or transmission of infection or contamination and to reduce the public health impact.

viii) The 1984 Act, which provided for regulation of notifiable diseases and pursuant to which the relevant notification regulations were made, had at s. 74, which remains in force, an interpretation section identifying the meaning of a number of epithets used in that Act. It provides:

> 'In this Act, unless the context otherwise requires-
>
> "authorised officer," in relation to a local authority, means-
>
> "an officer of the authority authorised by them in writing, either generally or specially, to act in matters of a specified kind or in a specified matter, or
>
> by virtue of his appointment and for the purpose of matters within his province, a proper officer of the authority, appointed for purposes corresponding to any of those of the former medical officers of health, surveyors and sanitary inspectors;
>
> …
>
> "proper officer" means in relation to a purpose and to an authority, an officer appointed for that purpose by that authority;'

ix) Local authorities who are notified by registered medical practitioners of cases of a notifiable disease are obliged to report them to the national authority (Public Health England at the time the policies were entered into, now UKHSA).

Discussion and Conclusions

84. The relevant terms require two separate elements: the closure or restriction must be placed on the premises by 'the Public Authority'; and that decision must be taken on

the advice of, or with the approval of, the Medical Officer of Health for such Public Authority. However, the term 'Medical Officer of Health for the Public Authority' must be construed as a whole and as a unitary exercise. What constitutes a Medical Officer of Health will be coloured by what constitutes the Public Authority. What constitutes the Public Authority may be coloured by what constitutes a Medical Officer of Health. Both aspects must therefore be considered. Neither uses the words as a defined term in the policies despite being capitalised: Medical Officers of Health do not exist as a defined post; and Public Authority is not given a defined meaning, and is not used elsewhere with capitals so as to assist in giving it a defined meaning. The insurers criticised the judge for starting with what was meant by 'the Public Authority'. The criticism is misplaced. It is a permissible and indeed natural place to start, provided that the process takes into account what if any influence on the interpretation can be gleaned from the fact that such authority must be treated as having someone who can be described as a Medical Officer of Health, as the judge did.

85. As a matter of ordinary language, 'public authority' does not distinguish between those acting locally and those acting more remotely or nationally. Its natural meaning is any such authority without distinction, both local and national. The inclusion in the cover in the *Why Not* policy of paragraph 6C) supports, rather than detracts from, that natural meaning: where it is intended to qualify it so as to confine it to a particular locality, additional words are added ('for the area in which the premises are situate…'). Without such language it would bear its natural wider meaning. There is no significance in the use of the definite article 'the' before 'Public Authority': it is used simply to denote the specific public authority which is placing the closure or restriction on the premises. In the *Kaizen* policy the cover is for an occurrence at the premises of a 'Notifiable disease' which is defined as one stipulated as notifiable by 'the competent public authority'. In that definition public authority clearly includes national government, which determines what diseases are notifiable.

86. There is nothing to suggest a narrower meaning in the fact that the other perils identified in the clause (vermin, sanitation etc) will most usually involve a local response. Mr Chapman was correct that in each case one could posit a realistic example which involved a response at a remoter or national level. Moreover, and importantly, the perils in each sub-paragraph are separate and involve different subject matter. The separate nature of the perils is reinforced in the *Why Not* policy by the fact that there is no mention of Public Authority, or any other definition of who does the closing, save for drains and sanitary arrangements in 6C) where it is expressly qualified. Notifiable diseases are a particular category of peril which by reason of their notifiability contemplate contagion or infection in others by spread, quite possibly by widespread and rapid spread, in the absence of closure or restriction. In particular, notifiable diseases inherently include cases where a national response is readily contemplatable, as for instance with SARS. That does not involve using the benefit of hindsight of the Covid-19 epidemic. It seems to us obvious that the purpose of the statutory requirement of onward reporting of notifiable disease by local authorities to UKHSA at a national level must be to enable a national response to take place where a national response is called for. Notifiable disease cover does therefore contemplate a national response as a normal incident of cover.

87. The use of the expression 'Medical Officer of Health', whose advice or approval is an additional element of the closure/restriction required by the peril, does nothing to

detract from this conclusion. In both policies it is used only for the notifiable disease peril. But it has no defined meaning. It cannot be permissible to construe it by reference to functions and responsibilities formerly exercised by medical officers of health when they existed, as the insurers seek to do, because knowledge of such functions and responsibilities was not something reasonably available to the policyholders. It seems somewhat artificial to credit them with deemed knowledge of the definitions in s. 74 of the 1984 Act, but even assuming it is correct to do so, that would not tell them that former medical officers of health exercised *only* local authority functions when they existed: it would indicate no more than that 'in relation to a local authority' a proper officer could be authorised to perform the responsibilities corresponding to those of former medical officers of health; in other words that insofar as local authorities were performing functions previously performed by medical officers of health they should authorise a proper officer to do so. Moreover s.74 would not tell policyholders that former functions of medical officers of health were now exclusively performed by local authority officers with none being exercised by national bodies, if indeed that were the case.

88. We add the qualification because although Mr Christie initially asserted that all functions formerly performed by medical officers of health were now performed by local authorities, the scope of national functions and responsibilities identified in Appendices 1 and 2 suggests that they include functions which were formerly performed at a local level by medical officers of health. By way of example only, national responsibilities include imposing notification requirements for infectious and contagious diseases; and receiving reports of cases of such diseases, which now takes place at a national level as well as a local level. Indeed section 13 of the 1984 Act, in which s. 74 appears, conferred power on the Secretary of State to make regulations to prevent the spread of any epidemic endemic or infectious diseases, which was historically the purpose of intervention by medical officers of health at a local level. In his reply submissions Mr Christie no longer contended that all the functions previously exercised by medical officers of health had been transferred to local authorities, but merely that the agreed facts did not identify any which had been transferred to national authorities. Even this, however, is not borne out by the content of the agreed facts set out in the Appendices.

89. It is worth pausing to consider what purpose might have been intended to be served by imposing an additional requirement of medical officer of health advice/approval to a peril which already by its other wording requires a decision to close/restrict the premises as a result of a notifiable disease being present there. It may be that it was inattentive inclusion of old wording which predated the abolition of medical officers of health and has become redundant, but neither side argued that it was redundant, and some search for its scope and meaning is required. It was said on behalf of the policyholders to be an additional safeguard against arbitrary or capricious action and to ensure that the closure/restriction had some, albeit subjective, medical foundation, so as to be an informed decision. Mr Howie, at least, did not disagree and Mr Christie did not advance any alternative purpose. However on insurers' case it would not fulfil this purpose. On insurers' case the person involved at a local authority need only have been someone appointed by a local authority to exercise functions previously exercised by former medical officers of health, which would include those authorised to deal with food hygiene, sanitation, drains or vermin, for example. These would not necessarily, or indeed usually, be people who have medical knowledge in relation to notifiable

diseases, let alone all of them, or any role in advising or approving closure decisions consequent on the presence of any notifiable disease. Requiring their advice or approval would therefore give no purposive content to the advice/approval requirement, as an additional requirement, over and above closure as a result of the disease's occurrence at the premises which is already required by the other wording of the peril. That would run counter to the wording of the clause, which in requiring advice or approval from someone implicitly assumes it is to come from someone qualified to give the advice or approval; and would be contrary to the concept of the advice or approval coming from someone 'medical'.

90. This suggests that a more purposive construction must be sought, in which the expression requires advice or approval from someone who does have some understanding of the notifiable disease from a medical point of view. It is not, after all, an additional requirement for any of the perils in the clause addressing other public health risks in either the *Kaizen* or *Why Not* policies: it only applies to the notifiable disease cover. What is required is advice or approval from someone with sufficient medical understanding of the disease to be qualified to express a view on whether to impose the closure or restrictions, although that may be by virtue of experience or expertise in public health rather than by way of formal medical qualification. Only in that way can it be given content as an additional requirement, over and above closure as a result of the disease's occurrence at the premises which is already required by the other wording of the peril.

91. Where the notifiable disease is a new one, or where the closure or restriction is imposed at a national level because of the extent of spread or potential spread of the disease, such medical knowledge is likely to be lacking at a local level. In such a case the requirement of advice or approval from someone 'medical' is most obviously directed at, and at least includes, those at national level responsible for collecting information about the disease and analysing it, most notably the Chief Medical Officer, Deputy Chief Medical Officer and other medical officers, as the judge held.

92. A purposive construction therefore supports the natural meaning of the words as not being limited to local authority officers.

93. The insurers can derive no useful assistance from what was said by Lord Mance in his arbitration award in the dispute between various policyholders and China Taiping Insurance (UK) Ltd. In that case the issue was whether action by 'competent local authorities' covered a national response. What was said about the meaning of that expression is simply irrelevant to the issue in this case on different policy wording which requires the interpretation of 'Public Authority', save perhaps that after consideration of all the various powers available to meet the kind of public health risks identified in the equivalent clauses, Lord Mance confirmed at [88] that they included both national and local powers. Ultimately, as we understood it, the insurers mainly relied on what was said in that case to make the point that there was nothing uncommercial about parties agreeing to restrict cover for these perils to local authority decisions. But conversely it was not and could not have been suggested that there would be anything uncommercial about parties agreeing to cover for decisions of all public bodies. What the parties have agreed is to be determined by the language of the policy wordings, which are critically different in this case from those in the China Taiping case.

94. For these reasons, which overlap with those given by the judge, 'Public Authority' is not limited to local authorities and includes measures by the government or any public body; and 'Medical Officer of Health' includes the Chief Medical Officer, Deputy Chief Medical Officer and other medical officers advising such public bodies. We dismiss the appeal on this issue.

E. NOTIFIABLE DISEASE

95. The judge determined that the cover only responded to a person who was at the premises at the time when Covid-19 was a notifiable disease, which in England was from 6.15 pm on 5th March 2020. The *Hairlab* and *Kaizen* policyholders cross appeal, arguing that it is enough if a person attends the premises with a disease which subsequent to their visit becomes notifiable, at least provided that it becomes notifiable prior to the BI which causes loss. So, it was contended, it would cover the policyholders if they could show a visit to their premises on, say, 4 March 2020 by someone who in fact had Covid-19, notwithstanding that Covid-19 was not a notifiable disease at the time of their presence. The argument was advanced by Mr Gruder on behalf of policyholders of both *Hairlab* and *Kaizen* policies. Mr Gruder argued that the relevant point of time at which to judge whether the disease is notifiable is when the loss arises and is felt by the policyholder, which is from the interruption or interference with the business; before then, the policyholder would not know that it had a claim.

96. The short answer to this point lies in identifying the insured peril. It is a fundamental tenet of insurance law that cover responds to insured perils and there is no cover unless an insured peril has been made out. In the *Hairlab* policy the insured peril is 'any occurrence of a Notifiable disease…at the premises'. This is what has been called pure disease cover, with no part of the peril requiring closure or restrictions by an authority or body. 'Loss resulting from the interruption or interference with the business' is not part of the insured peril, as the Supreme Court confirmed in *FCA v Arch* at [215].

97. An 'occurrence', which is part of the insured peril, is something which happens at a particular time, at a particular place, in a particular way, as also confirmed in *FCA v Arch* at [67]. In the *Hairlab* policy the occurrence must be of a notifiable disease at the premises. That requirement is not fulfilled if a person is present at the premises with what is not then a notifiable disease. Nor is it fulfilled if they have a notifiable disease at some later stage when they are not at the premises. The presence of a person with Covid-19 at the premises of the *Hairlab* policyholders before 6.15 on 5th March 2020 is simply not an occurrence of a notifiable disease at the premises; it is the occurrence of a non-notifiable disease at the premises. Thereafter, when Covid-19 becomes notifiable there is no occurrence of a notifiable disease at the premises because the person with the disease is not at the premises. If all a policyholder could point to was such a person, it would fail to establish the relevant insured peril.

98. The analysis is the same for the *Kaizen* policyholders, although their policy has different wording which requires separate consideration. It is a hybrid clause in which the insured peril operates in two stages: the first is 'a Notifiable Human disease occurring at the premises'; the second is 'Closure or restrictions placed on the Premises…as the result of [that occurrence]'. So it was argued on behalf of the *Kaizen* policyholders that the disease need only be notifiable when the insured peril is complete, which is the date when the closure or restriction is imposed. However the argument involves a failure correctly to identify the first stage of the insured peril. It is

not the occurrence of a disease which is not then notifiable. As with the *Hairlab* wording, it requires a notifiable disease to occur at the premises: it is the presence of the disease at the premises which constitutes the relevant occurrence and it is not all diseases which qualify, but only notifiable diseases. If the only presence of Covid-19 to which a *Kaizen* policyholder can point is the presence at the premises of a person with Covid-19 when it was not notifiable, it cannot establish the first and necessary limb of the relevant insured peril.

99. This was also the analysis by the Supreme Court in *FCA v Arch* of the stages of the insured peril in the Hiscox policy being considered in that case, which similarly required both an occurrence of a notifiable disease and a consequential restriction imposed by a public authority (see [111]). At [216] of the judgment of Lords Hamblen and Leggatt they said:

> '… the peril covered by the clause is itself a composite one comprising elements that are required to occur in a causal sequence in order to give rise to a right of indemnity. Setting out the elements of the insured peril in their correct causal sequence, they are: (A) an occurrence of a notifiable disease, which causes (B) restrictions imposed by a public authority, which cause (C) an inability to use the insured premises, which causes (D) an interruption to the policyholder's activities that is the sole and direct cause of financial loss.'

100. Mr Gruder had a second argument based on the notification requirement in Regulation 2 of the 2010 Regulations, which requires notification in relation to a patient whom the registered medical practitioner 'is attending'. The argument was that the practitioner is attending all those in his care for the period they are in his care, including those he has previously seen; so that if, when a notifiable disease became notifiable, the practitioner had earlier seen a patient exhibiting those symptoms, there would be a duty to notify that patient's disease when the disease was designated as a notifiable disease. We did not have any argument on whether a medical practitioner is 'attending' someone at a time when they are not in contact, nor whether it is the duty of a medical practitioner, when a disease first becomes notifiable, to go back through their records of past attendances of all their patients, which the argument necessarily entails. Neither of these is self-evident. However, for present purposes we will assume that the policyholders are correct in asserting that to be the case. Nevertheless, such a duty would not assist the policyholders on the issue being cross-appealed. The earlier diagnosis of a patient with symptoms of what later becomes a notifiable disease does not have the effect that the patient was suffering a notifiable disease when they were diagnosed. At that time they were suffering from a non-notifiable disease. If, when the disease became notifiable, they fell within the scope of the duty to notify, they were only suffering from a notifiable disease from that time. The argument suffers from the same defect as has been already identified, namely that there would be no occurrence of an insured peril in such a case: since a person is not suffering a notifiable disease until it becomes notifiable, and a notifiable disease is not present at the premises until it becomes notifiable, someone visiting the premises with Covid-19 before it became a notifiable disease cannot, in the words of the *Kaizen* policy, constitute 'a Notifiable Human Disease occurring at the premises'.

101. Mr Gruder also relied on charterparty cases where the nomination of a port from a range is then treated as if it had been originally written into the charterparty. These cases, however, are of no relevance or assistance in determining the scope of the peril in these insurance contracts.

102. For these reasons, which mirror those of the Judge, we dismiss the cross-appeal on this issue.

F. KNOWLEDGE

103. We have already addressed the issue of knowledge in the context of the causation requirements of the relevant ATP extensions. However, Mr Christie submitted that even if we were to resolve the causation issue in favour of the policyholders, on the specific wording of the *Why Not* policy extension, it was necessary to prove that the manifestation of a notifiable disease at the premises was reported to or otherwise known by the Medical Officer of Health of/for the Public Authority prior to their giving the relevant advice about (or approval of) closure or restrictions being placed on the premises. He contended that a reasonable reader would naturally understand the phrase: 'on the advice or with the approval of the Medical Officer of Health of the Public Authority as a result of a notifiable human disease manifesting itself at the Premises' to involve some active consideration by that officer of the situation at those premises with knowledge of the disease that had manifested itself there, placing particular emphasis on the word 'manifesting'.

104. Mr Christie submitted that when the clause is read as a whole, it is necessarily implicit that the advice given by the relevant officer concerns that particular instance of manifestation of the disease and is not about the disease in general. It would not be enough to have some retrospectively identified manifestation; the manifestation must be known contemporaneously and identified. He submitted that the judge failed to deal with this argument adequately when he addressed it briefly at [250] and rejected it.

105. Mr Christie's submissions were adopted by Mr Howie in respect of the *Kaizen* policy wording, which is virtually identical, save that the word 'manifesting' is replaced by 'occurring'.

106. We agree with the judge that the language of the clauses in question does not support the insurers' construction, and that the resolution of the causation issue is fatal to it. As a matter of construction, the advice or approval relates to the closure or restriction. The policy does not refer to 'informed' advice nor does it otherwise expressly specify any state of knowledge of the Medical Officer of Health. The words relating to causation (in this case, 'as a result of') provide the connection between the notifiable disease and the closure or restriction on the advice of that officer. Whilst the word 'manifesting' is narrower than 'occurring', it does not follow from the fact that a person at the premises must be displaying symptoms of Covid-19 or be diagnosed with it that the Medical Officer of Health must be aware of that specific manifested incidence of Covid-19 and be responding to it at the time when they issue the operative advice.

107. Although what is required to show causation is an independent matter from the identification of the insured peril, it follows inexorably from the resolution of the causation issue that the 'Medical Officer of Health' whose advice leads to the closure of or imposition of restrictions on the premises does not have to know about the

manifestation (or occurrence) of the notifiable disease at those specific premises. In those circumstances it is impossible to introduce a requirement of knowledge by implication. Indeed, once it is appreciated that the phrase 'the Medical Officer of Health of the Public Authority' is not restricted to local authority officers, as both these insurers unsuccessfully contended that it was, the argument becomes unsustainable.

G. OTHER

108. The first specific issue in relation to the *Mayfair* Disease Clause concerns the meaning of the phrase 'suffered by any visitor or employee', which does not appear in the other policies and did not feature in any of the radius clauses considered by the Supreme Court in *FCA v Arch.* On behalf of the *Mayfair* insurer, Mr Martyn Naylor submitted that the judge was wrong to find that 'suffered' meant 'occurred or sustained', and that in the context of this clause 'suffered' means the same as 'manifested' (in the sense in which that word was interpreted by the Supreme Court in Declaration 7).

109. This was a departure from the insurer's case in the lower court, which had been that 'suffering' required the visitor or employee to experience the disease subjectively. As a minimum such a person had to have displayed symptoms of the disease whilst at the premises, with the identity of the disease being established by a diagnosis of Covid-19 before, during or after their attendance at the premises: see [343] to [347]. The insurer was now adopting Mayfair's fallback position, set out by the judge at [342].

110. Although Mr Naylor accepted that there were two possible meanings of the word 'suffered', he contended that in choosing between them the judge failed to give weight to two important considerations, namely:

    i) the ordinary meaning of the word "suffered" in the context of someone suffering from a disease, which connotes that the individual concerned is experiencing a degree of discomfort as a result of the disease, and

    ii) the fact that the *Mayfair* clause does not simply require the disease to be suffered by any person at the premises, but requires it to be suffered by a member of one of two defined classes of persons at the premises, namely, visitors or employees.

111. Although the judge held at [355] that his interpretation made far more commercial sense, Mr Naylor submitted that in fact the contrary was true, in the context of a policy being sold to small and medium-sized nightclub businesses, because it is easier to prove that a disease was manifested by a visitor or employee at the premises than to prove that someone within those categories had sustained Covid-19 at the premises before the relevant measures were taken. In order to establish that a visitor or employee, as opposed to someone else at the premises, was suffering from Covid-19 at the relevant time, there would necessarily have to be evidence that the disease was manifest in such a person, i.e. that a visitor or employee displayed symptoms at the premises, or was diagnosed as suffering from Covid-19 at that time. Mr Naylor accepted that the difficulties of proof which he identified would apply to all 'occurrence' clauses, but submitted that they were particularly acute when the clause required it to be shown that a disease occurred in individuals falling within specified categories.

112. Mr Naylor also placed some reliance on the fact that the *Mayfair* policy expressly uses the word 'sustained' in other clauses, for example, there are various references to

'damage sustained' or 'loss sustained'. However, we did not find that advanced the insurer's argument. None of those other references concerns the context of someone suffering from a disease.

113. In response, Mr Neil Fawcett pointed out that whereas the word 'manifested' carries with it the obvious requirement that something is manifest, in the sense of apparent, the word 'suffered' does not. This is illustrated by some of the dictionary definitions of 'suffer', including 'to have something painful, distressing or injurious inflicted on one'. He submitted that the judge was right for the reasons that he gave.

114. We agree. It would be accurate to describe someone as suffering from cancer if they had the disease even though they were entirely asymptomatic, and the same is true of Covid-19. We do not consider that the restriction to visitors or employees has any impact on the correct interpretation of 'suffered' in this context. The judge rightly identified that most of the people attending a nightclub would be likely to fall into one or other of those categories, including an owner or director who did not live on the premises. The question whether the policyholder can satisfy the requirements of the clause will turn on the evidence in due course, but any difficulties of proof which may arise do not impel the court to prefer the alternative interpretation to the one chosen by the judge. On the contrary, we agree with the judge for the reasons that he gave that his interpretation is the one which makes more commercial sense.

115. The second issue which is specific to the *Mayfair* policy also relates to the requirement that the disease be suffered 'by any visitor or employee… at the Premises'. Mr Davie submitted that this requirement distinguished the *Mayfair* policy from the others in terms of causation. The use of the words 'visitor or employee', rather than anyone who happened to be on the premises, anchored the policy cover to the specific premises and indicated that it was not intended to address a general response to a national pandemic. He contended that the judge was wrong to read those words as if they meant the same as 'persons'.

116. As we have indicated in our consideration of the first issue, we consider that the judge was right to find that only a very small subset of persons who sustained the illness at the premises would fail to qualify as a visitor or an employee. We agree with him that the existence of that small subset makes no difference to the causation analysis. As we have explained in [72] above, on the assumption that there were occurrences of Covid-19 at each of the policyholders' premises, each of those occurrences together with all other cases of Covid-19 in the country were a cause of the closure of those premises. In ordering the national lockdown, the government was responding to the fact of disease having occurred at each of these premises. That analysis is unimpaired by the specific requirement of the *Mayfair* clause that the person who sustained Covid-19 at the nightclub premises prior to the lockdown had to be a visitor or an employee. It only required one occurrence of Covid-19 in a single visitor or employee at the material time to trigger the clause. As Mr Fawcett pointed out, even if the clause had been much narrower and had specified a named employee, it would not affect the analysis. The contracting parties intended that cover would be provided for diseases that spread rapidly and widely and therefore contemplated that the response of the government would be generalised in nature. Accordingly, the national lockdown would be as much a response to the fact that Joe Bloggs, an employee at the nightclub, was suffering from Covid-19 at the relevant time as it was a response to any other incidence of Covid-19 in those or any other premises.

117. For those reasons, we reject the arguments of the insurer on both these *Mayfair*-specific issues.

H. DISPOSAL

118. Each of the appeals and cross-appeals is dismissed.

Appendix 1 (Kaizen agreed and assumed facts extracts)

1. The first Medical Officer of Health was appointed in Liverpool, pursuant to the Improvement of the Sewerage and Drainage of Liverpool Act 1846, also known as the Liverpool Sanitary Act 1846 which provided for the appointment of such an officer "subject to the Approval of One of Her Majesty's Principal Secretaries of State". This was for the purpose of ensuring that sanitary conditions were improved in order to stem the spread of disease. The Public Health Act of 1848 (the "1848 Act") established a central authority, 'The General Board of Health', to oversee the execution of the 1848 Act. The General Board of Health was responsible for establishing and managing Local Boards of Health. The Local Boards of Health comprised those persons who were authorised to execute all or any of the powers, authorities and duties vested in the relevant Local Board of Health in respect of each district. These powers included the power for the Local Board of Health to appoint a fit and proper person, being a legally qualified medical practitioner or a member of the medical profession, to be an Officer of Health to perform such duties as the General Board of Health should direct.

2. The duties and responsibilities of local Officers of Health were set out in a statement issued by the General Board of Health in 1851. According to the website "The Potteries: a history of Stoke-on-Trent", these included "giving instructions and directions for the removal or prevention of causes of disease common to several persons, and also for the prevention or removal of causes of disease to individuals, where those causes come within the province of local administration under the Public Health Act." Under the Metropolis Local Management Act 1855 (the "1855 Act"), every vestry and district board was required to appoint a legally qualified medical practitioner, known as a 'Medical Officer of Health', to inspect and report periodically upon the sanitary condition of their respective parish or district in order to ascertain the existence of diseases.

3. Section 189 of the Public Health Act 1875 (the "1875 Act") made it a statutory duty that "every urban authority shall from time to time appoint fit and proper persons to be a medical officer of health". This was extended to include "every rural authority" under Section 190 of the 1875 Act. Section 5 provided that "urban and rural districts shall respectively be subject to the jurisdiction of local authorities called urban sanitary authorities and rural sanitary authorities". This did not include "the Metropolis" which was defined by Section 4 as "the city of London and all parishes and places mentioned in Schedules A, B, and C to the Metropolis Management Act, 1855".

4. Under Section 3 of the Infectious Disease (Notification) Act 1889 (the "1899 Act"), the Medical Officer of Health for the district was made responsible for receiving reports of cases of infectious disease in the district from householders and/or medical practitioners.

5. Under Sections 103, 106 and 107 of the Local Government Act 1933, it was stated that county councils, the councils of every borough and district councils were to appoint medical officers of health. The duties of borough and district council medical officers of health were to be determined by the Minister of Health (Section 108). These duties were also set out in the Sanitary Officers (Outside London) Regulations 1935 and included the obligation for a Medical Officer of

Health 'to inform himself as far as practicable respecting all matters affecting or likely to affect the public health in the county and be prepared to advise the county council on any such matter' and to 'Forward to the Minister and the county medical officer a weekly return of the number of cases of infectious disease notified' (Part II, Regulation 6(1) and (3)).

6. The creation of the National Health Service ("NHS") in 1948 altered the structure of public health. It removed the active medical functions of local health authority departments and reduced the role of Medical Officers of Health by shifting 'community medicine' out of local authorities' remit and into the NHS. Local authorities retained the responsibility for broad-based public health measures related to food hygiene and environmental health.

7. Under the Local Government Act 1972 and the National Health Service Reorganisation Act 1973, both of which came into effect in April 1974, the post of the Medical Officer of Health was abolished and replaced with 'District Community Physicians' and 'Regional and Area Medical Officers'. The effect of this was to replace Medical Officers previously employed by local government for each county with medical officers based on the new Area Health Authorities within the NHS.

8. The Public Health (Control of Disease) Act 1984 ("the 1984 Act"), as originally enacted, was a statute consolidating Victorian and other legislation, which defined notifiable disease as being cholera, plague, relapsing fever, smallpox and typhus (Section 10). It gave powers to local authorities in relation to the designation and control of notifiable diseases. This included the power to:(1) designate further diseases as notifiable in their own area (Section 16); (2) request any person to discontinue his work with a view to preventing the spread of a notifiable disease (Section 20); (3) prohibit or restrict the admission of persons under the prescribed age to places of assembly or entertainment with a view to preventing the spread of a notifiable disease (Section 23); (4) make an order for the prohibition of certain work on premises where a notifiable disease existed (Section 28); and (5) to cause a premises to be cleaned or disinfected to prevent the spread of an infectious disease (Section 31).

9. By Section 1 of the 1984 Act, "local authorities" are defined (in England) as meaning district councils, county councils, London borough councils, the Common Council of the City of London, the Sub-Treasurer of the Inner Temple and the Under Treasurer of the Middle Temple.

10. Section 13 of the 1984 Act (as originally enacted) further provided that the Secretary of State may make regulations for the control of diseases, including relating to the notification of disease, or to notifiable diseases.

11. These provisions have largely been repealed and replaced since 1984. The 1984 Act was amended by further legislation including in 1995, 1996, 2000, 2002, most notably in 2008 (in part to fulfil UK obligations under the 2005 WHO regulations) and in 2012. Under the Act as amended by the Health and Social Care Act 2008 ("the 2008 Act"), as well as certain regulations made under that Act, powers were conferred on the Secretary of State in relation to infection and contamination, including by introducing Sections 45B to 45F and Sections 45P to 45R to the

1984 Act. Section 13 (as amended) confers a power on the Minister to make regulations inter alia with a view to the treatment of persons affected with any epidemic, endemic or infectious disease and for preventing the spread of such diseases, including notifiable diseases; for preventing danger to public health from vessels or aircraft arriving at any place; and preventing the spread of infection by means of any vessel or aircraft leaving any place, so far as may be necessary or expedient for the purpose of carrying out any treaty, convention, arrangement or engagement with any other country. Section 45C confers a power on the Minister "by regulations [to] make provision for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in England and Wales (whether from risks originating there or elsewhere)", such powers being exercisable "in relation to infection or contamination generally or in relation to particular forms of infection or contamination, and … so as to make provision of a general nature, to make contingent provision or to make specific provision in response to a particular set of circumstances", and such regulations may include provision for (a) imposing or enabling the imposition of restrictions or requirements on or in relation to persons, things or premises in the event of, or in response to, a threat to public health (Section 45C(3)(c)); (b) a prohibition or restriction relating to the holding of an event or gathering (Section 45C(4)(c)); and (c) a "special" restriction or requirement, namely one that otherwise could be imposed by a justice of the peace under other provisions of the 1984 Act (as amended) (Section 45C(4)(d) and (6)(a)) (as to the powers of a justice of the peace in this respect, see further below). Pursuant to Section 45F, such regulations may "(a) confer functions on local authorities and other persons; ... (d) provide for the execution and enforcement of restrictions and requirements imposed by or under the regulations". Pursuant to Section 45P(2), the power to make regulations "includes power to make different provision for different cases or different regulations".

12. Public Health England ("PHE") (now UKHSA: see further below) was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service. It was an executive agency of the Department for Health and Social Care ("DHSC") and provided national government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific expertise and support. PHE's responsibilities included protecting the nation from public health hazards and preparing for and responding to public health emergencies. Within PHE, there were 24 local Health Protection Teams ("HPTs") which represented the most local level of PHE. The teams were further grouped into 8 sub-regional centres and 4 regions including London. HPTs controlled communicable disease at a local level with support from the PHE Health Protection Directorate if an incident affected a larger geographical area, was complex, or of national significance.

13. A government website gives the following information about HPTs:

> *Local HPTs lead the UK Health Security Agency (UKHSA)'s response to all health-related incidents. They provide specialist support to prevent and reduce the impact of:*
>
> – *infectious diseases*
>
> – *chemical and radiation hazards*

– *major emergencies*

HPTs can help with:

– *local disease surveillance*

– *maintaining alert systems*

– *investigating and managing health protection incidents and outbreaks*

– *implementing and monitoring national action plans for infectious diseases at local level*[3]

This support is provided to NHS, local authorities and other agencies.

14. PHE was disbanded and its health protection functions taken over by the UKHSA from April 2021. The UKHSA is an executive agency sponsored by the Department of Health. It fulfils the Secretary of State's statutory duties to protect health and address health inequalities and executes the Secretary of State's power to promote the health and wellbeing of the nation.

15. The UKHSA delivers a specialist health protection service which includes responding to incidents and outbreaks through local HPTs (formerly Health Protection Units). According to a 2014 operational guidance document issued by PHE, Health Protection Teams are staffed by Consultants in Communicable Disease Control, Consultants in Health Protection, Health Protection nurses and practitioners and other staff with specialist health protection skills. They "have a key role in" responding to, investigating and managing outbreaks of communicable disease.

16. The same document records that:

(1) The roles of local authorities and the UKHSA (then PHE) in the public health system are complementary in investigating and managing outbreaks of communicable disease.
(2) In practice these organisations work closely as part of a single public health system to deliver effective protection for the population from health threats.

17. Every local authority with public health responsibilities must, acting jointly with the Secretary of State, employ a specialist Director of Public Health.

18. The Chief Medical Officer ("CMO") acts as the UK government's principal medical adviser, and the professional head of all directors of public health in local government and the medical profession in government. As of 2020, there were four CMOs in the United Kingdom: Professor Chris Whitty, the CMO for England, Chief Medical Adviser to the UK government and head of the public health profession; Dr Michael McBride, the CMO for the Department of Health

in Northern Ireland; Professor Sir Gregor Smith, the CMO to the Scottish government; and Sir Frank Atherton, the CMO to the Welsh government.

19. The CMO is the country's most senior medical adviser, providing advice to the secretary of state for health and, when necessary, the prime minister. The CMO is also the head of the public health profession and represents it within government. The role has three overarching responsibilities: to provide independent advice on public health issues, in particular during public health emergencies; to recommend policy changes to improve public health outcomes; and to act as an interface between the government and medical researchers and clinical professionals.

20. The CMO plays a prominent role in supporting the government's response to public health emergencies. Alongside ministers, the CMO is responsible for keeping the public informed on health issues of high public concern and explaining the government's response. The CMO plays a leading role in advising on the national response to public health emergencies and attends COBR meetings on health issues. The CMO co-chairs the Scientific Advisory Group for Emergencies ("SAGE") with the government's chief scientific advisor. SAGE is responsible for ensuring that a single source of coordinated scientific advice is provided across government and into COBR.

21. The CMO can also set up ad hoc advisory groups in response to a public health emergency. During the Ebola outbreak in 2015, Professor Davies set up the Ebola Scientific Assessment and Response Group to draw in additional expert advice on specialist issues relating to the disease.

22. The CMO plays a key role in working with the Department of Health and Social Care public health agencies, and the National Health Service, to convert the scientific advice from expert committees into a policy response.

23. The regulations made by the Secretary of State pursuant to the 1984 Act include the Health Protection (Notification) Regulations 2010 ("the 2010 Regulations"), which includes a list of notifiable diseases at Schedule 1 and causative agents at Schedule 2.

24. Under the 1984 Act as amended by the 2008 Act (and the regulations enacted thereunder), local authorities no longer have the statutory power to designate diseases as notifiable, nor to make an order for the prohibition of certain work on premises where a notifiable disease existed, or to cause a premises to be cleaned or disinfected to prevent the spread of an infectious disease. However, local authorities do have the power to restrict access (for example by requiring an infectious child not to attend school) and have the power to request (but not require) co-operation for health protection purposes (Section 8 of the Health Protection (Local Authority Powers) Regulations 2010); and to apply to a justice of the peace for a 'Part 2A Order' which may include an order that infected or contaminated premises be closed and/or disinfected or decontaminated (Sections 45I and 45M).

25. All registered medical practitioners have a statutory duty to report every case of a notifiable infectious disease to the 'proper officer' of the local authority or local

UKHSA Health Protection Team via a Statutory Notification form where they have reasonable grounds for suspecting that a patient whom they "are attending" has a notifiable disease. This is in accordance with Section 45C(3)(a) of the 1984 Act and the Health Protection (Notification) Regulations 2010.

26. Section 74 of the 1984 Act, which remains in force, is an interpretation section identifying the meaning of a number of epithets used in the Act. It provides:

> 'In this Act, unless the context otherwise requires-
>
> "authorised officer," in relation to a local authority, means-
>
> "an officer of the authority authorised by them in writing, either generally or specially, to act in matters of a specified kind or in a specified matter, or
>
> by virtue of his appointment and for the purpose of matters within his province, a proper officer of the authority, appointed for purpose corresponding to any of those of the former medical officers of health, surveyors and sanitary inspectors;
>
> …
>
> "proper officer" means in relation to a purpose and to an authority, an officer appointed for that purpose by that authority;
> …'

27. Proper officers are required every week to inform the UKHSA of anonymised details of each case of each disease that has been notified. This must take place within 3 days of a case being notified, or within 24 hours of notification for urgent cases.

28. Laboratories conducting a "*primary diagnostic role*" are also required to notify UKSHA. Government guidance states as follows:

> *All laboratories in England performing a primary diagnostic role must notify UKHSA of specified causative agents (organisms), in accordance with the Health Protection (Notification) Regulations 2010. SARS-CoV-2 is the notifiable causative agent for COVID-19. All registered medical practitioners in England must notify the proper officer of the relevant local authority or the local UKHSA health protection team of specified infectious diseases, in accordance with the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010. All proper officers must disclose the entire notification to UKHSA. COVID-19 is a notifiable infectious disease.*

Appendix 2 (Why Not additional agreed and assumed facts extracts)

23. Section 10 of the Public Health Act 1872 (the "**1872 Act**") made it a statutory duty for every urban sanitary authority and every rural sanitary authority "*to appoint from time to time a medical officer or officers of health*" being a legally qualified medical practitioner. A medical officer of health was permitted under the terms of the Section to "*exercise any of the powers with which an inspector of nuisances is invested by the Sanitary Acts or any of them*." This was reaffirmed in sections 189 and 190 of the 1875 Act.

41. The Health Protection (Notification) (Wales) Regulations 2010 ("the Wales 2010 Notification Regulations") include a list of notifiable diseases at Schedule 1 and causative agents at Schedule 2. These Regulations were implemented as part of a health protection legislation update in Wales from 26 July 2010 (see the Wales 2010 LA Regulations and the Wales 2010 Part 2A Regulations referenced below). These updates provided "local authorities with wider, more flexible powers to deal with incidents or emergencies where infection or contamination presents, or could present, significant risk to human health. Some powers, relating to specific circumstances, can be exercised directly by local authorities. In other circumstances, local authorities can apply to a justice of the peace (JP) for a Part 2A Order to impose restrictions or requirements to protect human health."

43. The Wales 2010 Notification Regulations impose a statutory duty on registered medical practitioners to notify "*the proper officer of the relevant local authority*" where they have reasonable grounds for suspecting that a patient has a notifiable disease. The primary aim of notification by registered medical practitioners is to enable the proper officer of the local authority to investigate promptly and take health protection measures to prevent the further spread or transmission of infection or contamination and to reduce the public health impact.

44. Following receipt of notification, proper officers of the local authority are required to inform the fact of the notification and its contents to (amongst others) the Public Health Wales National Health Service Trust in writing within 3 days or, in urgent cases, orally as soon as reasonably practicable (and always within 24 hours).

45. The Health Protection (Part 2A Orders) (Wales) Regulations 2010 ("the Wales 2010 Part 2A Regulations") made further provision about the making by a justice of the peace of Part 2A Orders, including as to the duty on local authorities including to report Part 2A applications to the Welsh Ministers (Regulation 10). As to the duty to report applications to the Welsh Ministers, *"[i]t is important to note that the purpose of these reports is to allow the use of Part 2A Orders to be monitored, not to initiate any action on individual cases"*.

46. A number of organisations play a role in investigating, managing and responding to communicable disease outbreaks in Wales including the Welsh government and Public Health Wales. A key role is played by local bodies including local authorities and local health boards. Each local authority has to employ a Lead Officer in Communicable Disease whose role is to (amongst other things) (i) provide expert advice and information on all aspects of the communicable disease function within the local authority; (ii) advise on specific aspects of investigation of serious or significant incidents of communicable disease; and (iii) provide expert advice on the use of health protection legislation.