



**REPUBLIC OF KENYA  
IN THE COURT OF APPEAL  
AT KISUMU  
(CORAM: OMOLO, O’KUBASU & WAKI, J.J.A)  
CIVIL APPEAL NO. 88 OF 2002**

**BETWEEN**

**NIZAR VIRANI T/A KISUMU BEACH RESORT ..... APPELLANT**

**AND**

**PHOENIX OF EAST AFRICA ASSURANCE**

**COMPANY LIMITED ..... RESPONDENT**

**(Appeal from the judgment of the High Court of Kenya  
at Kisumu (Tanui, J.) dated 1.03.2002**

**in**

**H.C.C.C. No.174 OF 1997)**

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**JUDGMENT OF THE COURT**

This dispute relates to a policy of insurance issued by **M/S Phoenix of East Africa Assurance Co. Ltd.** (hereinafter “the insurer”) to Nizar Virani (hereinafter “the insured”) to cover the business of Bar & Restaurant carried on by the insured in the name or style of **Kisumu Beach Resort** (1977) on LR No. 2642, East Kisumu, Kogony.

The insured went before the High Court in Kisumu on 5th July, 2000 and filed a suit claiming that he entered into an agreement with the insurer who issued a policy of insurance **No. O1BG6330** on the 22nd day of January, 1999. The policy covered, inter alia, the risk of burglary on the business premises for a period of one year (renewable) at an annual premium of **Sh.13,028/=**. The sum insured was Sh.3,080,000/=. During the currency of the policy, the business premises were broken into on the night of 5th & 6th July, 1999 and various items he valued at Sh.736,550/= were stolen. The insured submitted his claim to the insurer but, to his consternation, it was rejected on the ground that he had not paid the insurance premium in full and the insurer was therefore entitled to disclaim liability.

In its written statement of defence, the insurer denied totally that it issued any policy of insurance or that there was burglary that resulted in the loss pleaded. It was not aware of any claim made by the insured for payment. In a series of paragraphs however, which were pleaded “*absolutely without prejudice to the foregoing and in the alternative,*” the insurer pleaded that the loss was not caused by the burglary; lack of safety precautions in the business premises; lack of good faith contrary to the contract of insurance; fraudulently exaggerated claim; fundamental breach due to non-payment of premium; non-disclosure of cause of action; failure to give notice of damage and loss; exemption clauses on employee involvement in the loss; and cancellation of the policy.

Only the insured testified on his own behalf before B.K. Tanui J, at Kisumu. He produced the Policy of Insurance issued through a Firm of insurance brokers and gave evidence of part-payment of premium through that firm. He readily admitted however that he was in arrears of premium payment in the sum of **Shs.20,000/=**. For verification of the burglary, he produced a Police abstract report dated 12.5.99 listing the stolen property and their approximate values totaling **Shs.631,550/=**. He also produced the claim made to the insurer on an unspecified date for a sum of **Shs.759,300/=**. He recalled that the insurer had sent loss assessors to the business premises and that he had supplied them with an assets book and stock cards for his stock-in-trade. The assessors prepared a report on the claim but he had not seen it until it was shown to him in court.

The insurer also called one witness in the person of its Claims Officer, **Nathan Benson Andago**. He was brief. As far as the Insurer was concerned, the insured had not paid his premium despite notice having been served on him to do so. Consequently the Policy of Insurance was cancelled. Secondly, the Loss assessors, **M/S M'Larens Toplis**, had valued the claimable loss at **Shs.398,119/55** and recommended a settlement at that figure and therefore the claim made at a figure of **Shs.759,300/=** was fraudulent.

The learned Judge of the superior court agreed with the insurer on those two assertions and dismissed the suit. He summarized the issue of non-payment of premium as follows: -

**“The first defence to this claim is based on the submission that the plaintiff did not pay the premium and as such there was no consideration. It was stated that there was a balance of Kshs.20,000/= unpaid on the premium. This amount was admitted by the plaintiff when he was cross-examined. He also admitted that the brokers whom he was using went burst and that the defendant had written to cancel the cover for non-payment of the premium. This in my view is a valid defence. A failure to pay a premium would show that the consideration has failed and the insurer would be entitled to cancel the deal as was done in this case.”**

As for fraudulent claim he stated: -

**“Following the burglary of his premises the plaintiff appears to have filled the form seeking compensation on a loss of Ksh.736,550/= and the defendant on receipt of the claim appointed an adjuster who in his report stated that the actual loss suffered by the plaintiff was Kshs.398,119/55. In his testimony he denied that he deliberately exaggerated the loss as claimed. Although the plaintiff denied the defendant’s claim it is a fact that he deliberately exaggerated the claim.”**

The third reason for dismissing the suit was that the claim was in the nature of special damages but it had not been strictly proved by production of receipts for the purchase of each item claimed.

Aggrieved by those findings, the insured came before us and laid out eight grounds of appeal as follows: -

THAT the learned Judge erred in: -

**“1. finding that the respondents were not liable to compensate the appellant the loss incurred by the appellant due to the burglary which occurred on the appellant’s premises.**

**2. not finding that as the respondents had not repudiated the contract of Insurance before the said burglary, the respondents were bound by the said Policy and could only counterclaim for the arrears of the unpaid premiums.**

**3. dismissing the appellant’s case in totality when part of the loss was admitted.**

**4. dismissing the suit on the ground that there was no strict proof in the light of clear concession on the part of the respondents’ agent that the appellant had in fact incurred losses.**

**5. finding that the appellant had exaggerated his claim thus entitling the respondents to repudiate the claim when that was not the ground for the purported repudiation.**

**6. deciding the case on extraneous matters not brought properly before him.**

**7. not taking judicial notice of the notorious practice in the Insurance Industry where non payment of the full premium is never a bar to compensation under the Policy.**

**8. failing to find that part of the premium was paid to the agent appointed by the respondents which fact was never challenged.”**

As this is a first appeal we are under a duty to reconsider and re-evaluate the evidence on record and to draw our own conclusions, always bearing in mind, and giving due allowance for it, that the trial Judge had the advantage of seeing and hearing the witnesses testify before him. The evidence on record is scanty, but even scanty evidence must be evaluated for what it is worth.

Learned counsel for the insured, Mr. Odunga, condensed the eight grounds of appeal into three. The first ground of attack was directed at the finding that nonpayment of a premium amounted to a failure of consideration in the contract of insurance and therefore vitiated it. He submitted that a policy of insurance remains valid once issued and liability attaches despite non-payment of a premium due. The point however was not belaboured since it was conceded, and we think rightly so, by learned counsel for the insurer Mr. Menezes. The only qualification to that general proposition of law is that the policy itself may provide that the failure to pay the premium would avoid liability for the insurer or the failure to pay the premium amounts in the circumstances to a repudiation of the contract.

We have looked at the Policy of Insurance issued on 22nd January 1999 which was exhibited before the superior court and it clearly acknowledges that the insured had *“paid or agreed to pay the first premium”*. It was on that basis that the insurer’s commitment was made, that is: *“during the Period of Insurance specified in the schedule or during any subsequent period for which the Insured shall pay and the Company shall agree to accept the premium for the renewal of this policy in the event of theft or any attempt thereat involving entry to or exit from the Premises by forcible and violent means resulting in*

*(a) loss or damage to the Property or any part thereof contained within the Premises or*

*(b) damage (other than breakage of glass) to the Premises falling to be borne by the Insured, the Company will pay or make good to the Insured such loss to the extent of the intrinsic value of the Property so lost or such damage to the amount so sustained but not exceeding during any one period of insurance in the case of the Property or part thereof of the sum or sums of money insured thereon as stated in the Schedule.”*

As stated in **MacGillivray & Parkington on Insurance Law**, 7th Edition at paragraph 851:

**“Where the risk is not described as running from any specified date, the presumption is that it runs from the date of the policy. The risk may begin to run either before or after the policy is issued. It may run from the date of acceptance of the offer or from the payment of the first premium or from the execution or delivery of the policy. The date when a risk attaches is in each case a matter of construction of the terms of the preliminary agreement or of the policy when executed. There is no principle of law which compels a company to assume a risk as from the date of acceptance or from any other particular date.”**

and on payment of premium at paragraph 861:

**“There is no rule of law to the effect that there cannot be a complete contract of insurance concluded until the premium is paid, and it has been held in several jurisdictions that the courts will not imply a condition that the insurance is not to attach until payment. It would seem to follow that, if credit has been given for the premium, the insurer is liable to pay in the**

**event of a loss before payment, although, as has been held in a South African decision, the insurer would be entitled to deduct the amount of the premium from the loss payable, at least where the period of credit had expired by that time, since the assured could not insist on payment when in breach of any obligation assumed on his part under the contract.”**

We respectfully agree with the principles as stated in those paragraphs.

Before the burglary in May 1999 there was no attempt to raise any issue of non-payment of premium or threats to cancel the Policy. This attempt was made in September, 1999, four months after the event, but clearly there was no basis in law or fact to resort to such threats. That ground of appeal succeeds.

The second ground taken up was the alleged fraudulent exaggeration of the claim by the insured. Mr. Odunga submitted in the first place, that there was no proper pleading of such claim since no particulars of fraud were given as required under **Order VI rule 8 of the Civil Procedure Rules , Cap 22** Laws of Kenya. Secondly a mere exaggeration of figures was not a ground for repudiation of liability unless it was shown that it was intentional. An inference of fraud cannot merely be drawn from the only evidence on record that the amount claimed was more than was recommended by the loss assessors appointed by the Insurer. At all events that was not the expressed reason for repudiation of liability and it must therefore be an afterthought.

The position taken by Mr. Menezes was of course the opposite. He referred to the clause in the policy that covered fraudulent claims and submitted that the claim here was intentional and fraudulent and the evidence on record so confirmed.

The clause alluded to provides: -

**“2. If the Proposal of the Insured is untrue in any material respect or if any material information be omitted therefrom or if any claim made shall be fraudulent or intentionally exaggerated or if any false declaration or statement shall be made in support thereof then the Company shall be under no liability to make any payment under this Policy.”-**

emphasis provided

Mr. Menezes referred to the report made to the police which quantified the claim at **Shs.631,550/=**; the report made to the insurer quantified at **Shs.759,300/=**; the plaint which pleads a figure of **Shs.736,550/=**; and the figure arrived at by the loss assessors for the same loss and recommended for payment at **Shs.398,119.55/=**. Such claims, he submitted, could not have been made unless fraud was intended and it was not necessary therefore to plead particulars of fraud in defence. It follows therefore that the insured cannot recover payment of any part of the claim and it does not avail him to contend that it was not the initial reason expressed for repudiating the claim.

Both counsel cited various authorities to illustrate their respective submissions including an authority, to Mr. Menezes’ credit as an officer of the Court, which was against him. That was **Jimnah Munene Macharia v John Kamau Erera** C.A 218/1998 (ur) for the proposition that the failure to call the loss assessors to produce their report which was admitted in evidence rendered such report of minimal, if any, probative value. We have considered the rival submissions and the authorities cited before us and are of the view that this ground of appeal is also meritorious for the following reasons:

Firstly, there is no denying that there were no particulars supplied in the defence pleading under **Order VI rule 8(1)** which requires in mandatory terms that:

*“every pleading shall contain the necessary particulars of any claim defence or other matter pleaded including, without prejudice to the generality of the foregoing: –*

*(a) particulars of a ny .....fraud ..... on which the party relies.*

*(b) Where a party pleading alleges .....fraudulent intention.....particulars of the facts on which the party relies.”*

In the absence of such pleading, the insurer is not at liberty to agitate the allegation of fraud or fraudulent intention. Fraud is a serious quasi – criminal imputation and it requires more than proof on a balance of probability though not beyond reasonable doubt. Sufficient notice and particulars must therefore be supplied to the party charged for rebuttal of such allegation.

Secondly, it is common ground that in law the making of a fraudulent claim is a breach of the duty of good faith and consequently the insured forfeits all benefits under the policy whether it contains an express condition to that effect or not. There is indeed clause 2 of the policy which is reproduced above to cover that legal position. The issue is, what claims are “fraudulent” or “intentionally exaggerated”? We turn to **Halsbury’s Laws of England 4TH Edition Vol. 25 at page 273:**

**“A claim which is put forward when the assured knows that he has suffered no loss or which is supported by false evidence is clearly fraudulent. The position is not so clear where the claim is for an amount in excess of the real amount of the loss and the charge of fraud is based upon the suggestion that the claim has been fraudulently exaggerated. The mere fact that the assured has claimed an excessive amount is not necessarily proof of fraud; questions of amount are largely matters of opinion and the assured may have honestly over-estimated the value of his property or the amount of his loss. The excess may be so great as to justify the conclusion that, having regard to the circumstances, the exaggeration of the amount cannot be an honest estimate but must have been intended to deceive the insurers and to induce them to pay a larger sum than is properly payable; in this case the exaggeration is fraudulent. An exaggerated amount may also be classified as fraudulent where the assured puts forward deliberately exaggerated figures, not for the purpose of inducing the insurers to pay the full amount of the claim, but for the purpose of fixing a basis upon which to negotiate a settlement.”**

**Chitty on Contracts** substantially summarises the principle in similar wording in Vol. 2, 22nd Edition at page 844:

**“Mere exaggeration, however, is not conclusive evidence of fraud, for value is often a matter of opinion, though such exaggeration will amount to fraud if it is dishonestly made or so greatly in excess of the true amount as to be incompatible with good faith.”**

Again we respectfully agree with that exposition of the legal principle.

The entire evidence relied on by the superior court to infer fraud or fraudulent intention in respect of the claim came from the sole witness of the insurer. He stated: -

**“I look at MFI D1. This is an adjustment report by the McLarens Toplis who had been assigned to adjust the report. They put in their report on 29.12.1999. They adjusted the loss at Kshs.398,119/55. That was the recommended settlement figure.”**

Clearly the learned Judge was of the view that the difference between the assessors’ figure and that of the insured was evidence of fraud, but on this he was in error. In the first place the evidence of the assessors was not properly on record as the maker of the document was not called and therefore the figure was of no validity. Even if it had been properly on record, it showed that the insured produced all available and relevant documents in support of the claim and the assessors confirmed that liability for the insurer validly engaged. The difference in the figures was not because the stock and equipment were not stolen but because of their valuation after depreciation. At all events there was nothing in the evidence of the claims manager to show that the difference in the figures stated at the police station, the insurance claim form or in the plaint was wilful and fraudulent exaggeration. For our part we consider it, at best, no more than a variance of estimated values of an otherwise honest claim. Indeed, as we will show presently, it was worse than that. We find no evidence of fraud, intentional or otherwise.

Finally we agree with Mr. Menezes, as it is the law, that a claim for special damages should not only be pleaded but strictly proved. There is a long line of authorities on that principle but we only cite **Eldama Ravine Distributors Ltd & Anor vs Samson Kipruto Chebon** C.A No. 22/1991 (ur) where the court stated:

**“It has time and again been held by the courts in Kenya that a claim for each particular type of special damage must be pleaded. In Ouma v. Nairobi City Council (1976) K.R 304 after stressing the need for a Plaintiff in order to succeed on a claim for specified damages, Chesoni, J. quoted in support the following passage from Bowen, L.J’s judgement on page 532, 533, in Ratcliffe v. Evans (1892) 2Q.B 524, an English leading case on pleading and proof of damage:**

***“The character of the acts themselves which produce the damage, and the circumstances under which those acts are done, must regulate the degree of certainty and particularity with which the damage done ought to be stated and proved. As much certainty and particularity must be insisted on, both in pleading and proof of damage, as is reasonable, having regard to the circumstances and to the nature of the acts themselves by which the damage is done. To insist upon less would be to relax old and intelligible principles. To insist upon more would be the vainest pedantry.”***

There was a specific pleading in this case of the special damage suffered and a valuation for it. The challenge is that there was no strict proof. What amounts to strict proof must of course depend on the circumstances as was stated in **Ratcliffe’s case**, that is to say, the character of the acts producing damage, and the circumstances under which those acts were done. It is not lost to us that insurance is in the nature of an indemnity contract. The sum insured in this matter was upto **Shs.3,080,000/=**. That figure would not simply be paid without verification by the Insurer, both on liability and quantum. In point of fact the insurer here instructed loss assessors to verify the claim and the circumstances surrounding it. The insured also made his report to the police and he itemized and quantified his claim. The figure appearing in the police report is **Shs.631,550/=**. He also itemized the claim and showed a figure of **736,550/=** in the amended plaint. We have compared both itemized lists and values put against each item and found that they are identical. The difference is in the total figure appearing on each list. We have also crosschecked the additions and found that the police report figure was erroneous. The total amounts to **Shs.736,550/=** and not **631,550/=**. It was purely a mathematical error. There was no cross-examination of the insured on the valuation he put against each item. There was no valid other evidence to challenge those valuations. In view of all those circumstances we agree with Mr. Odunga that the material on record was sufficient proof for the insured’s claim.

The upshot is that the appeal is allowed. The judgment of the superior court is set aside. There will be substituted therefor judgment for the plaintiff in the sum of **Shs.736,550/=** with costs and interest thereon. The appellant shall also have costs of this appeal.

**Dated and delivered at Nairobi this 17th day of December, 2004.**

**R.S.C. OMOLO**

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**JUDGE OF APPEAL**

**E.O. O’KUBASU**

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**JUDGE OF APPEAL**

**P.N. WAKI**

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**JUDGE OF APPEAL**

I certify that this is a true copy of the original.

DEPUTY REGISTRAR