

IN THE COURT OF APPEAL
HOLDEN AT LAGOS
16TH JUNE, 1986. CA/L/102/84
CORAM:- A. ADENEKAN, P. NNAEMEKA-AGU,
I. L. KUTIGI, JJCA

LION OF AFRICA INSURANCE CO. LTD. DEFENDANTS/
APPELLANTS

AND

S. A.. FISAYO PLAINTIFF/RESPONDENT

ACTIONS - Claim - The court cannot give more than what is claimed -
But can always give less.

EVIDENCE - Inferences - A judge can make inferences from established
facts.

INSURANCE - Premium - Payment of - From the conduct of the parties
- The appellants would be estopped from saying that the usual practice of
debiting the respondent's account - With the amount did not apply.

INSURANCE - Renewal of policy - By their conduct the appellants can-
not rely on clause 6 of the Policy - Which stipulates that they are not
bound to renew the policy.

INSURANCE - Liability - Where the appellants with full knowledge agreed
to revive the policy retrospectively - They are liable on it.

INSURANCE - Claims - Clause 10 of the policy which provides for a
time bar - Has nothing to do with law suits brought against the company
- But is intended to give the insured a maximum period within which to
lodge his claim with the company.

PLEADINGS - Defences - Raised in the statement of defence - It is for the defendant to prove this in a court of law - And not to be deemed admitted because the plaintiff did not file a reply.

FACTS

In the suit filed in the High Court of Lagos State the Plaintiff/respondent claimed against the defendants/appellants for the sum of N50,000.00 (Fifty Thousand Naira) payable to the plaintiff in the event of death or permanent general disablement under a personal accident Insurance Policy No. L/PA15775/7 and now PA/512/01167.36. Alternatively, the plaintiff claims the sum of N50,000.00 for breach of contract. The Plaintiff's case is that he was appointed agent and customer of the defendants in 1957. In 1959 he was granted credit facilities under which he was allowed to do business with the defendants on credit and debit basis and made payments at the end of each month. Sometimes in 1973 the plaintiff decided to take out a personal Accident policy from the defendants for himself. The policy took effect from the 17th July 1973 and made renewable each year on the annual premium of N110.00. The plaintiff did not pay cash. His account with the defendants was debited in 1974 when the policy was due for renewal he again did not pay cash. The premium was debited to his account and the policy was accordingly renewed.

In July 1975 when the policy was again due for renewal for some unknown reasons the plaintiff's account was not debited. The plaintiff was not aware of this omission. On 17th August 1975 the plaintiff was involved in a motor accident and he sustained multiple fracture on his left leg. On 15th September 1975 he conveyed the news of the accident to the defendant. When the plaintiff later discovered that the premium for 1975 was not debited to his account, he paid cash on 1st march 1976. The defendants by an endorsement on 6th may 1976 renewed the policy effective from 18th July 1975 for another twelve months and to expire on 17th July 1976. Immediately after the policy was renewed the plaintiff on 7th June 1976 submitted a claim of N25,000.00 to the defendants. On 19/7/76 the defendants declared the endorsement earlier made to the policy as null and void. The policy was then said to

have been reinstated from 1/3/76. By a letter dated the 22/7/76 the defendants specifically denied that the claim was covered by the policy. On 4/8/76 the policy was cancelled by the defendants and finally by a letter dated 10th August, 1976 the defendants completely repudiated plaintiff's claim. The defendants did not deny that plaintiff was their agent but denied any credit and debit agreement between them. They said the policy had lapsed before the accident occurred and as such no claim can be founded on it. The defendants also claimed that the action against them was time barred. They contended that the reinstatement or renewal of the policy took place after the accident and they were not bound to pay anything to the plaintiff.

At the end of the trial the learned trial judge found in favour of the plaintiff and awarded him N15,000 damages. The defendants being dissatisfied appealed to the Court of Appeal, Lagos Division.

ISSUE FOR DETERMINATION

Whether or not there was any form of agreement by the parties that the premium payable in respect of the policy by the respondent were chargeable to the respondent's account with the appellants.

HELD (Unanimously dismissing the appeal per lead judgment of KUTIGI, JCA)

Insurance - Premium

1. I am therefore equally inclined to agree with the learned trial judge that the agreement as could be gathered from the conduct of the parties was that the premium payable by the respondent in respect of the personal accident policy were to be debited to his account with the respondents. It then follows from the above premises that the appellants would be estopped from saying that in 1975 when the policy was due for renewal, the usual practice of debiting respondent's account with the amount did not apply and that the respondent was to pay cash and that he failed to do so. I have no doubt in my mind that on the facts and circumstances of the case as a whole the trial judge was right. (p. 2316 E)

Renewal of policy

2. By the same token the appellants cannot rely on clause 6 of the policy, which stipulates that they are not bound to renew the policy, or send any notice of the premium becoming due to the respondent. (p. 2316 G)

B

Actions - Claim

3. First of all I do not think that the appellants counsel was correct when he said that the award was made suo motu as it was not claimed by the respondent. I am mindful that he cannot give more than what is claimed but he can always give less. The award of N15,000 is clearly less than N50,000 claimed by the respondent and is therefore in order (See on this EKPENYONG & ORS. V. NYONG & ORS (1975)2 SC 71). (p. 2317 D)

D ***Evidence - Inferences***

4. It must be noted that the evidence was that of multiple fractures in one leg, and not just a single fracture! On this state of affairs, it is not unreasonable in my view to infer that the respondent must have suffered "permanent general disablement". That is what the learned trial judge did in the case. It is settled that a judge can make inferences from established facts, (See for example FABUMIYI VS. OBAJE (1968) N.M.L.R. 244. I think he is right. (p. 2318 E)

F

Insurance - Liability

5. I am of the opinion that in the circumstances of the case as a whole and the conduct of the parties, it can safely be implied that appellants all along with full knowledge of the accident, did agree to revive the policy retrospectively and to cover interim losses as well. The appellants were therefore rightly held to be liable on the policy. I also agree with the learned trial judge that appellants' letters of July 1976 and August '76 declaring the policy null and void is ineffectual. (p. 2320 F)

H

Pleadings - Defences

6. I think learned counsel got the law upside down. The true position is the other way round. It is when a defendant fails by his statement of

Defence to admit or deny an averment in plaintiff's Statement of Claim, that the former will be deemed to have admitted such averments. A defendant is normally expected to file a defence to the statement of claim and unless new matters are raised in the statement of Defence, which warrant a Reply from the plaintiff, no reply will be expected from him. B So in this case para. 19 of the Amended statement of Defence is nothing more than a defence that the action was time barred. And this was for the appellants to prove or establish in court of law. (p. 2321 B)

Insurance - Claims

7. I have looked at clause 10 very carefully and in my view the clause has nothing to do with law suits brought against the company in respect of claims. The clause cannot and must not be read in isolation from the other provisions or clauses in the policy. So in my view, Clause 10 is D only intended to give the insured a maximum period of twelve months from the occurrence of the accident or event to lodge his or her claim with the company. It is only that kind of interpretation that will in my view give sensible and credible meaning to other clause of the policy E especially Clause 9. (p. 2322 C)

NOTABLE POINT OF INTEREST

NNAEMEKA-AGUJCA

1. Difference in the pleadings of various types of estoppel

I think it is necessary here to advert to the difference in practice in the pleading of different types of estoppel. It must be noted that whereas an estoppel by record or by deed must be specially pleaded (for which see Bowman v Rostron (1835)2 A.& E, 295) estoppel by conduct may, in G some case, be given in evidence without being specially pleaded: see Freeman v Cook (1948)2 Ex. 654; also Philips v. Im-thurm (1865) 18 C.B. (N.S.) 400. For these see Odgers: Principles of pleading & practice (31st Edn.) 184, foot note 38. On the premises that pleadings are no H longer required to be technical, it is enough in case of estoppel by conduct that facts pleaded and evidence in support thereof are sufficient to support the inference of estoppel. (p. 2323 F)

CASES REFERRED TO

Hawkins v. Bristol 1 A. C. Rep. 52

Sanders v. Sanders (1952) 2 A.E.R. 767 at 769

Wambai v. Kano N.A. (1965) N.W.L.R. 15

B Olubode v. Oyesina (1977) 5 S.C. 79 at 87

Ekpenyong Nyong (1975) 2 S.C. 71

Fabumiyi v. Obaje (1968) N.W.L.R. 244

BOOKS REFERRED TO

C MacGillivray & Parkinson on Insurance Law, 6th Edition p. 422 para. 1010

Halsburys Laws of England, 4th Edition vol. 25. page 268 para. 498

Odgers, Principles of Pleadings & Practice (31st Edn.) 184, foot note 38

D

LEAD JUDGMENT BY KUTIGI JCA

In suit No.LD/923/1976 the Plaintiff's writ of summons was endorsed as follows:-

E *"The plaintiff's claim is against the Defendant Company for the*
sum of N50,000.00 (Fifty thousand Naira) payable to the Plaintiff in the
event of death or permanent general disablement under a personal acci-
dent Insurance Policy NO.L/PA15775/7 and now PA/51/2/01167.36 in-
F *consideration of an annual premium of N110.00 payable under credit*
and debit arrangements; the Plaintiff did sustain injuries and permanent
general disablement in a road accident company 17th August 1975, and
the defendant company refused neglected and or refused to pay the said
sum despite repeated demands. Alternatively, the Plaintiff claims the
G *sum of N50,000.00 for breach of contract."*

As revealed by the pleadings and evidence led at the trial the plaintiff's case is that he was appointed agent and cash customer of the defendants in 1975. He paid cash for every business he introduced. In H 1959 he was granted credit facilities under which he was allowed to do business with the defendants on credit and debit basis and made payments at the end of each month. This was not to exceed N5,000.00 at the end of each month. Sometimes in 1973 the plaintiff decided to take

out a personal Accident Policy from the defendants for himself. He was issued with a policy No.LP/3PA/15775/7 which took effect from the 17th July 1973 and made renewable each year on the annual premium of N110.00. The plaintiff never paid cash for the first premium in 1973. His account with the defendants was debited as shown in the statement of account (EXHIBIT B.3) . In 1974 when the policy was due for renewal he again did not pay cash. The premium was debited to his account and the policy was accordingly renewed. (See EXHIBIT B.1). In July 1975 when the policy was again to be renewed for some unknown reasons the plaintiff's account which was still in operation, was not debited with the premium payable. The plaintiff was not aware of this omission.

On 17th August 1975 the plaintiff was involved in a motor accident and he sustained multiple fracture on his left leg. On 15th September 1975 he conveyed the news of the accident to the defendants. When the plaintiff later discovered that the premium for 1975 was not debited to his account, he made a cash payable of N110.00 to the defendants on 1st March 1976 as per EXHIBIT D. On 6th May 1976 the defendants by an endorsement No.E/0002/76 (EXH.D.1) renewed the policy effective from 18th July 1975 for another twelve months and to expire on 17th July 1976.

Immediately after the policy was renewed as above, the plaintiff on 7th June 1976 submitted a claim of N25,000.00 to the defendants. On 19th July 1976 the defendants wrote to the plaintiff referring to payment of premium made by him on 1/3/76 and subsequent endorsement of the policy on 18/3/76 and declared the endorsement null and void. The policy was then said to have been reinstated from 1/3/76. The plaintiff was also given fifteen days notice of cancellation of the policy. (See EXH.C.) by another letter dated 22nd July 1976 the defendants specifically denied that the claim was covered by the policy (see EXH. C.1).

I think there is no doubt at all that the defendants were provoked into writing both Exhs. C & C1 as a result of the claim of N25,000.00 put up by the plaintiff against them.

On 4th August 1976 the policy was cancelled by the defendants

and a return of premium of N63 was to be made to the plaintiff. By their letter dated 10th August 1976, the defendants completely repudiated plaintiff's claim.

B The defendants denied most of essential averments contained in the plaintiff's Amended Statement of Claim. But while the defendants do not deny that the plaintiff was their agent, they denied any credit and debit agreement between them. They said the policy subject matter of the claim had lapsed before the accident occurred and as such no claim can be founded thereon. It was also contended that the reinstatement of C renewal of the policy also took place after the accident and they were therefore not bound to pay anything to the plaintiff. The defendants also claimed that the action against them was time barred since it was not commenced within 12 months from the happening of the accident.

D At the end of the trial the learned trial judge found in favour of the plaintiff and awarded him N15,000.00 damages under Clause 4 of the Table of Benefits for permanent General Disablement at the rate of N5,000 per annum for three years.

E The defendants (hereinafter called the appellants) have appealed to this Court against the award. By leave of the Court, seven Amended grounds of appeal were filed and argued. The plaintiff will also be referred to as the respondent henceforth. I ought to state that the respondent was not represented at the hearing of this appeal. His solicitors F Messrs. S.G. Elabor & Co. have however filed a brief on his behalf. It was after we have satisfied ourselves that the solicitors had been served with the hearing notice that we decided to proceed with the appeal, the briefs having been filed on both sides.

G Arguing the appeal Mr. Thompson learned counsel, for the appellants said he relied on his brief and amplified same by oral submissions.

H On grounds 1,2, &3 counsel submitted that there was no basis for the judge's finding that the agreement between the parties was that premiums payable by the respondent were to be debited to his account with the appellants. He said the only agreement between the parties was for the respondent to incur up to N5,000.00 debit each month. That

since the evidence showed that at the time the policy fell to be renewed in 1975 the respondent had exceeded the N5,000 limit allowed him that agreement cannot avail him. It was also submitted that it is a well known principle of insurance business that it is the duty of the insured to renew the policy and that the insurer is not duty bound to renew the policy or send any notice to the insured of the premium becoming due. That the respondent herein failed to renew the policy when it expired on 18th July 1975 and that there was no evidence before the court that he intended to renew the policy with the appellant before the accident. Counsel also submitted that payment of premium being a condition precedent for the existence of any policy, the question of estoppel could not arise since the appellant cannot be stopped from denying payment of premium. That estoppel has to be established on the basis of facts pleaded and proved at the trial and that it was not enough for the respondent to have merely stated that he was a Credit and Debit Customer of the appellants. It was also contended that estoppel was wrongly introduced into the case by the learned trial judge himself. The following cases were then cited in support:-

HAWKINS v. BRISTOL & WEST OF ENGLAND FRIENDLY SOCIETY (1927) 1 A.C. Rep. 52;

SANDERS v. SANDERS (1952) 2 A.E.R. 767 at 769;

AFRICAN CONTINENTAL SEAWAYS LTD. V. NIGERIAN DREDGING & GENERAL WORKS LTD. (1977) 5 S.C. 235

Reference was also made to MacGillivray & Partington on Insurance Law, 6th Edition, page 422 para. 1010.

Mr. Elabor in his brief for the respondent submitted therein that the respondent by his pleading and evidence clearly established that he was a Credit and Debit customer of the appellants. That respondent's account was debited in 1973 and 1974 in respect of payment of premiums for those years. That by their conduct the trial judge rightly held that the appellants are estopped from denying that was not the agreed method of payment of premium. He said a contract may be oral or in writing; it may also be expresses or implied. He said from EXHIBITS B.L B.3,D-D.1 and N . And respondent's testimony , the agreement as to

the method of payment could easily be inferred. It is by debiting respondent's account.

The first point that calls for consideration under the above submissions is whether the respondent was a mere cash agent or a Credit and Debit customer of the appellants. In other words whether or not there was any form of agreement by the parties that the premium payable in respect of the policy by the respondent were chargeable to the respondent's account with the appellants. On this point I say straight away that there is ample evidence in support of the trial judge's finding that the respondent enjoyed credit facilities with the defendant and that when he took out the policy in 1973 the arrangement was that his account was to be debited with the premium payable. EXHIBITS "B.1 and B.3 two of the statement of account, clearly show that the premiums for the Year 1973 and 1974 were debited to the respondent's account with the appellants. Further more some of the statements of account relating to the respondent's transaction with the defendants such as EXHS. D-D1 & N show that the parties dealt with each other on credit and debit basis.

I am therefore equally inclined to agree with the learned trial judge that the agreement as could be gathered from the conduct of the parties was that the premium payable by the respondent in respect of the personal accident policy were to be debited to his account with the respondents. It then follows from the above premises that the appellants would be estopped from saying that in 1975 when the policy was due for renewal, the usual practice of debiting respondent's account with the amount did not apply and that the respondent was to pay cash and that he failed to do so. I have no doubt in my mind that on the facts and circumstances of the case as a whole the trial judge was right. By the same token the appellants cannot rely on clause 6 of the policy, which stipulates that they are not bound to renew the policy, or send any notice of the premium becoming due to the respondent. Grounds 1,2, & 3 therefore fail.

Grounds 4 & 5 were argued next. They deal with the award of N15,000 to the respondent. Appellants' counsel submitted that the award

was not supported by evidence. He said the respondent gave no evidence of permanent disablement of any leg and that the Medical Certificate (EXH.F) cannot be proof of what it says in the absence of direct testimony from the doctor, its maker. He referred to section 56 of the Evidence Act and WAMBAL v. KANO N.A (1965) N.M.L.R 15.

It was further submitted that the judge suo motu awarded N15,000 to the respondent, which he did not ask for. He said the trial judge having found that there was no basis for the claim of N50,000 should have dismissed the action instead of awarding what he has no power to award. He argued us to set aside the award. The case of OLUBODE v OYESINA & ORS (1977) 5 S.C. 79 at 87 was cited in support.

The respondent in reply said the award made by the trial judge was based on EXHIBIT A, E & F and that the award was right. He said the judge was entitled to use his discretion to make any award to the respondent provided he used the Table of Benefits in the policy, which he did.

First of all I do not think that the appellants counsel was correct when he said that the award was made suo motu as it was not claimed by the respondent. Para. 14 of the respondent's Amended Statement of Claim dated 25/3/77 reads as follows:-

"14. The Plaintiff shall contend at the trial of this action that the Defendant company is liable to the plaintiff under the said policy for the sum of N50,000 under item 3 of the Table of Benefits."

Item 3 on the Table of benefits provides for loss of one or both hands or both feet. The judge found that the respondent has not lost one or both hands or both feet and rightly held in my view that there was no basis for the claim of N50,000 under Item 3. But immediately under item 3 of the Table is item 4 which clearly provides for permanent General Disablement where no benefit is payable under item 2 or item 3. So the trial judge was already bound to consider depending and in accordance with the evidence led before him, making an appropriate award as provided under the Table. **I am mindful that he cannot give more than what is claimed but he can always give less. The award of N15,000 is clearly less than N50,000 claimed by the respondent and is therefore in**

2318 Lion of Africa v. Fisayo (1998) 9 KLR Kutigi JCA
order (See on this EKPENYONG & ORS v NYONG & ORS (1975)
2/S.C. 71).

I also do not share the view of counsel for the appellant that the award was not supported by evidence apart from the Medical Report which he said was hearsay because the doctor who wrote the report was not called to give evidence. At the trial the respondent in his examination in chief in support of his claim said on p. 27 of the record as follows:-

"I remember 17th August 1975. On that day I had a motor accident and sustained multiple fractures of my left leg. On 15/9/75 I notified the Defendant about my accident On 7/6/76 I submitted my claim from and the Medical Certificate to the Defendants. This is the claim form. Admitted and Marked EXHIBIT E. This is the Certificate. Admitted and Marked EXHIBIT F" (underlining by me is for emphasis only)

It is significant that under cross-examination the respondent was not asked a single question in respect of the accident or in respect of anything he had said above. So that even if the Medical Report is ignored, and I believe the learned trial judge did just that because he made no reference to it in the judgment before coming to the conclusion that the respondent was entitled to the award, the evidence of the respondent referred to above remained unchallenged and uncontroverted. **It must be noted that the evidence was that of multiple fractures in one leg, and not just a single fracture! On this state of affairs, it is not unreasonable in my view to infer that the respondent must have suffered "permanent general disablement". That is what the learned trial judge did in the case. It is settled that a judge can make inferences from established facts, (See for example FABUMIYI vs. OBAJE (1968) N.M.L.R. 244. I think he is right.**

Both grounds 4 & 6 must therefore fail.

On ground 5 counsel submitted that in insurance law, the revival of a policy after the expiration of the preceding period operates as a new contract and the rights and liabilities of the parties do not begin until the new contract has started to run. That the mere fact that the revived policy is ante-dated to the expiration of the period previously covered

does not mean that the loss which has happened before the date of the revival has to be paid for by the insurers. He said in this case the accident doubtlessly occurred before the renewal of the policy and that there is nothing on record to show that the appellants intended to cover interim losses which cannot even be covered here because the policy had lapsed B completely. He referred to HALSBURYS LAWS OF ENGLAND, 4TH EDITION, VOL.25. Page 268, para.498.

The respondent replied by saying that the renewal or the policy was not to create a new contract but a renewal of the old policy referred C to in the instrument of renewal. It was then submitted that the renewal has the effect of covering interim losses particularly when the responsibility to pay the premium by debiting the respondent's account fell equally on the appellants which they failed to carry out.

Now para. 498 on p.258 of Halsburys Laws of England (supra) D relied upon by appellants' counsel reads as follows:-

"Revival as new contract: A revival of an insurance policy operates as a new contract, and the parties rights and liabilities, according to ordinary principles do not begin until the new contract has started to E run. Even if the revived policy is antedated to the expiration of the period previously covered, this does not necessarily mean that a loss which has happened before the date of the revival has to be paid for by the insurers, to achieve this there must be clear evidence of the parties hav- F ing intended to make the revival retrospective so as to cover even interim losses -- therefore there may be a considerable difference in effect between a premium paid before the expiration of the period of grace, which the insurers may have to accept even if a loss has already occurred, and G a premium paid after the expiration of the period of grace, which will not commit the insurers to accepting a loss which has already occurred unless it is clearly their intention, expressly or impliedly, to do so. (Underlining is for emphasis only).

I must observe first that the learned trial judge on the court be- H low also relied on para. 498 of Halsbury's above in addition to para. 497 (ss pp. 39-40 of the judgment) before coming to the conclusion that the appellants are estopped from denying that there was a subsisting policy.

I too will not hesitate in saying that I agree with that conclusion judging from the conduct of the parties herein. I have earlier stated that I agree with the trial judge that the practice of debiting respondent's account with the amount of premium by the appellants was still very much alive and that the appellants could not be heard to say that the respondent failed to renew the policy by not paying the premium by cash when it fell due in July 1975. When the policy fell due for renewal in July 1975 it was the fault of the appellants when it was not renewed. When the defendant was involved in the accident in August 1975, this fact was communicated to the appellants. By their letter, EXH. D dated 6/5/76 the appellants wrote to the respondent thus:-

"It is hereby agreed and declared that effective from 18th July 1975 this policy is renewed for another period of twelve months and will expire on the 17th July 1976."

This letter was written after the respondent had paid the premium in March 1976. It was not until after the appellant had submitted his claims to the appellants the they (appellants) in July 1976 wrote to the respondent declaring the above endorsement of 6/5/76 null and void on the ground that the policy could not be renewed retroactively. Another reason they gave was that the respondent withheld a material fact from them. What material fact? If one may ask. The information about the accident was communicated to the appellants as far back as 15/9/1975. I think as the learned trial judge rightly put it - "It is a plain case of blowing hot and cold." **I am of the opinion that in the circumstances of the case as a whole and the conduct of the parties, it can safely be implied that appellants all along with full knowledge of the accident, did agree to revive the policy retrospectively and to cover interim losses as well. The appellants were therefore rightly held to be liable on the policy. I also agree with the learned trial judge that appellants letters of July 1976 and August '76 declaring the policy null and void is ineffectual.** Ground 5 also fails.

The last ground is ground 7. Mr. Thompson for the appellants submitted that the judge was wrong when he held that the respondent's action was not time-barred. He said it was clear on record that the

accident occurred on 17/8/75 while the writ of summons was only filed on 3/9/76. That the period between the occurrence of the accident and the issuance of the writ of summons was over twelve months contrary to the provision of Clause 10 of the conditions of the policy (EXH. A.). He referred to p.19 of the Amended Statement of Defence where the time limitation was pleaded and submitted that since the respondent's filed no reply he must be deemed to have agreed that his action was time barred. I will take this last point first. **I think learned counsel got the law upside down. The true position is the other way round. It is when a defendant fails by his statement of Defence to admit or deny an averment in plaintiff's Statement of Claim, that the former will be deemed to have admitted such averments. A defendant is normally expected to file a defence to the statement of claim and unless new matters are raised in the statement of Defence, which warrant a Reply from the plaintiff, no reply will be expected from him. So in this case para. 19 of the Amended statement of Defence is nothing more than a defence that the action was time barred. And this was for the appellants to prove or establish in court of law** and not admitted otherwise there will be no necessity of filing the action in the first place. I now return to clause 10 of the policy which reads:-

"10. In no case whatever shall the Company be liable for any death injury or disablement after the expriation of twelve months from the happening of the death injury or disablement unless the claim is the subject of pending action or arbitration."

(Underlining is mine)

There is no dispute about the following facts:

- (1) that the accident occurred on 17/8/75;
- (2) that the appellants were duly informed about the accident on 15/9/75;
- (3) that the respondent submitted his claims on 7.6/76;
- (4) that the appellants repudiated the claim by their letter of 21/7/76;
- (5) The appellants finally cancelled the policy by their letter of 4/8/76;

(6) The respondent issued a writ of summons against the appellants on 3/9/76.

The period between 17/8/75 when the accident occurred and 7/6/76 when the respondent forwarded his claim is clearly less than twelve months. Nothing therefore stopped the appellants from paying up before 16/8/76 when the accident was twelve months old. But instead of doing just that they first of all repudiated the claim on 27/7/76 and finally cancelled the policy itself on 4/8/76. This action was then instituted barely one month thereafter on 3/9/76. Needless to state that the appellants had always looked for loopholes not to pay.

I have looked at clause 10 very carefully and in my view the clause has nothing to do with law suits brought against the company in respect of claims. The clause cannot and must not be read in isolation from the other provisions or clauses in the policy. For example, clause 3 therein provides that Notice of the accident must be given within 14 days to the Company and that a preliminary claim be lodged with the Company within 28 days of the accident. Clause 9 also provides, inter alia, that where the company disclaims liability to the insured, such a claim must be referred to arbitration within twelve calendar months from the date of such disclaimer otherwise the claim shall be deemed to have been abandoned. The disclaimer in this case was by the letter dated 22/7/76. So that even by the letters of Clause 9 the claim could not be deemed to have been abandoned before 31/7/1977. It is therefore understandable why clause 10 excludes pending action or arbitration. "pending action" is nowhere defined in the policy but in the context of other provisions in the policy it cannot mean more than action pending in the company in respect of a claim. In other words it refers to a situation where due notice and claim have been lodged with the Company and for one reason or the other the Company has not yet completed action on the claim. Such a claim cannot therefore be deemed to have lapsed under the policy conditions. **So in my view, Clause 10 is only intended to give the insured a maximum period of twelve months from the occurrence of the accident or event to lodge his or her claim with the company. It is only that kind of interpretation that**

will in my view give sensible and credible meaning to other clause of the policy especially Clause 9. This ground of appeal therefore fails.

On the whole the appeal fails completely. It is accordingly dismissed. The judgment of the High court delivered on 5th February 1979 B is hereby confirmed. The respondent is awarded costs of this appeal which is assessed at one hundred and fifty Naira (N150,00).

ADEMOLA JCA

I agree. I have nothing to add.

NNAEMEKA-AGU JCA

I have had the opportunity of reading in draft the judgment of my brother, Kutigi, JCA. just delivered. I agree with his reasoning and conclusion that the appeal has no merit.

This is yet another case, rather common before us these days, E of some insurance companies being rather too quick to pocket the insured's premium but trying to hang on every straw to frustrate the very intention of the policy by repudiating liability when a claim arises.

I wish to comment on a few points in support of my learned F brother's conclusions.

On the issue of estoppel, the appellant contends that it was not pleaded, and so the learned Judge was in error in finding on it on the evidence before him. I think it is necessary here to advert to the difference in practice in the pleading of different types of estoppel. It must be G noted that whereas an estoppel by record or by deed must be specially pleaded (for which see Bowman v Rostron (1835)2 A.& E, 295) estoppel by conduct may, in some case, be given in evidence without being specially pleaded: see Freeman v Cook (1948)2 Ex. 654; also philips v H Im-thurm (1865) 18 C.B. (N.S.) 400. For these see Odgers: Principles of pleading & practice (31st Edn.) 184, foot note 38. On the premises H that pleadings are no longer required to be technical, it is enough in case

of estoppel by conduct that facts pleaded and evidence in support thereof are sufficient to support the inference of estoppel. It is noteworthy that in the case of John Esan v Fagbemide Olowa (1974) 3 S.C. 125 in which it was admitted that estoppel per rem judicatem was not pleaded but evidence was let in at the trial pointing to that fact, the Supreme Court held at p.135-136:

"The gravamen of his argument as a whole was on the issues of res judicata. We are in agreement that, when such a plea becomes necessary for a defence, it must be specially pleaded. But when a defendant does not base his defence on such a plea., then when materials are let in evidence by the plaintiff as to constitute estoppel, then the latter cannot be heard to complain about the evidence as considered, so long as it is a relevant fact on the issue before the Court."

So it is in this case. But this case is even stronger in that it is a question of estoppel by conduct, as opposed to estoppel per rem judicatam in esan's case (supra). My learned brother in the lead judgment has spotlighted the accepted evidence upon which the finding of estoppel was based. It is enough to say that in view of the finding on the evidence that the respondent is a credit customer; that in 1073 and 1974 the premia for his policy were not paid in cash but were simply debited by the appellants to his account with them; that they were expected to do so when the policy fell due for renewal in July 1975, but did not; that the fact that the respondent had an accident in August 1975 was communicated to the appellants in September, 1975; and that when, on the instances of the appellants, the respondent paid cash for the renewal of the policy and not for a new policy, the appellants, with the full knowledge of all the facts, renewed the policy "effective from 18th July, 1975," for another period of twelve months" which "will expire on the 17th of July 1976," the law will hold the appellants to the full force and effect of their own representation. It appears clear to me that there could have been no reason why the respondent in March, 1976, would have accepted his policy to run for one year from July 1975- a loss of nearly nine months - if he did not believe that he would be fully indemnified by the appellants of the losses resulting from the accident, the fact of which he had communicated to

them some nearly eight months earlier. I believe that by the acceptance of the renewal of a policy which had less than four more months to run for full payment for one year, the respondent had altered his position to his prejudice. The appellant cannot be allowed to repudiated the situation that had arisen simply because the respondent had put up a claim for the accident. B

On the question of limitation of the action, apart from the view my brother has expressed about the true meaning of clause 10 of the policy with which I agree, it is, I believe, a sound proposition of law that in a case in which parties who had agreed to go to court within a particular time if their claim is not settled get into correspondence in which the defendant is expected to give a decisive answer one way or the other, the cause of action does not accrue until that answer is given. So the learned Judge was right when he said that the cause of action in this case accrued not when the respondent's injury occurred but when the appellants repudiated his claim on 22nd July, 1976. This appears also to be the contemplation of that part of clause 10 which stipulates 12 months from the death, injury or disablement "unless the claim is the subject of pending action or arbitration." C D E

I also agree that on the facts of the case and the unchallenged evidence before the court the learned Judge was right in the amount of damages he awarded. For, although what was claimed was in the nature of special damages, the learned Judge by accepting, as he must, the unchallenged evidence as to damages, must have come to the conclusion, rightly in my view, that the respondent was entitled to damages under that head. For the Supreme court laid down what is required in proof of special damages in Oshinjinrin & Ors. v. Alhaji Elias & Ors. (1970) 1 All N.L.R. 153, at p.156 thus: F G

"Undoubtedly the rule that special damages must be strictly proved applies to cases on tort. In effect the rule requires any one asking for special damages to prove strictly such special damages as he claimed. This however does not mean that the law requires a minimum measure of evidence to establish entitlement to special damages. What is required is that the person claiming should establish his entitlement to that type of H

damages by credible evidence of such a character as would suggest that he indeed is entitled to an award under that head, otherwise the general law of evidence as to proof by preponderance or weight usual in civil cases operates."

B In the case in hand, there is no doubt that on the accepted evidence, the respondent was entitled to an award. Having come to that conclusion the learned Judge was right on the basis of paragraph 14 of the statement of claim, to conclude from the evidence that the respondent was entitled to an award of a smaller sum in the table of benefits and not the larger sum
C which he claimed under the same table. It appears therefore that appellant's argument in this respect is misconceived. In my view, it is necessary to distinguish cases in which a trial Judge rejected the evidence in support of an item of special damages (as was the case in Jaber v Basma 14
D W.A.C.A. 140, at p. 142) from those in which he accepted the evidence, as in the instant case.

I therefore also dismiss the appeal with the same orders as made in the lead judgment.

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