Annual Review of Insurance Law

2001

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The summaries in this review do not seek to express a view on the correctness or otherwise of any court judgment. This publication should not be treated as providing any definitive advice on the law. It is recommended that readers seek specific advice in relation to any legal matter they are handling.

PREFACE

Following the tremendous response to previous editions, we are pleased to present again our annual review of insurance law. There has been an unprecedented number of contributors to this year's review, reflecting the continuing growth of the Allens Arthur Robinson insurance practice. It also reflects the benefits of the merger on 1 July 2001 between Allen Allen & Hemsley and Arthur Robinson & Hedderwicks to form one national firm, enabling us to service the requirements of insurers and other clients across Australia most effectively and efficiently.

As in past years, our aim is to include cases of general interest to the insurance industry, or which represent a significant development in the law. This publication, as well as the annual review for past years, is now available on our website at **http://www.aar.com.au/publications/ari/**. There you will also find a feedback page, and we warmly welcome your comments on this publication.

The year 2001 has certainly been eventful for the insurance industry. Domestically, it was dominated by the dramatic collapse of the HIH Group. Whilst the ramifications continue to be felt and will impact the industry for some considerable time yet in the form of rating adjustments and even greater consolidation, some short to medium term effects have been readily observable. The collapse was instrumental in accelerating the passage through Parliament of the General Insurance Reform Act 2001, discussed in this Review. A Royal Commission has been established to investigate the causes of the collapse, and its findings, when published, will be of significant interest to everyone involved in the industry. The Commonwealth Government has established a relief scheme to assist certain categories of HIH policyholders who will be financially disadvantaged as a result of the failure.

On the global front the shocking events of September 11 continue to reverberate. The impact on the global insurance industry has been profound. Closer to home, the implications of the withdrawal by reinsurers of terrorism coverage give rise to significant issues, particularly in relation to statutory classes where withdrawal or the imposition of exclusions at a primary cover level is not possible. At the time of going to press a number of states and territories had announced measures and in some cases draft legislation to ameliorate the difficulties faced by CTP and workers' compensation insurers. The Federal Government has also announced a review of the issue. Cover for terrorism risks is a significant socio-economic issue which requires government input in reaching a solution.

For their contributions to this publication I would like to thank Melissa Atkins, Prue Campton, Dean Carrigan, Clare Cunliffe, John Edmond, Eugene Elisara, Emma Flood, Sergio Friere, Yvette Holt, Rohini Jannu, Jessica Kelly, Mark Lindfield, Andrew Maher, Kerren Murray, Rachel Nemes, Allan Parapuram, Steven Sander, Melita Simic, Matthew Skinner, Malcolm Stephens, Joe Tan, Terence Walsh and Roger Wong.

I hope you find this publication both interesting and useful as a reference tool. I welcome your feedback and comments.

Andrea Martignoni
Insurance Partner (Sydney)
Editor

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Section 54: High Court delivers judgment in FAI v Australian Hospital Care

Case Name:

FAI v Australian Hospital Care

Citation:

[2001] High Court of Australia, Gleeson CJ, McHugh, Gummon, Kirby and Hayne JJ

Date of Judgment:

27 June 2001

Issues:

- s54 of Insurance Contracts Act
- failure to give notice of circumstances arising during the policy period
- *FAI v Perry* overruled

Allens Arthur Robinson

The High Court on 27 June gave its long awaited decision in *FAI v Australian Hospital Care Pty Limited*. The decision concerns the application of s54 of the Insurance Contracts Act 1984 (Cth) to a standard "claims made and notified" professional indemnity policy. Although the decision on the whole is bad news for insurers and good news for insureds, it removes some uncertainty which has existed concerning the application of s54, while there are still other issues which remain unresolved. The decision has important practical implications for insurers.

The facts

The facts may be stated briefly as follows:

1. The insured hospital had a professional indemnity policy with FAI. The policy covered the hospital against any claims first made and notified during the period of cover. The policy also contained a number of standard conditions, one of which provided that, if the hospital became aware of any occurrence which may subsequently give rise to a claim and gave notice of that occurrence during the period of the policy, then any subsequent claim arising out of the occurrence will be covered. This provision may be referred to as an "occurrence notified" clause.
2. During the period of cover the insured received a letter from the firm of solicitors representing a former patient. The letter gave notice that a claim may be made by the hospital in respect of treatment received by the patient. The hospital, contrary to its usual practice, gave no notice of this occurrence to the insurer during the period of cover.
3. The central issue was whether s54(1) of the ICA precluded FAI from refusing to pay the hospital's claim on the ground that it failed to give to FAI, within the period of cover, notice of any occurrence which may give rise to a claim.
4. Section 54 deals with acts or omissions occurring after the contract of insurance was entered into where the effect of the contract of insurance is that the insurer may refuse to pay a claim by reason of that act or omission. It provides that the insurer may not refuse to pay the claim by reason only of that act or omission. The insurer may only reduce its liability to the extent to which its interests were prejudiced.

The decision

The decision of the majority is contained in the joint judgment of McHugh, Gummow and Hayne JJ. In giving their reasons, those judges placed considerable reliance on the decision of the High Court in *Antico* and in particular the finding that, for the purpose of s54, an "omission" may be "a failure by the insurer to exercise a right, choice or liberty which the insured enjoys under the policy". The

majority considered that it followed that s54 can be engaged by an omission by the insured to give notice of an occurrence, even if that omission results from a deliberate choice by the insured. Consequently, the decision of the majority of the New South Wales Court of Appeal in *FAI v Perry* has been overruled. The majority also expressly rejected the proposition that a distinction can be drawn between omissions and "non events" as the New South Wales Court of Appeal had attempted to do in *Greentree* and Hodgson CJ in Eq had done in *Permanent Trustee v FAI*.

The majority considered that if a contract has an occurrences notified clause and an insured becomes aware of an occurrence that may subsequently give rise to a claim during the period of cover, an event of the type contemplated by the contract of insurance has occurred. The effect of the contract of insurance was that FAI could refuse to pay the claim by reason only of the fact the insured did not give notice of the occurrence to it. Section 54 therefore required the conclusion that FAI may not refuse to pay the insured's claim.

However, the majority noted that the decision in *Greentree* was correct on its facts. In that case, the third party had failed to make a claim or demand within the period of the policy. Consequently, there was no notifiable claim or circumstance within the policy period. While s54 can be engaged to excuse a failure to notify, it cannot extend the operation of the policy to cover claims or circumstances which did not arise during the policy period.

Kirby J delivered a separate but concurring judgment. In finding that the hospital's failure to give notice was an "omission" for the purpose of s54, Kirby J appeared to place some reliance on evidence to the affect that it was the hospital's usual practice to have notified its insurer about such matters. It is not clear whether his decision would have been different if the hospital had made a deliberate decision not to notify.

Implications for the insurance industry

The broad interpretation of s54, which has now been endorsed by the High Court, has important implications for insurers not only at the claims level but also at the underwriting level:

1. the decision means that the policies do not mean what they say. In particular, the notification requirements have been dispensed with altogether. Consequently, insurers in setting reserves and fixing premiums on renewal will need to make allowances not only for *claims made* during the period which were not notified but also for claims arising out of *circumstances which became known* to the insured during the period of the policy, but were not notified. The policies are therefore inherently less certain and longer tailed;
2. the decision reduces the pressure or compulsion on insureds to give full and complete disclosure when completing proposals for successive cover. Insureds can now be more comfortable that if they become aware of circumstances even if they do not notify their current insurer of them that insurer would have to meet the claim. It is now clear that even where the insured makes a deliberate decision not to notify of circumstances for the purposes of obtaining more favourable terms on renewal, s54 will prevent the insurer from denying liability;
3. the case illustrates that there will be reduced scope for a gap in the insured's

coverage, and increased scope for double insurance. On the one hand, but for s54 the insurer would be able to deny liability on the basis that no notification was given during the period of the policy. If the known circumstances are then not disclosed prior to a renewal, the insurer may deny liability under the subsequent policy on the basis of non disclosure. On the other hand, by reason of the decision, in some cases the claim may be covered under both policies. This can arise where the insured becomes aware of circumstances which may give rise to a claim but does not in fact believe (or reasonably believe) that a claim is likely to be made. In such cases, the claim may be a notifiable occurrence for the purposes of the existing policy but not a matter calling for disclosure for the purposes of the duty of disclosure under the subsequent policy. This was in fact the case in *Hospital Care* itself. In 1999, the Queensland Court of Appeal in *Australian Hospital Care v Swinbank* held that the hospital's claim was also covered by a subsequent Lloyd's policy. The Queensland Court held that the hospital, having investigated the matter after receiving the letter from the patient's solicitor, did not believe that a claim was likely and therefore had not breached its duty of disclosure;

4. the possibility of double insurance may be significant where the insured changes insurer or where the level of cover is increased. Insurers should consider whether provisions excluding claims covered by any prior policy and questions in proposal forms which may have an impact on notification requirements are adequate to ensure that a subsequent policy will not apply where liability attaches under a prior policy by reason of s54;
5. in appropriate cases insurers may argue prejudice within the meaning of s54(1) to reduce their liability. One source of prejudice may be loss of an opportunity to charge additional premiums on renewal. Even if that argument were valid, its proof would inevitably involve the discovery of documents relevant to the insurer's practices and policies in fixing premiums. Such documents are likely to be highly confidential and commercially sensitive. Consequently, it is unlikely that insurers will wish to run such arguments. In any event, now that the decision has been handed down, insurer's policies and practices are bound to have regard to it and to factor in the longer-tail nature of the business. The consequence is likely to be increased premiums;
6. the decision does not make it clear whether s54 will apply to a failure to notify circumstances which might give rise to a claim when the contract contains no "occurrences notified" provision. In those circumstances, the insured would have to rely on s40 of the ICA to obtain cover for notified occurrences. Section 40 provides that, *whatever the terms of the contract,* if the insured becomes aware of circumstances which might lead to a claim and notifies the insurer of those circumstances before the insurance cover provided by the contract expires, any claim later arising from those circumstances will be covered by the policy. In *Einfeld*, Rolfe J found that s40 provided a statutory extension to the policy and there was no reason why the provisions of s54 could not apply to it. However, s40 does not expressly provide that its provisions become a term of the policy as such. Section 40 confers a statutory entitlement. The majority in *Hospital Care* stated that any tension or overlap between s54 and s40 should not be resolved by reading s54 down. However, that begs the question whether there really is any tension or overlap between the two sections. In its terms, s54 is concerned with the effect of contracts of insurance rather than with the effect of statutory provisions. The recent decision of Chesterman J in *CA & MEC McInally*

Nominees Pty Ltd, also reported in this Review, drew this distinction in holding that, where an insured must rely on s40, the notice requirement is mandatory and s54 has no application. If they were commercially able to do so, insurers might wish to consider removing from their policies provisions relating to the notification of circumstances and leaving their insureds to rely on s40 in that regard;

7. a question arises as to whether the insured has any incentive to give notice of circumstances which the insured becomes aware of during the period of the policy. There may still be reasons why the insured may want to give such notification:
   (a) it leaves less room for argument as to whether the insured has become aware of circumstances which might give rise to a claim. It was accepted for the purpose of the High Court appeal in *Hospital Care* that the insured had that knowledge. However, this issue, which can be a difficult factual one, was a significant issue for the trial judge to judge;determine.
   (b) where the insured relies on s40 rather than a contractual provision, there is uncertainty whether s54 will assist the insured (see 6 above);
   (c) in some circumstances the insured's conduct in failing to give notice may amount to a breach of its duty of good faith;
   (d) notification avoids the possibility of any issue of prejudice being raised by the insurer to reduce its liability to the insured;

The decision effects a rewrite of claims made and notified policies to dispense with notification requirements altogether. As such, it undermines the purpose for which such policies were developed, namely to achieve greater certainty and to assist insurers in setting reserves and closing their books at the end of the policy period. In view of these uncertainties, the case for legislative reform is now stronger than ever. The Insurance and Superannuation Commissioner in 1995, after considering relevant authorities, rejected the suggestion of a legislative amendment to s54, seeing no need for it in light of the decision in *East End* and *FAI v Perry*. In light of the High Court's decision in *Hospital Care*, the Commissioner's successor, the Australian Prudential Regulation Authority or ASIC may be prepared to take a different view. At the time of print, the ICA is presenting a case to those authorities for legislative reform.

Section 54 unable to assist insured relying on section 40: notification requirement mandatory

Case Name:

CA & MEC McInally Nominees Pty Ltd & Ors v HTW Valuers (Brisbane) Pty Ltd & Ors

Citation:

[2001] QSC 388 per Chesterman J

Date of Judgment:

16 October 2001

Issues:

- sections 54 and 40 of the Insurance Contracts Act
- professional indemnity policy
- effect of failure to give notice of circumstances in the policy period

The facts

The defendants comprised certain valuers and a firm of solicitors in the business of lending money on the security of mortgages over real property. The plaintiffs were clients of the solicitors. The plaintiffs lent money to finance the acquisition of a gymnasium and fitness centre in reliance on valuations prepared by the valuers. The valuations were negligent in that they grossly inflated the sustainable market rent and inflated the true value of the property.

The valuers had a policy of insurance issued by Commercial Union Assurance Company of Australia Limited ***(CUA)*** for the period 15 September 1998 to 15 September 1999. The policy covered claims made against the valuers during that period and claims about which CUA was given notice in that period.

No claim was made against the valuers until 6 December 1999 when the plaintiffs made a claim and 22 November 2000 when the solicitors made a claim. The valuers did not give CUA notice of the claim, or indeed, of the possibility that there might be a claim, until March 2000.

The valuers argued that they had nevertheless become aware of circumstances in the policy period which may give rise to a claim. They argued that they were entitled to rely upon a combination of s40 and s54 of the Insurance Contracts Act (the ***Act***). Section 40 applies to claims made and notified policies of the type issued by CUA. It provides that, where the insured gives notice of facts that might give rise to a claim as soon as practicable after the insured becomes aware of those facts but within the policy period, the insurer is not entitled to deny liability by reason only that the claim was made after the expiry of the policy period. Section 54 provides that, where the effect of a contract of insurance is that the insurer may refuse to pay a claim by reason of some act or omission of the insured after the contract was entered into, the insurer may not refuse to pay the claim by reason only of that act or omission.

The valuers argued that their failure to give the notice required by s40 was an omission for the purpose of s54 the effect of which was that CUA could refuse to pay the claim.

The decision

Chesterman J rejected the valuers' submission. He reasoned:

(a) Although s40 applied to the policy, the valuers did not comply with its requirements. They did not give notice of facts which might give rise to a claim against them before the expiry of the policy. The critical distinction between this case and the *Australian Hospital Care* case was that in *Australian Hospital Care*

the policy contained a provision expressly granting coverage in the event that the insured became aware of any occurrence which might give rise to a claim within the policy period and gave notice to the insurer within that period. The present case was different. The policy would not have entitled the valuers to indemnity even if CUA had been given notice of their negligent valuation within the policy period. The statute would have required CUA to grant indemnity, but that indemnity would have flowed from the intervention of the statute, not the effect of the policy. The judge placed some significance on the words "but for this section" which appears in s54. He considered that those words could not be read as if they meant *"but for this section and s40"*.

(b) Section 40 does not imply into policies of insurance a term to the same effect as the sub-section in the way in which terms are implied, for example, under the *Sale of Goods Act*.

Chesterman J concluded that s40 confers rights on an insured and obligations on an insurer, but to obtain the section's protection an insured must comply with its terms, by giving notice in the policy period.

Strictly speaking, the judge's remarks are obiter because he held that the valuers did not become aware of facts which gave rise to the plaintiff's claims against them until after the policy had come to an end. It was therefore unnecessary for the judge to decide the issue concerning s40 and s 54.

This case provides some comfort to insurers. It supports the proposition that where a professional indemnity policy contains no "occurrences notified" clause of the type considered by the High Court in *Australian Hospital Care*, then an insured, becoming aware of a circumstance which might give rise to a claim during the policy period, must give notice of that claim in order to obtain cover. The decision is contrary to the view expressed by Rolfe J in *Einfield v HIH Casualty* reported in our 1999 Annual Review. The final resolution of this issue must await further decision of the High Court. In the meantime, as a consequence of the *Australian Hospital Care* decision and in the expectation that this decision is correct, insurers may wish to consider removing occurrences notified clauses from policies if they are commercially able to do so.

Section 54 – High Court considers what amounts to prejudice

Case Name:

Moltoni Corporation Pty Limited v QBE Insurance Limited

Citation:

[2001] High Court of Australia per Gleeson CJ, Gaudron, McHugh, Kirby and Hayne JJ

Date of Judgment:

13 December 2001

Issues:

- Section 54 of the Insurance Contracts Act
- Loss of opportunity to reduce liability
- Meaning of "prejudice" to the insurer

Allens Arthur Robinson

This was an appeal from the decision of the Supreme Court of Western Australia (Wallwork, Ipp and Murray JJ) reported in our 2000 Annual Review.

The facts

An employee of the insured was injured on 7 November 1992. The insurer was not informed of the injury until 6 April 1994. Were it not for s54 of the Insurance Contracts Act, the insurer would have been entitled to deny liability due to this delay.

Section 54(1) provides, in part, that an insurer's liability in respect of a claim is reduced by the amount *"that fairly represents the extent to which the insurer's interest were prejudiced as a result of,"* in this case, the failure to inform the insurer of the injury.

The insurer argued that, had it been informed of the injury within the timeframe required by the policy, it would have had the opportunity to refer the employee to a medical specialist who might have advised the employee to discontinue heavy work. The trial judge found that, on the balance of probabilities, such advice would not have been given and the relevant employee would have continued working in the same manner as he actually did.

However, an issue before the Full Court of the Western Australian Supreme Court was whether:

- the insurer had to show that, on the balance of probabilities, it suffered a prejudice; or
- the insurer merely needed to show that it had lost the opportunity to reduce its liability.

The decision of the Western Australian Court of Appeal

There were a number of different issues considered in three separate judgments of the Court. One of the judges (Wallwork J) did not consider the issue whether the loss of an opportunity was sufficient to establish prejudice, and found for the insurer on other grounds.

Ipp J held that: *"once it is accepted that the opportunity comprised both the opportunity to investigate and the opportunity to refer the claimant to an appropriate medical practitioner, it is self evident that it had some value"*. He would therefore have referred the matter back to a trial judge to determine the value of this lost opportunity.

Murray J, on the other hand, held that there should be a two stage test:

(a) the court must determine, *on the balance of probabilities*, whether the insurer suffered a prejudice;
(b) having determined that some prejudice would have been suffered, the loss of the opportunity would be relevant in determining the value of that prejudice.

Murray J followed the decision of the trial judge that, on the balance of probabilities, there would not have been any prejudice.

It follows that Ipp J held that the loss of opportunity constitutes the prejudice in itself, whereas Murray J held that the loss of opportunity was only of relevance in determining the value of the prejudice.

The decision of the High Court of Australia

The High Court considered that prejudice for the purpose of s54 is to be measured by reference to what *would* have happened (as distinct from what *could* or *might* have happened) if the act or omission had not occurred. The court agreed that the insurer had lost the opportunity to exercise, at an earlier date than it did, its undoubted rights under the policy to investigate the claim, to have the employee examined by a doctor of its choosing and to have him undergo different treatment. However, the insurer had not proven, to the requisite extent of proof, what would have been done. The trial judge was not persuaded by its evidence and in those circumstances he was right to conclude that it had not demonstrated that it had suffered prejudice. In those circumstances, the insurer did not establish that its liability to the insured should be reduced by any amount.

Further issue – s9(1) of the Insurance Contracts Act

The court also considered, arising from the insurer's cross appeal, the question whether the Insurance Contracts Act could apply to the policy by reason of s9(1)(e)(i), which provides that the Act does not apply to contracts entered into for the purposes of a law relating to workers compensation. The court noted that the policy in the particular case covered both common law claims and claims arising from the statutory workers compensation scheme. The court was of the view that s9(1)(e)(i) should be understood as excepting from the application of the Act only those aspects of the contract made pursuant to the obligation imposed under the statutory scheme to have insurance against liability under the scheme. Since the claim by the employee in this case was a common law claim, the application of the Insurance Contracts Act was not excluded.

This decision confirms that, where an insurer wishes to reduce its liability by reason of prejudice for the purpose of s54, it must establish:

(i) that, on the *balance of probabilities*, it would have acted differently;

(ii) that had it acted differently its liability would have been reduced.

This two stage test will inevitably involve persuasive evidence from relevant underwriting and/or claims staff. Further, the existence of well-documented practice guidelines may assist insurers in arguments relating to prejudice.

Section 54: the importance of identifying the relevant act/omission and the relevant loss

Case Name:

Gibbs Holdings Pty Ltd v Mercantile Mutual Insurance (Australia) Ltd

Citation:

[2001] 11 ANZ Ins Cas 61-484 Supreme Court of Queensland Court of Appeal per Thomas JA, Mackenzie J, Pincus JA

Date of Judgment:

22 December 2000

Issues:

- s54(1), (2), (3) and (4) of the Insurance Contracts Act 1984
- broker's negligence

This is an appeal from a decision reported in our 2000 Annual Review.

The facts

Gibbs Holdings Pty Ltd *(Gibbs)* insured its building with Mercantile Mutual Insurance (Australia) Ltd *(Mercantile Mutual)*. The insurance was effected through a broker, who had a "binder" agreement with Mercantile Mutual.

Gibbs' policy contained a condition that if there was any change after the commencement of the policy which might increase the risk of any claim being made (and in particular relating to the nature of the business carried on, or the nature of the occupation of, or other circumstances affecting, the insured building), then no benefits would be payable under the policy unless Gibbs had advised Mercantile Mutual in writing of such changes and Mercantile Mutual had agreed to them.

On 5 August 1992 the building was destroyed by fire. Mercantile Mutual rejected Gibbs' claim on the basis that it had not been informed that a plastics manufacturer had gone into occupation of part of Gibbs' building during the period of insurance. Mercantile Mutual contended that the occupation by the plastics manufacturer constituted a material alteration of risk and that had it known, it would have rejected the risk. Gibbs commenced proceedings against Mercantile Mutual to recover the costs of reinstating its building and for loss of rent. Gibbs also sued the broker on the ground that it had informed the broker of the facts constituting the material alteration of risk, but that the broker had failed to communicate this to Mercantile Mutual.

Under the terms of the "binder" agreement between the broker and Mercantile Mutual, the plastics factory constituted a "referred risk". In the circumstances, the broker did not have the authority to issue cover that would bind the insurer and was required to refer the risk to Mercantile Mutual.

The trial judge's decision

Moynihan J was satisfied that the plastics manufacturer entering into occupation of the building constituted a material change of the risk so as to require notification under the policy. He was also satisfied that had Mercantile Mutual been notified of the material change in the risk it would have declined the risk.

Moynihan J then had to consider whether Gibbs had given notification of the material change in risk to Mercantile Mutual via the broker. He had to decide between two conflicting versions of the events leading up to the plastic factory's occupation of the building. The broker's version was that the occupation was

merely foreshadowed or contingent and to be confirmed if and when it became certain. On Gibbs' manager's version, the broker was informed of the proposed occupation as a matter of fact prior to the fire. Moynihan J was not prepared to conclude that what Gibbs' manager had said in a conversation with the broker constituted notification of facts which might increase the risk in terms of the policy, as distinct from foreshadowing the prospect of a plastics manufacturer going into operation.

Having decided that Mercantile Mutual would have gone off risk had it been notified of the plastic manufacturer's occupation, Moynihan J held that s54 of the Insurance Contracts Act could not assist the insured, because the prejudice suffered by Mercantile Mutual was equivalent to its prima facie liability under the Act which was thus reduced to nil. The actions against Mercantile Mutual and the broker were accordingly dismissed.

The decision of the Court of Appeal

The most important part of the Court of Appeal's decision is its consideration of the relevant act or omission for the purpose of s54 and identification of the relevant loss for the purpose of the application of sub-sections (1), (2), (3) and (4) of s54.

It was accepted that in this case, the fire had been deliberately lit and the occupation of the premises by the plastics manufacturer did not cause or contribute to the loss. Sub-section 54(2) provides that where the relevant act/omission of the insured could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract, the insurer may refuse to pay the claim. Sub-section 54(3) provides that where the insured proves that no part of the loss that gave rise to the claim is caused the act, the insurer may not refuse to pay the claim by reason only of the act. The question in this case was what was the relevant act and what was the relevant loss for the purpose of the application of these sub-sections.

Thomas JA observed that a threshold question was whether the relevant "act of the insured" for the purpose of s54 was its granting of possession to a tenant which manufactured plastics or its failure to notify the insurer of the occupancy of such a tenant, or a composite of both. If the former is a relevant act and the relevant loss is that of the insured, the insured must win whether s54(1) or s54(2) applies.

The insured's case was that sub-sections (2), (3) and (4) are closely inter-related and all concerned with the act or omission of the insured that causes the loss that gives rise to the claim. In this case, the granting of possession to a plastics manufacturer could, within the meaning of s54(2), "reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract". The insured submitted that, because he had proved under s54(3) that no part of the loss that gave rise to the claim was caused by that act, he was entitled to full indemnity.

Thomas JA observed that if the matter were free of authority he would construe the sections so that the word "act" should be given the same meaning throughout s54. In this case, that would mean the relevant act was the omission to notify the insurer of a fact relevant to the risk. Such an act could never be described as causing "the loss that gave rise to the claim" for the purpose of s54(3) or s54(4).

Thomas JA reasoned as follows:

(a) The relevant act or omission must be one by reason of which the insurer is entitled to refuse to pay the claim. In this case that was not the insured's granting of possession to a tenant who manufactured plastics, but the failure to notify the insurer of the occupancy of such a tenant.
(b) The "loss" for the purpose of s54 in this instance arose from the insurer's loss of the chance to go off the risk by cancelling the policy.
(c) It followed that the insurer's prejudice for the purpose of s54(1) was the full amount of the claim, which it would not have had to meet had it gone off risk.

MacKenzie J considered that, following the decision of the High Court in *Ferrcom Pty Ltd v Commercial Union Assurance Co. of Australia Ltd* (1992) 176 CLR 332, s54 prescribed the effect to be attributed to two classes of acts. Firstly, s54(1) related to acts or omissions that could not reasonably be regarded as being capable of causing or contributing to the loss. Sections 54(2) to (4) related to acts or omissions that could reasonably be regarded as capable causing or contributing to the loss. Mackenzie J considered that the present case fell within s54(1). It followed that the insurer was entitled to refuse to pay a claim because it would have gone off risk had it been notified of the change in use of the premises.

Pincus JA delivered a dissenting judgment.

Claim against broker

Thomas JA and MacKenzie J considered that the broker had breached its duty to the insured to take steps to ensure that he understood the risk to his insurance policy if he accepted the plastics manufacturer as a tenant.

Since there was no evidence as to what the insured would have done had the broker given that advice, the majority agreed that the damages payable by the broker should be discounted by 15%, to take into account the possibility of higher premiums or the consequences of termination of the tenancy.

This case illustrates the importance of defining the relevant act or omission for the purpose of s54 and identifying the relevant loss caused by that act or omission. The case illustrates that insureds will not be able to prevent insurers making claims for prejudice under s54(1) merely because an act of the insured which was capable of causing the loss did not in fact do so. The case also illustrates the obligations may rest on brokers even in circumstances where no specific request for advice is made by the insured.

When is a claim first made against the insured?

Case Name:

HIH Casualty & General Insurance Ltd v Pade & Anor

Citation:

[2000] NSWCA 325

Date of Judgment:

15 November 2000

Issues:

- meaning of "claim"
- professional indemnity insurance
- letter asserting a cause of action

This case considers the issue of what constitutes the making of a claim for the purpose of identifying when a claim is 'first made' against the insured.

The facts

Mr and Mrs Pade invested $380,000 in a real estate development. The investment was made by way of two loans to the promoter secured by mortgages, only one of which was registered. In 1994 the Pades executed discharges of the two mortgages in expectation of receiving some form of payment by the promoter. The Pades received no payment.

The Pades alleged that their solicitors (the insured) were negligent in failing to retain the security documents and in parting with them without their (informed) authority.

In September 1999, the Pades commenced proceedings against the insured solicitors.

HIH was the insured's professional indemnity insurer for the 1998-2001 period i.e. the period during which the proceedings served on the insured. The policy covered claims made against the solicitors in that period.

HIH alleged that Pades had first made their claim against the insured solicitors in a letter dated 24 November 1995 from the Pades' then solicitor, Mr Abernethy (the ***1995 Letter***). Accordingly, HIH denied indemnity.

The 1995 Letter expressed alarm at the fact that the insured solicitors appear to have instructed another solicitor on the release and for the purpose of paying the Pades on discharge. It asserted that no money had been received and went on to say:

> My clients are becoming concerned at their inability to obtain possession of their Mortgage document and the Title Deeds secured thereby. In the circumstances that have developed one can readily understand their concerns and my clients look to you as the solicitor who acted on their behalf to allay their concerns and to do so promptly. I have therefore been instructed to inform you that unless Mortgage... together with Certificate of Title... are placed in my possession within seven (7) days from the date hereof the matter is to be taken further.

The decision

At first instance in the District Court, it was held that the 1995 Letter was not a claim but rather a demand for the return of the Pades' security documents and an assertion of a right to the return of those documents.

In upholding HIH's appeal, the NSW Court of Appeal unanimously held that the 1995 Letter went beyond a reservation of rights and asserted a cause of action against the insured similar to that which was ultimately brought.

The Court of Appeal agreed with the parties that the relevant principle on this issue is that espoused by Bowen JA in *Walton v National Employers' Mutual General Insurance Association Ltd* [1973] 2 NSWLR 73 at 82 where he said:

> In my opinion, the word "claim" is here used in its primary sense of a demand for something as due, an assertion of a right to something. It imports the assertion, demand or challenge of something as a right.

In reaching his decision, Mason P (with whom Stein and Heydon JJA agreed) stated that it was not relevant to examine the subjective intent of the Pades or Mr Abernethy in November 1995. He reasoned:

> Suppressed concern or unexpressed nonchalance cannot alter the impact of what is asserted against the Insured. A claim is what is brought to the Insured's attention. Of course, what is conveyed to the Insured must be construed in context.

Mason P saw very little relevance in the insured's response to the putative claim and commented that it was easy to envisage situations where the most explicit claim is met with a brazen or very stupid response.

Mason P noted that merely because the 1995 Letter offered the insured a further 7 days to extricate themselves or alternatively provide a satisfactory explanation, this did not render the letter any less a 'claim'. Nor did it matter that any feared loss had not crystallised at that stage. The letter in substance contained an assertion that if the solicitors had parted with the security documents they would be sued.

This case demonstrates that the courts take an objective approach in ascertaining whether a letter making certain demands amounts to a claim. Insureds and their brokers need to be alert to the fact that a letter expressing concern and asserting rights may amount to a claim, even if the rights asserted and the action threatened are not specifically identified.

Workers supplied by labour hire companies: who should shoulder vicarious liability in respect of their negligent acts?

Case Name:

Deutz Australia Pty Ltd v Skilled Engineering Ltd & Anor

Citation:

[2001] VSC 194

Supreme Court of Victoria per Ashley J

Date of Judgment:

26 June 2001

Issues:

- nature of the employment relationship in the context of workers hired out by labour hire companies
- subrogation
- vicarious liability
- s66 of the Insurance Contracts Act 1984 (Cth)

This case examines the nature of the employment relationship between a worker supplied by a general labour hire company and the party that hires the worker. Defining the worker's employment relationship becomes important for the purpose of determining whether the labour hire company remains vicariously liable to third parties (including the hirer) for the tortious acts of the worker.

The facts

Skilled Engineering Pty Ltd ***(Skilled)*** carried on business supplying skilled labour for hire to business. On 21 January 1997, Skilled supplied Eric Sutton, a qualified forklift driver, to Deutz Australia Pty Ltd ***(Deutz)***. Using a forklift truck provided by Deutz, Sutton was assigned to pick up motors which had been unloaded outside Deutz's warehouse, bring them into the warehouse and place them into racks. On 28 January 1997, Sutton was reversing a forklift along a main aisle of the warehouse. The mast of the forklift was in an elevated position. On either side of the aisle were racks of shelving which were used to store diesel motors. A bridge, constituted of two parallel beams, spanned the shelving. The mast of the reversing forklift struck the first beam in its path. The impact triggered a domino collapse of the racks of shelving and as a consequence, many valuable motors were damaged.

Deutz was insured against the losses which it sustained in the incident. Deutz's insurer subsequently brought proceedings against both Skilled and Sutton by way of its right of subrogation.

Right of subrogation against employees

Sutton argued he was entitled to the protection afforded by s66 of the *Insurance Contracts Act* 1984 (Cth) (the ***Act)***, which excludes the exercise of the insurer's rights of subrogation to an employer's rights against an employee. Sutton contended that the circumstances of the case fell within the scope of s66: the rights of Deutz were "exercisable against a person who [was its] employee" and "the conduct of the employee that gave rise to the loss occurred in the course of or arose out of the employment".

The issue faced by Ashley J was whether Sutton was an "employee" of Deutz's for the purpose of s66 of the Act. The term "employee" is not defined by Act. Ashley J considered that the term "employee", where used in s66, means an employee in the ordinary conventional sense (that is, a person employed under a contract of service).

Given such a meaning, what is the operation of s66 in the case of a person who is at the material time a servant "pro hac vice" (that is, a servant "for the time

being") of another? The answer depends on what is meant by the term servant "pro hac vice". Deutz submitted that the essence of pro hac vice employment was that the worker agrees to be transferred as a contracting party to another employer. Upon the concession of both Skilled and Sutton, no contract of service ever arose between Deutz and Sutton. However, Skilled and Sutton submitted that a person becomes a servant pro hac vice not by the coming into existence of a contract between worker and temporary employer, but from the relationship established between them. Ashley J rejected this submission. As there was never an employment pro hac vice, Ashley J held that Sutton was not entitled to the protection of s66.

Nature of the relationship between worker and temporary employer

The key issue for determination by Ashley J was whether Sutton was, at the time of the incident, a servant "pro hac vice" of Deutz or whether he remained an employee of Skilled for all purposes. This issue was crucial for the purposes of imposing vicarious liability in tort.

Skilled was unquestionably Sutton's general employer. Skilled engaged Sutton on the basis that, as Skilled's employee, Sutton would be hired out to various clients. Skilled supplied Sutton with overalls, hard hat and any necessary safety equipment. Skilled's logo was emblazoned on the overalls and hard hat, and Sutton was expected to wear them when at a work site. The overalls were laundered at Skilled's expense. It was Sutton's task to go to jobs as assigned by Skilled's managers, and to undertake work as required. Sutton's wages were calculated and paid by Skilled. Skilled also covered Sutton for workers' compensation and paid superannuation contributions.

Skilled's contention was that because of the factual relationship established between Sutton and Deutz, Sutton was a servant "pro hac vice" of Deutz. Deutz's supervisors showed Sutton how to operate the particular forklifts used at the warehouse. Sutton worked under the direction of Deutz's warehouse manager and was in the same position regarding directions as was Deutz's employees. Sutton was also expected to work the same hours as Deutz's employees and would have required permission to leave early.

This evidence failed to persuade Ashley J that there had been a change in employer for the purposes of imposing vicarious liability. Several other matters put into context the evidence relied upon by Skilled. It was significant to Ashley J that Deutz had no role in the selection of Sutton. Deutz had no power to dismiss a Skilled employee. Nor could Deutz direct a Skilled employee to leave the work site forthwith in circumstances in which it could direct an employee to do so. Deutz was, however, entitled to indicate dissatisfaction with a worker's performance and request a substitute. Deutz had no power to direct Sutton to perform any other duties other than "general forklift driving". Sutton was obliged to adhere to a safety regime which stood apart from anything done by Deutz. Sutton also had recourse to a potential intervener, quite external to Deutz or any union to which Sutton belonged, in the event of a concern about safety.

Ashley J concluded that Sutton, whilst undertaking his Skilled work at Deutz, was serving the interests of Deutz, rather than serving Deutz itself. In the circumstances, Skilled had not discharged the burden which it carried to establish

that there was a transfer of employer. As Sutton was not, at the time of the incident, the servant pro hac vice of Deutz, it necessarily followed that Skilled was vicariously liable for the tortious conduct of Sutton. Given Ashley J's rejection of Sutton's reliance on s66 of the Act, it further followed that Sutton was also liable to Deutz in tort.

This case highlights the difficulties faced by general employers, such as labour hire companies, in attempting to shift vicarious liability in respect of the tortious acts of one of its worker to the party that actually hires the worker. The construction placed on s66 of the Insurance Contracts Act by the Court is also of interest. In a few cases, workers will be deprived of the protection of s66 and as such, will be exposed to actions brought by insurers exercising their rights of subrogation to an employer's rights against an employee.

In New South Wales, by virtue of the Employees Liability Act 2001, workers will still be protected except in the case of serious or wilful misconduct.

"Other insurance" not sufficiently specified to form the basis for an exclusion clause

Case Name:

HIH Casualty & General Insurance Ltd v Pluim Constructions

Citation:

(2000) 11 ANZ Ins Case 75-476, Supreme Court of New South Wales, Court of Appeal, per Mason P (dissenting), Handley JA & Foster AJA

Date of Judgment:

17 October 2000

Issues:

- insurance contracts
- double insurance/ contribution
- "other insurance" provisions
- s45(2) of the Insurance Contracts Act 1984
- injury "caused by the ownership or operation of any vehicle"

The facts

Pluim Constructions ***(Constructions)*** was doing building work at a club. Related companies Pluim Detail Joinery Pty Ltd ***(Joinery)*** and Pluim Commercial Landscapes Pty Ltd ***(Landscapes)*** were also involved with the job.

Mr Knight, a Landscape employee, was asked to assist Constructions by removing debris from the site using vehicles belonging to Landscapes, and in the course of doing so sustained a knee injury from glass shards. There was not meant to be glass in the relevant rubbish.

Knight sued Constructions and Joinery in the District Court. Constructions was found to have breached its duty of care to Knight and damages were assessed against it. Constructions had filed third party notices propounding claims for contribution or indemnity under various insurance policies and against the club for damages for breach of the building contract.

Constructions had public liability insurance with the appellant ***(HIH)***. The club also had relevant public liability insurance for Constructions as a result of the contract with the Commercial Union Assurance Company of Australia Ltd ***(CU)***. CU denied liability, relying upon various exclusions in their policy including clause 6(b). At first instance, it was held that Constructions' claims fell within clause 6(b) which relevantly related to compulsory motor vehicle insurance.

Although HIH did not deny indemnity, it argued that condition 7 of the HIH policy allowed it to escape liability. Condition 7 provided that, in the event that the Principal agreed to provide a policy of insurance, then HIH would only indemnify the insured for such liability not covered by the policy of insurance provided by the Principal. The trial judge found condition 7 was rendered void by s45(1) of the Insurance Contracts Act 1984. That section renders void any provision in contract of insurance which has the effect of limiting or excluding liability of the insurer under the contract by reason that the insured has entered into some other contract of insurance, not being a contract required to the effect by law. Further, the CU Policy was not "specified" in the HIH policy for the purposes of the exception provided in sub-section 45(2).

On the facts, the trial judge also rejected HIH's attempt to rely directly on exclusion clause 4(a) in the HIH policy (which excluded liability for injury caused by the ownership or operation by or on behalf of the insured of any vehicle covered by compulsory insurance).

The decision

The New South Wales Court of Appeal held by majority of 2:1 that exclusion clause 6(b) of the CU policy did not apply because the relevant claim was not one in

respect of which insurance was required by legislation.

As to condition 7, the issue was whether or not the words "the policy of insurance provided by the Principal" in condition 7 were sufficient to *specify* the CU policies within the meaning of s45(2). The court reviewed the Explanatory Memorandum relating to s45 and various academic writings on the meaning of "specified" for the purpose of s45(2). These emphasised that the sub-section was intended only to permit "true excess policies". The court was of the view that the language of the condition was too general and not of sufficient specificity to satisfy s45(2). There was no identification of any particular policy with any particular insurer.

The Court also formed the view that the trial judge was correct in concluding that HIH could not invoke exclusion clause 4(a), as there was no operation of the truck by or on behalf of Constructions, the relevant insured. Nor was Knight's injury "caused by such operation", as required for the exclusion to operate.

It followed that Constructions had double insurance. The absence of formal claims for contribution between the two insurers did not prevent the court from making appropriate orders to finally dispose of the disputes in order to avoid further litigation.

This case gives guidance on the operation of s45(2). It demonstrates that an insurer who seeks to escape liability where coverage is granted under another insurance policy must clearly specify that other insurance policy in order to satisfy s45(2) of the Insurance Contracts Act. The case also contains a useful illustration of the principles applicable to determining whether damage is caused by ownership or operation of a motor vehicle.

Fraud: insurers entitled to deny claim despite existence of an underlying valid claim

Case Name:

Tiep Thi To v Australian Associated Motor Insurers Ltd

Citation:

[2000] VSCA 48; (2001) 11 ANZ Insurance Cases 61-490

Supreme Court of Victoria, Court of Appeal per Buchanan, Charles and Callaway JJA

Date of Judgment:

26 April 2001

Issues:

- Fraudulent claims
- ss 54 and 56 of the Insurance Contracts Act 1984 (Cth)

This case involved an insured making a fraudulent claim under her motor vehicle insurance policy in the mistaken belief that the policy did not cover the loss. The decision of the trial judge, Mandie J ([1999] VSC 287), was reviewed in our 1999 Annual Review.

The facts

The insured was the owner of a Toyota Landcruiser which was comprehensively insured under a policy issued by Australian Associated Motor Insurers Ltd ***(AAMI)***. The vehicle was damaged in an accident whilst it was being driven by the insured's 15 year old son without her consent. The insured returned home to find her son and the damaged vehicle near her home. She moved the vehicle a short distance and then reported to police that the vehicle had been stolen and damaged when her son was set upon by a gang of youths. She lied about the circumstances in which her vehicle was damaged, in the mistaken belief that the policy did not cover damage caused when her son was driving it. However, the policy did in fact cover damage when the vehicle was driven by an unlicensed person without the insured's consent.

AAMI denied the claim and the insured brought proceedings in the Magistrates' Court to recover the cost of repairing the vehicle. The magistrate held that the claim was not fraudulent and that as AAMI's interests had not been prejudiced by the insured's breach of the obligation of utmost good faith, s54(1) of the *Insurance Contracts Act* 1984 (Cth) (the ***Act)*** precluded AAMI from refusing to pay the claim. AAMI appealed to the Supreme Court of Victoria. Mandie J held that the claim was fraudulent because the insured had knowingly made false statements and intended to deceive AAMI by obtaining money which she knew (or believed) she had no right to receive.

Section 56 of the ICA provides that where a claim is made fraudulently, the insurer may not avoid the contract but may refuse payment of the claim.

The decision of the Victorian Court of Appeal

On appeal to the Victorian Court of Appeal, the insured argued that the purpose of s56(1) of the Act was to prevent a fraudulent claimant being punished by limiting the effect of fraud to a reduction of the insurer's liability by the extent to which the insurer had been prejudiced by the insured's fraud. Accordingly, the insured contended that no dishonesty, however gross, could ever satisfy s56 where there was a valid underlying claim that could have been advanced.

The Court of Appeal rejected the insured's construction of s56 of the Act. The position at common law was that an insurer was entitled to avoid an insurance

policy under which a fraudulent claim was made. The Court held that s56 altered this position by limiting the insurer's remedy in the event of a fraudulent claim to the denial of the claim, rather than the avoidance of the policy. The section enables the Court to order payment where only a minimal or insignificant part of the claim is fraudulent and it would be harsh and unfair for the insurer not to pay the balance of the claim. Otherwise, the legal position remains the same: an insurer is entitled to refuse to pay a fraudulent claim, whether or not there is an underlying loss which is covered by the policy. Whilst s56 is remedial in nature, and is to be construed beneficially, its effect cannot be pushed beyond the meaning of the words in the section.

The insured then argued that her claim was not in fact false. The claim was the assertion that the vehicle was stolen. That claim was true in that the insured's son had stolen the vehicle. The identity of the thief had simply been misstated. The Court of Appeal also rejected this argument. The opinion of Buchanan JA was that if a false statement is knowingly made in connection with a claim for the purpose of inducing the insurer to meet the claim, then the claim is made fraudulently within the meaning of s56(1) of the Act. On this point, Callaway JA differed slightly. Callaway JA thought that a false statement made recklessly in connection with a claim would suffice.

The insured's next contention was that a fraudulent claim required knowledge on the part of the claimant that he or she was not entitled to the claimed benefit. It was not sufficient that the claimant held a belief that he or she was not entitled to the benefit. As such, an insured who was entitled to indemnity could not make a fraudulent claim. This argument also failed. The Court of Appeal held that the mental element required to establish fraud is an intention to deceive (i.e.an intention to create a false belief in the person deceived for the purpose of obtaining money or some other benefit). There is no need to go further by looking at the claimant's knowledge or belief as to a lack of entitlement to the benefit claimed.

The insured finally submitted that s56 of the Act only applied to fraudulent misstatements which were material (i.e. misstatements which would influence a prudent insurer's decision to accept, reject or compromise a claim). This submission adapted the requirement of materiality which is applicable to innocent non-disclosure and misrepresentation prior to the formation of a contract of insurance. The Court of Appeal also rejected this submission. Section 56 does not distinguish between material and non-material fraud. As such, there is no reason to think that the section was intended to alter the common law in this respect.

The Court of Appeal accordingly dismissed the appeal.

This decision confirms that insurers may be entitled to refuse to pay a claim made fraudulently within the meaning of s56(1) of the Act, whether or not there is an underlying loss which is covered by the policy. The existence of an underlying valid claim does not render fraud irrelevant. Whilst most fraudulent claimants are well aware that they are not entitled to the benefit they claim, a claimant who lies because of a mistaken belief as to entitlement is equally dishonest.

Case Name:

Ricciardi v Suncorp Metway Insurance Limited

Citation:

Supreme Court of Queensland, Court of Appeal [2001] QCA 190 per Williams JA, Mackenzie and Chesterman JJ

Date of Judgment:

22 May 2001

Issues:

- fraudulent claims
- s56(2) of the Insurance Contracts Act
- court's discretion to excuse fraud in relation to "minimal or insignificant" part of claim

The Queensland Court of Appeal upheld the decision of a trial judge that s56(2) did not assist an insured who gave false instructions to a valuer so as to increase the amount claimed by at least 50%.

The facts

After his house was destroyed by fire the plaintiff deliberately gave a valuer, who had never seen the house, false instructions to inflate his claim. A claim was put in for $30,000 on the basis of this valuation, whereas the house was in fact worth less than $20,000. The insurer refused the claim because of the fraud.

The plaintiff sought relief under s56(2) of the Insurance Contracts Act, which empowers a court to order an insurer to pay a claim "*if only a minimal or insignificant part of the claim is made fraudulently, and non-payment of the remainder of the claim would be harsh and unfair*".

The primary finding of the trial judge was that the fraud in this case was not "minimal or insignificant".

The decision

The Court of Appeal also referred to two other interesting arguments about the application of s56(2). The first argument, put forward by the insured, was that one should take a "qualitative" rather than a "quantitative" approach in determining whether fraud was "minimal or insignificant". It was submitted that, even if $10,000 was not a minimal amount, the type of fraud in this case was "reckless indifference," rather than "a deliberate fraudulent purpose", and was therefore only a minimal fraud. The court appeared to be sceptical about this argument, but held that in any case the fraud fell outside s56(2) on both a qualitative and a quantitative approach.

The court also considered whether s56(2) only applied where a claim was divisible into honest and dishonest parts. On this approach the plaintiff could not succeed because there was only one indivisible claim being pursued, and that claim was tainted by fraud. The court seemed sympathetic to this argument, but did not need to decide the point for the purposes of this case.

This case illustrates the principles to be applied when the Court is exercising its discretion whether or not to make an order under s56(2) of the *Insurance Contracts Act*.

No double insurance arises despite claim falling within workers compensation policy and public liability policy

Case Name:

WorkCover Queensland v Royal & Sun Alliance Insurance Australia Limited

Citation:

(2000) 11 ANZ Insurance Cases ¶61-489, Supreme Court of Queensland, per Wilson J

Date of Judgment:

13 March 2001

Issues:

- workers compensation scheme
- meaning of "subcontractor"
- double insurance
- s45(1) of the Insurance Contracts Act

This case concerns the issue of double insurance where there is more than one party that may be described as the insured.

The facts

Cameron Slagle was hired by Barclay Mowlem Construction Pty Limited *(**Barclay Mowlem**)* from his employer, Leica Bride Pty Limited *(**Leica Bride**)*, to work on the construction of apartments on a site in Brisbane. He was injured in the course of his employment on site and claimed damages from Leica Bride and Barclay Mowlem. Both companies carried compulsory workers' compensation insurance but Barclay Mowlem was also insured by Royal & Sun Alliance Insurance Australia Limited *(**RSA**)* for public liability. WorkCover Queensland sought a declaration that it and RSA were equally liable to indemnify Barclay Mowlem against any liability it had to pay damages to Slagle.

The RSA policy contained a fairly standard clause excluding liability for personal injury sustained by a person in the course of their employment with the insured under a contract of service with the insured. The first question was whether "the insured" for the purpose of this exclusion referred to Leica Bride or Barclay Mowlem. The policy defined the insured to include sub-contractors of Barclay Mowlem. Wilson J considered that Leica Bride was a sub-contractor of Barclay Mowlem because it supplied a service, Slagle, necessary for the performance of Barclay Mowlem's contract with the principal. It followed that Leica Bride was an insured within the meaning of the exclusion clause.

The judge went on to consider a second issue whether, if he was wrong in that conclusion, RSA could rely on various other exclusions the effect of which was that occurrences involving insured sub-contractors that were covered by other insurance were not covered under the RSA policy.

To overcome these exclusions, WorkCover Queensland sought to rely on s45(1) of the Insurance Contracts Act, which renders void any provision of an insurance policy that limits liability under the policy by reason that the insured entered into some other contract of insurance, *"not being a contract required to be effected by a law or under a law, including a law of the State"*. WorkCover Queensland argued that the policy it issued to Barclay Mowlem was not required to be effected at law. Wilson J disagreed. It was not necessary for the purposes of the exception in s45(1) that there be a requirement that the other policy be effected in respect of the particular claim under consideration.

The case provides a useful illustration of the following:

(a) who is a "sub-contractor" for the purposes of policy coverage and exclusions;

(b) s45(1) of the ICA will not render void provisions in policies excluding claims covered by compulsory workers compensation insurance, even if the particular workers compensation insurance invoked was not required in the case of the particular claim under consideration.

Contribution not available – contractual indemnity did not give rise to "co-ordinate liability"

Case Name:

Speno Rail Maintenance Australia Pty Limited v Hamersley Iron Pty Ltd

Citation:

Supreme Court of Western Australia Court of Appeal per Malcolm CJ, Ipp and Wheeler JJ

Date of Judgment:

19 December 2000

Issues:

- construction of policy
- construction industry
- contribution – meaning of "co-ordinate liabilities"
- duty of utmost good faith

The facts

Speno entered into a contract with Hamersley to perform "rail grinding" work. During the course of this work Mr Nolan, an employee of Speno, was injured due to the negligent operation of rail switches by employees of Hamersley.

Hamersley was vicariously liable to Mr Nolan for the negligence of its employees. These proceedings concerned the following actions:

(a) Hamersley sought to rely on an indemnity from Speno to cover its liability to Mr Nolan;

(b) Hamersley sought to recover under an insurance policy taken out by Speno with Zurich;

(c) Speno sought to recover from Zurich for any liability to Hamersley; and

(d) Zurich sought contribution from Speno for any liability it owed to Hamersley.

(e) These various claims raised the following important issues:

  (i) what is meant by, and what is the difference between, "arising out of" and "caused by";

  (ii) in what circumstances does a right to contribution arise; and

  (iii) what is the scope of an insurer's duty of utmost good faith to an insured?

"Arising out of" and "Caused by"

The policy issued by Zurich provided cover to Hamersley for *"liability arising out of the performance by* [Speno] *of any contract…for the performance of work for* [Hamersley]*"*.

Applying this clause raised an important issue: Should a distinction be drawn between a liability and the incident giving rise to that liability? In the context of this case, Zurich argued that the liability of Hamersley arose out of the negligence of its employees. It argued that there was no causal connection between the work performed by Speno and Hamersley's liability.

All three judges rejected this argument. Malcolm CJ held that it sufficed that the underlying incident giving rise to the liability arose out of Speno's performance of the contract. Ipp J also held that the policy applied because the incident giving rise to liability occurred in the course of Speno's performance of the contract.

Wheeler J recognised the importance of the distinction between the liability of Hamersley and the incident giving rise to that liability. She agreed that it was the liability which must arise out of the performance by Speno of its contract.

Wheeler J held, however, that the liability of Hamersley could be divided into two parts: the duty of care and the breach of that duty. A duty of care was owed to Mr

Nolan because of the performance by Speno of the contract. She therefore concluded that the liability also arose out of Speno's performance of the contract.

The court took a different approach, however, in interpreting an exclusion for injury "caused by a vehicle". The court held that in this case one should not look at the underlying incident that gives rise to the liability. Although the underlying incident involved the use of a vehicle, the "liability" (i.e.the negligence of Hamersley's employees) did not. A clear distinction was therefore drawn in this regard between the phrases "caused by" in the context of an exclusion clause and "arising out of" in the context of an insurance clause.

Contribution

Speno was contractually liable to indemnify Hamersley for its liability to Mr Nolan. Zurich sought contribution from Speno for its own liability to Hamersley.

Contribution is only possible where the relevant liabilities are "co-ordinate". The court held that the liability of an insurer and the liability of a party with an obligation to indemnify were not co-ordinate liabilities. There was therefore no right to contribution. Wheeler J expressly followed the frequently discussed decision of the Scottish Court of Sessions in *Caledonia North Sea Limited v London Bridge Engineering Limited* (unreported, 17 December 1999) on this point.

The court also noted that Speno was not covered by Zurich for its liability to Hamersley. An interesting consequence of the court's decision, therefore, would appear to be that Zurich would have been entitled to bring a subrogated action against Speno for its entire liability to Hamersley under the contractual indemnity. It is not clear from the decision whether the policy contained a clause which would have prevented such an action.

The duty of utmost good faith owed by an insurer

Prior to the contracts of insurance being put in place, the broker for Speno expressly requested that Zurich provide cover for liabilities such as its liability to indemnify Hamersley. Zurich provided a copy of the policy to the broker, but made no express representation as to the scope of its cover. The policy provided by Zurich did not in fact provide such cover. Ipp and Wheeler JJ held that Zurich did not thereby breach its duty of utmost good faith. In their view, the silence of Zurich did not imply a representation that the cover being requested was provided and that providing a copy of the policy was an appropriate method of responding to the broker.

Malcolm CJ held that Zurich did breach its duty of utmost good faith as the express request by the broker gave rise to a duty on Zurich's part to inform Speno that the policy did not provide the cover sought. He held, however (following a decision of the House of Lords), that the only remedy available to Speno was to rescind the contract and obtain a refund of the premium. He held, somewhat surprisingly, that this was so even though the Insurance Contracts Act provides that the obligation of utmost good faith is an implied term of the contract. It is difficult to see why a breach of an implied term of a contract would not give rise to a right to damages, and it is doubtful that other courts will follow this part of the decision.

The court's interpretation of the words "liability arising out of" is of real concern to both insurers and insureds. An insurer might find that cover which was intended for certain liabilities will be construed to apply more broadly.

The judgment of the court on Zurich's claim for contribution conformed to the accepted understanding of what constitutes "co-ordinate liabilities".

This case highlights the importance of insurers in a construction setting considering at an early stage the wording of any relevant contractual indemnities to determine whether they give rise to a claim for contribution or a possible subrogated action. The discussion of an insurer's duty of utmost good faith may be important in the development of this duty, which is rarely considered by the courts.

Insurer unable to claim contribution from other insurer where it had no legal liability to indemnity

Case Name:

Bovis Construction Limited v Commercial Union Insurance Co Plc

Citation:

[2001] Lloyd's Rep 416

Date of Judgment:

29 November 2000

Issues:

- double insurance
- rights of contribution
- where original indemnifier a "volunteer"

The facts

Bovis was responsible for managing the construction of an office block in London. A claim was made against Bovis for property damage allegedly caused by its negligence. Bovis settled this claim and recovered the settlement payment from Eagle Star, its liability insurer.

Bovis was also an insured under a project specific policy with Commercial Union. Bovis and Eagle Star sought to recover part or all of the settlement payment from Commercial Union.

The two main issues before the court were:

(a) whether the project-specific policy with Commercial Union responded to claim; and, if so

(b) whether Commercial Union was obliged to compensate Bovis and/or Eagle Star.

Did the project specific policy respond?

This policy covered both Bovis and the owner of the building and included cover for property damage (section 1) and cover for liability for property damage (section 3).

Section 3 excluded liability for damage to property that was covered under section 1. The intention, presumably, was that there was no need for liability cover if the underlying property damage was itself covered by the policy.

For reasons which are unstated in the judgment, the owner of the damaged property did not lodge a claim with Commercial Union under section 1, despite being entitled to do so. The owner instead recovered under a separate policy. There was also no claim for contribution against Commercial Union in respect of its liability under Section 1. Commercial Union could therefore only be liable if Section 3 responded.

Steel J agreed with Commercial Union that section 3 did not respond because of the exclusion for property covered by section 1. He rejected an argument put on behalf of Bovis that the phrase *"loss of or damage to material property not insured under section 1"* should be interpreted as requiring that the loss or damage, rather than the property, be insured under section 1.

Double Insurance

Where two policies respond to a claim one normally the rules of contribution apply to apportion the loss between the insurers. Each of Bovis, Eagle Star and Commercial Union however sought to obtain a better result.

(a) <u>Bovis</u>

Bovis sought to recover from Commercial Union notwithstanding the fact that it

had already been indemnified by Eagle Star. It is well accepted that an insured cannot normally claim under an insurance policy for a loss in respect of which it has already been indemnified – the correct course being for the indemnifier to seek contribution. Bovis argued that this general rule should not apply as the insurance policies held with Eagle Star and Commercial Union were not co-extensive. This argument was rejected by Steel J.

(b) Eagle Star

Eagle Star was initially not a party to the action. It presumably hoped that Bovis would recover a full indemnity from Commercial Union, and then account to Eagle Star. Eagle Star joined the proceedings when it was clear that this strategy would fail.

(c) Commercial Union

Commercial Union also advanced a creative argument to avoid the normal rules of contribution. Surprisingly, the judge also accepted this alternative argument.

Clause 6 of the Eagle Star policy stated that Eagle Star should not be liable to pay or contribute more than its rateable proportion should there be other insurances covering the same liability. Commercial Union argued that, pursuant to this clause, Eagle Star was therefore only liable to indemnify Bovis for half of its loss (on the assumption that Commercial Union was liable under its policy). The fact that Eagle Star fully indemnified Bovis, when it was not legally obliged to do so, meant that it was a "volunteer" for half of its liability to Bovis.

An indemnifier cannot seek contribution unless it was under a legal liability to provide the indemnity. It is unfortunate that Steel J applied this rule in circumstances where there would be a legal liability for the entire loss but for the possibility of contribution. The result of his reasoning is to penalise an insurer which promptly indemnifies its insured.

Steel J felt "fortified" in this conclusion by a term in Commercial Union's policy providing that a policy shall only respond in so far as claims are not recoverable under any other policy of insurance. It is debatable, however, whether such clauses do in fact override the normal principles of contribution.

The most important part of the judgment of Steel J is his conclusion that a clause which limits an insurer's liability, where more than one policy responds to the claim, thereby disentitles that insurer from seeking contribution. This conclusion penalises insurers which compensate their insureds promptly and rewards those which are dilatory.

There does not appear to be any binding authority which required this conclusion and an Australian Court might well not follow it. Note, however, that in Australia clauses which restrict liability by reason of the existence of other insurance covering the claim may be void by reason of s45 of the Insurance Contracts Act 1984.

Interpretation of contract for interim cover: relevant considerations

Case Name:

Royal & Sun Alliance Life Assurance Australia Limited v Feeney

Citation:

[2001] SASC 294 (Supreme Court of South Australia per Doyle CJ, Perry and Bleby JJ)

Date of Judgment:

22 August 2001

Issues:

- interim cover
- offer and acceptance
- whether a certificate of interim cover formed part of the offer for interim cover

The Court in this case held that it was possible for an individual who had submitted an application for death benefit insurance coverage issued pursuant to a superannuation scheme to accept an offer for free interim cover notwithstanding the fact that:

(a) the processing of the insured's application had not been finalised;

(b) the insured had not paid a first premium; or

(c) the insured had not submitted a deduction authority.

The facts

Mr Feeney had, on 1 October 1999, signed an application form contained in the back of a brochure for Term Life Insurance in the sum of $500,000 and an application for membership in the Royal & Sun Alliance Superannuation Fund (the ***Fund***). The brochure contained a special offer pending processing by the appellant, Royal & Sun Alliance Life Assurance Australia Limited (the ***Insurer***), of any application for Term Life Insurance of free interim cover. On 7 October 1999, before processing of the application from Mr Feeney was complete and before Mr Feeney had submitted a deduction authority to the Insurer, he died unexpectedly by drowning whilst on holiday.

The offer of free interim cover was referred to in several parts of the brochure and, on page 5 of the brochure, applicants were informed that acceptance was subject to the receipt of a completed application form and to the conditions set out on pages 49-50 of the brochure. The brochure also contained a Certificate of Interim Cover on page 48 which stipulated that acceptance of the offer of free interim insurance was subject to the completion of an application form and payment of a first premium or completion of a deduction authority (the ***Relevant Conditions***). Mr Feeney neither paid a first premium nor completed a deduction authority at the time he submitted his application form.

The insured's widow brought an action in the District Court seeking to enforce the contract for free interim cover. The primary judge upheld that contract and gave judgment against the insurer in the sum of $500,000 plus interest. The insured appealed to the Supreme Court of South Australia submitting that no contract could exist in the circumstances where Mr Feeney failed to have regard to the conditions contained on the Certificate of Insurance.

The decision

The Court upheld the decision of the primary judge, although for different reasons. Doyle CJ held that an offer must be interpreted in the sense in which it would

reasonably be understood by an ordinary person, even though the intention of the offeror may not coincide with that interpretation. He thought it germane that:

(a) the Relevant Conditions did not appear on pages 1-8 of the brochure which dealt with Term Life Insurance;

(b) applicants for the free interim cover were also referred to pages 49-50 of the brochure which did not contain reference to the Relevant Conditions;

(c) the Certificate of Interim Cover appeared before pages 49-50 of the brochure; and that

(d) there was nothing in the brochure to suggest that an applicant should read the whole of the document or that it was not sufficient to read only those parts of the brochure dealing with the type of insurance in which the applicant was interested.

Bleby J delivered a judgment with which Perry J agreed in which it was considered that fatal to the Insured's argument was the fact that the Certificate of Interim Cover was not a necessary part of the agreement. Bleby J considered that there were a number of significant terms of the free interim cover that were set out in parts of the brochure other than in the certificate and that the true nature of the certificate was such that it should not be treated as containing contractual terms.

Despite the fact that Doyle CJ reached the same conclusion as the majority by different means, he did comment that, if his reasoning was incorrect and the relevant question was whether the contract could be said to be complete without the additional terms contained in the certificate rather than whether a reasonable interpretation of the meaning of the contract excluded those terms, then he would nonetheless have come to the same conclusion as the majority.

This case illustrates the caution insurers must exercise when offering interim cover. The conditions for acceptance of such interim cover should be clearly specified if they are to have contractual force.

Superannuation trustees acting as insurers: duties owed to members

Case Name:

United Super Pty Limited v Built Environs Pty Limited & Anor

Citation:

[2001] SASC 339 (Supreme Court of South Australia)

Date of Judgment:

5 October 2001 (Gray J)

Issues:

- superannuation
- contract of insurance between trustee and fund member
- duty of good faith

The Court in this case held that a valid contract of insurance existed between the trustee and the fund member and that, by failing to inform him that his insurance cover was likely to be terminated, the trustee had breached its fiduciary duties as insurer and trustee. The Court found that the fund member's employer, by virtue of its conduct and the trustee's consent and acquiescence to that conduct, was not in breach of his employment contract.

The facts

Mr Hollier was engaged as a subcontractor for Built Environs Pty Limited ***(Built Environs)*** and was a member of a superannuation scheme for the building industry (the ***Fund)*** of which United Super Pty Limited ***(United Super)*** was the trustee. During April 1996, Mr Hollier applied to the Fund for the payment of a total and permanent disability ***(TPD)*** benefit. United Super rejected Mr Hollier's application claiming that he did not have valid insurance cover because monthly contributions had not been received. The Fund was insured by Australian Casualty & Life Limited ***(ACC)***.

Built Environs, in accordance with industry practice, dealt with its subcontractors on a different basis to other employees and made annual payments on behalf of those subcontractors to the Fund rather than on a monthly basis. Built Environs had given United Super written notice that it would make payments with respect to subcontractors on an annual basis and did so for a number of years without complaint from United Super.

The decision

The Court upheld the decision of the primary judge and determined that United Super had entered into a contract of insurance with Mr Hollier that co-existed with the trust relationship. The Court adopted the reasoning in *Prudential Insurance Co v Commissioners of Inland Revenue* [1904] 2 KB 658 in determining whether a contract of insurance existed and found that the trustee's contractual arrangements with Mr Hollier conformed to the following criteria:

(a) there was a contract for the payment of a sum of money on the happening of a certain event (namely TPD);
(b) the event was one involving some amount of uncertainty (either as to its happening or the time at which it will happen); and
(c) the event had an adverse impact on the interests of Mr Hollier with the contract formed to provide compensation to him upon the happening of the event.

The Court looked at the contract documentation and considered it relevant that:

(a) the application form implied that Mr Hollier would be applying for insurance cover with United Super;
(b) there was no mention of ACC (or any other entity) acting as insurer; and
(c) ACC indemnified United Super for cover provided under the Fund trust deed.

Notwithstanding that the Court considered some aspects of the contract not to be in the nature of insurance, it was held that United Super had breached its obligation to act with the utmost good faith in failing to positively inform Mr Hollier that the inadequacy of Built Environs' annual payments put his insurance cover at risk. The Court also held that, even if the contract was not an insurance contract, United Super had breached its obligations as trustee in failing to inform Mr Hollier that payments were not being made on his behalf with sufficient regularity. The Court found that because United Super did not:

(a) refuse to accept annual contributions;
(b) respond to Built Environs' notice that it would make contributions annually with respect to subcontractors;
(c) indicate to Built Environs that Mr Hollier may lose his cover;
(d) have internal systems appropriate for dealing with the payment of contributions on other than a monthly basis; and
(e) disclose its insurance obligations to Built Environs or Mr Hollier, it was not exercising the same care and diligence that an ordinary prudent man of business would if conducting his own business.

In light of United Super's consent and acquiescence to the payment by Built Environs of annual contributions on behalf of Mr Hollier, the Court found that Built Environs was not in breach of the contract of employment it held with Mr Hollier.

The facts of this case and the nature of the contract formed are such that it is arguable whether all superannuation contracts are also contracts of insurance governed by the *Insurance Contracts Act 1984*. The Court also considered it relevant that United Super held itself out to the fund member as having a particular skill, knowledge and experience on which it invited reliance from the public. It is, however, open to conclude that the Court may have come to a different decision if Mr Hollier was aware, or ought to have been aware, that his insurance cover was at risk.

Case Name:

Retail Employees Superannuation Pty Ltd v Crocker; Colonial Mutual Life Assurance Society Ltd v Crocker

Citation:

[2001] FCA 1330 (Federal Court of Australia – NSW District Registry)

Date of Judgment:

20 September 2001 (Allsop J)

Issues:

- appeal by Trustee and Insurer against determination of the SCT as to entitlement to total and permanent disablement insurance cover;
- nature of task of SCT; and
- meaning of "unfair and unreasonable" decision.

The Court in this case examined the powers of the Superannuation Complaints Tribunal *(SCT)*. The Court found that the overriding consideration for the SCT must be the Trust rules and insurance policy terms when considering whether a decision is unfair or unreasonable.

The facts

Ms Crocker was an employee of Myers Stores Ltd and on 25 November 1989, joined the Retail Employees Superannuation Trust (the ***Fund)***. Retail Employees Superannuation Pty Ltd was appointed Trustee of the Trust (the ***Trustee)*** which was governed by a set of rules annexed to the Trust Deed which formed a part of the Trust (the ***Fund Rules)***. Two of the benefits provided by the Fund were death benefits and total and permanent disability ***(TPD)*** cover. The benefits were made available through an insurance policy provided by the Colonial Mutual Life Assurance Society Ltd (the ***Insurer)*** to the Trustee.

Shortly prior to 29 May 1996, Ms Crocker made a claim for a TPD benefit upon the development of Crohn's disease which is a chronic inflammatory bowel disease. Upon consideration of Ms Crocker's claim, the Trustee found that although Ms Crocker was entitled to a death benefit pursuant to the Fund Rules, she had no cover for TPD.

Ms Crocker applied to the SCT for a review of the Trustee's decision. The Insurer was joined to the complaint and its review and took the position that it would have rejected Ms Crocker's claim had the trustee decided to make it. The SCT decided on 8 March 2000 that the decision to deny Ms Crocker's claim, on the ground that she did not have the appropriate level of insurance cover for a TPD claim, was unfair and unreasonable. It determined that the claim be remitted to the Trustee and Insurer for reconsideration, on the basis that Ms Crocker be assessed and dealt with sharing the appropriate insurance cover for the payment of a TPD benefit.

Both the Trustee and the Insurer appealed against the decision of the SCT pursuant to s46 of the *Superannuation (Resolution of Complaints) Act 1993* (Cth) (the ***Act)*** to the Federal Court of Australia.

The decision

Justice Allsop upheld the appeals brought by the Trustee and Insurer, finding that Ms Crocker had no entitlement to cover for TPD under the relevant policies. The Court found that the SCT had incorrectly construed the relevant policies and therefore erroneously determined that Ms Crocker was entitled to make a claim for payment of a TPD benefit.

Justice Allsop made the following observations about the powers of the SCT to review a decision of a Trustee or Insurer pursuant to a superannuation scheme:

(a) the SCT is not empowered to engage in an exercise of judicial power and, as such, its task is not to determine all the rights and obligations of parties. Rather, the SCT must decide whether the Trustee's decision and any decision of the Insurer was and is unfair or unreasonable;

(b) the SCT must decide whether the decision is made under and in conformity with the governing rules or terms of the policy and not whether there is some other perceived (whether rightly or wrongly) unfairness or unreasonableness in and about the conduct of the fund;

(c) if the SCT finds that the decision of the trustee or insurer is in conformity with the governing rules or terms of the policy, then it cannot other than be satisfied that the decision is fair and reasonable. However, if the SCT finds that the decision is in conformity with, but is not required by, the governing rules or terms of the policy, then it may supplant the decision of the trustee or insurer with its view of the merits (bearing in mind the limitations of ss37(4) and 37(5) of the Act). Those sub-sections prevent the SCT from doing more than necessary to remove the unfairness or unreasonableness, or from doing anything contrary to the fund rules or the terms of the policy.

The most important aspect of this case is the determination by the Federal Court that, notwithstanding the provisions of the governing rules or insurance policy terms, it is not the place of the SCT to make decisions that are contrary to those rules or policy terms. If the governing rules and policy terms themselves are to be challenged, that challenge may only be mounted in a Court.

Other *obiter* comments of Allsop J worth noting are the following:

(a) in determining what is unfair or unreasonable, the SCT should undertake that task as if it were 'in the shoes of' the trustee and insurer; and

(b) a decision of a trustee or an insurer about a matter of judgment (such as one that involves weighing competing expert or lay opinion about a state of affairs) might be lawful and in conformity with the governing rules and policy terms.

The duty of disclosure: when must an insured tell its insurer that it has decided to take its business elsewhere?

Case Name:

Permanent Trustee Australia Company Limited & Anor v FAI General Insurance Company Limited

Citation:

[2001] NSWCA 20; (2001) 11 ANZ Insurance Cases 61-491

Supreme Court of New South Wales, Court of Appeal per Meagher, Handley and Powell JJA

Date of Judgment:

12 March 2001

Issues:

- duty of disclosure
- misrepresentation
- ss21 and 26 of the Insurance Contracts Act 1984 (Cth)

This case examines the scope of the duty of disclosure owed by an insured to its existing insurer during the course of arrangements for the renewal of cover. In seeking a 30 day extension to its policy, the insured (through its broker) failed to disclose to its insurer its provisional decision to exclude that particular insurer from its programme for the following year. The decision of the trial judge, Hodgson CJ ((1998) 10 ANZ Insurance Cases 61-408), was reviewed in our 1998 Annual Review.

The facts

FAI General Insurance Company Limited ***(FAI)*** provided professional indemnity cover for the Permanent Trustee Australia Company Limited group ***(PT)*** for the 1990/1991 year. In August 1991, PT's broker arranged for FAI to extend PT's policy for a further 30 days on the expiry of its cover. During the 30 day extension, PT became aware of possible claims arising out of its trusteeship of the Aust-Wide Property Trusts and the 1 O'Connell Street, Sydney development. Unit holders subsequently commenced proceedings against PT. PT settled the proceedings and sought indemnity under its professional indemnity policy. PT had earlier decided not to invite FAI to participate in the subsequent year's programme but its broker did not inform FAI of PT's decision.

The trial judge's decision

The trial judge accepted FAI's defences of misrepresentation and non-disclosure in respect of the extension. He held that PT's broker should have disclosed to FAI the provisional decision of PT not to offer renewal of cover to FAI and to attempt to place its share of the business elsewhere. He found that the relevant employees of PT's broker believed that if they had disclosed this fact to FAI, it was likely that the 30 day extension would not have been granted. This belief was held with sufficient assurance to constitute knowledge. This was a breach of PT's duty of disclosure and a misrepresentation which entitled FAI to relief under s28 of the *Insurance Contracts Act* 1984 (Cth) (the ***Act)***.

The appeal

On appeal to the New South Wales Court of Appeal, PT challenged the following findings of the trial judge:

(a) that the non-disclosure by PT of its provisional decision not to offer renewal to FAI and to attempt to place its share of the business elsewhere (the ***relevant fact)*** was a non-disclosure within s21(1) of the Act (that is, non-disclosure of a matter that the insured knows to be a matter relevant to the insurer's decision

whether to accept the risk and, if so, on what terms);
(b) that the non-disclosure was known to be relevant;
(c) that there had been a misrepresentation; and
(d) that PT's claim be reduced to nil under s28(3) of the Act.

FAI cross-appealed, challenging the trial judge's findings that the non-disclosure and misrepresentation were not fraudulent.

The test of relevance in relation to the duty of disclosure

PT first contended that the relevant fact was not relevant to the risk that FAI would incur during the extension. Accordingly, the relevant fact was not relevant to a decision to accept that risk. It was submitted that commercial and other considerations not relevant to the risk were not relevant for the purposes of s21(1)(a) of the Act and therefore, did not have to be disclosed. Reliance was also placed on s21(2)(a), which provides that the duty of disclosure does not extend to a matter that diminishes the risk. The Court rejected PT's construction of s21(1). The matter to be disclosed must be "relevant to the decision of the insurer". This is a decision whether to accept the risk and if so, on what terms. It is not simply a decision about the risk. On that basis, commercial considerations known to be relevant to the insurer's decision to accept must be disclosed even if they do not relate to the risk itself. The Court also held that s21(1)(a) leaves no room for the continued operation of the previous test of materiality (that is, whether the fact would reasonably have affected the mind of a prudent insurer).

Does a belief held by the broker amount to knowledge?

Section 21(1)(a) of the Act requires disclosure of "every matter *known* to the insured" that "the insured *knows* to be a matter relevant to the decision of the insurer". PT argued that belief was not knowledge and therefore, the broker's employees did not know that the relevant matter was relevant. The Court disagreed. The belief of the broker's employees in the likely attitude of FAI was held with sufficient assurance for them to conduct themselves in a business transaction as if it were true. Where a person, on the basis of some information, holds a belief on which that person is prepared to act in the world of practical affairs, he or she knows that fact for most legal purposes, and certainly for the purposes of s21. If followed that the broker's employees knew that the relevant matter was relevant to FAI's decision to accept the risk involved in the extension.

Is the knowledge of the broker while acting for other clients imputed to the insured?

The broker's knowledge of the likely reaction of FAI to a request for an extension if it knew that it was not to be offered renewal was knowledge that was acquired by the broker in the Australian insurance market. PT contended that the knowledge of the broker acquired while acting for other clients was not imputed to PT, even though it was present in the minds of the broker's employees while they were acting for PT. Further, the broker's knowledge, acquired otherwise than in the course of its agency on behalf of PT, could only be imputed to PT if it had expressly delegated to the broker the duty of making the required disclosure on its behalf.

The Court also rejected these submissions. The case law on this point establishes that an agent to insure (such as a broker) has a duty to disclose all material facts within its knowledge, however acquired, and that such knowledge is treated as knowledge of the principal. Where an agent is authorised to commit its principal to a transaction and the agent's state of mind is relevant to that transaction, the acts of the agents are the acts of the principal and the agent's state of mind must also be the state of mind of the principal. The Court found that the broker was the agent of PT "to know", and it could fairly be said that PT, by retaining the broker, had purchased the broker's knowledge. The relevant knowledge of the broker could be properly imputed to PT, but in any event, PT was bound by the knowledge of its broker who negotiated the extension on its behalf. The Court also found that the relevant employee of the broker had an obligation to communicate his knowledge to the officer of PT who handled insurance matters in order to obtain proper instructions. For these reasons, the knowledge of the broker was the knowledge of PT for the purposes of deciding whether there had been any non-disclosure in breach of s21(1)(a).

Section 21(1)(c) of the Act

PT's next submission sought to invoke the application of s21(2)(c) of the Act, which provides that the duty of disclosure does not require the disclosure of a matter that the insurer knows or in the ordinary course of the insurer's business as an insurer ought to know. PT contended that FAI knew, or ought to have known, that PT was free to place its business elsewhere, and was not bound to offer renewal. However, FAI did not know that PT had already decided to do this, provided they could obtain satisfactory cover elsewhere at an acceptable cost. These circumstances, in the view of the Court, converted the known risk into an unknown near certainty. The relevant matter was not the chance that renewal would not be offered to FAI, but the provisional decision of PT not to do so. Therefore, s21(1)(c) had no application.

Misrepresentation

The trial judge found that one of the broker's employees had made a misrepresentation during his discussions with an employee of FAI which led FAI to grant the extension. PT submitted that no misrepresentation had been made. In this regard, PT relied on s26(2) of the Act, which provides that a statement made by a person in connection with a proposed contract of insurance shall not be taken to be a misrepresentation, unless the person making the statement knew that the statement would be relevant to the insurer's decision whether to accept the risk and, if so, on what terms.

The broker's employee knew that the question of renewal was relevant. However, PT's contention was that the non-disclosure of the relevant matter did not make what the broker said a misrepresentation. PT also argued that nothing could be a misrepresentation within s26(2) unless it was a "statement", and that a misrepresentation by omission or silence did not involve a statement. The Court held that PT's submissions on this point were contrary to established case law and on that basis, PT's challenge to the findings of misrepresentation failed. The incomplete statement by the broker was the misrepresentation, not the silence or omission as such. Therefore, there was a "statement" made by the broker for the purposes of s26(2).

Fraud

The trial judge held that the misrepresentation and non-disclosure by one of the broker's employees were not fraudulent. This case represents one of the comparatively rare occasions on which an appellate court has been prepared to disturb the finding of a trial judge who has acquitted a witness of fraud. The representation made by the broker to FAI was a continuing one and was repeated by the broker in follow-up correspondence. The supervening event was the broker's discovery that his statement to FAI's employee had conveyed more than he intended. He knew his statements, as understood by FAI's employee, were false and that FAI's employee would rely on his own understanding. With that knowledge, the broker chose to remain silent and knowingly allowed his deception of FAI's employee, originally unintended, to continue to operate. This amounted to fraud. However, the Court did not disturb the trial judge's finding that the broker was not guilty of fraudulent non-disclosure in failing to mention the relevant matter in his initial presentation of the risk to FAI.

The Court accordingly dismissed PT's appeal and partly allowed FAI's cross-appeal on the question of whether the misrepresentation by the broker's employee was fraudulent.

This decision confirms that commercial considerations known to be relevant to the insurer's decision to accept a risk must be disclosed, even if they do not relate to the risk itself. The insured's duty of disclosure therefore extends to a decision by the insured to exclude the relevant insurer from the following year's programme. The decision has important implications for insureds and their brokers. Clearly, to the extent the duty of care is not complied with, brokers will be exposed.

Insurer not informed of change in level of business use at insured's home

Case Name:

GIO General Limited v Wallace

Citation:

[2001] NSW CA 199 per New South Wales Court of Appeal per Priestley, Heydon and Hodgson JJA

Date of Judgment:

23 October 2001

Issues:

- home and contents insurance
- duty of disclosure
- s21(b) Insurance Contracts Act

The facts

Mr Wallace's home was insured with the defendant GIO General Limited under a home building insurance policy which was renewed annually.

On the original policy proposal entered into in December 1987 the insured represented that the house was used as a private home and that part of the home would be used for business purposes for storage of equipment only. From about 1992, there was a significant increase in the use of the premises for the purposes of Mr Wallace's wood chipping and tree surgeon business. Mr Wallace moved the business office, some machinery and inflammable liquids onto the premises and began using the premises for wood storage, the parking of trucks and the sale of wood. In early 1993, a worker's compensation claim was made against Mr Wallace by an employee. The employee made some ambiguous threats towards Mr Wallace. Mr Wallace also experienced minor damage to property and anonymous threats. As a result, he contacted various parties including the police and the insurance broker but not the defendant.

The policy was reworded in February 1994 and the GIO claimed that a copy of the reworded policy was sent to Mr Wallace with the annual renewal notice (and the duty of disclosure printed on the back) in December 1994. In 1995 the premises were damaged by a fire which was deliberately lit but for which Mr Wallace was not responsible. The GIO denied any duty to indemnify Mr Wallace on the basis that Mr Wallace had breached his duty of disclosure under s21(1) of the Insurance Contracts Act by not disclosing the change in business activities and the receipt of threats before the 1994 renewal.

Verdict and judgment was entered for Mr Wallace at the trial. The trial judge found that Mr Wallace had not breached his duty of disclosure under s21(1)(b) of the ICA and in any event, the GIO had breached s22(1), which requires it to inform the insured in writing of the general nature and effect of the duty of disclosure before the contract of insurance was entered into.

The Decision

The Court of Appeal allowed the GIO's appeal, holding:

(a) Mr Wallace did not breach his duty of disclosure under s21(1)(b);
(b) the GIO did not breach its duty under s22 to "clearly inform the insured in writing of the general nature and effect of the duty of disclosure";
(c) the GIO's liability should be reduced to nil under s28(3), which relates to the liability of an insurer when the insured has breached their duty of disclosure. The Court was satisfied the GIO would not have renewed had the relevant circumstances been disclosed.

Under Section 21(1)(b) it is necessary, in ascertaining what a reasonable person could be expected to know, to take into account the circumstances affecting the actual insured, **but the ultimate question turns on what could be expected of a reasonable person's state of mind, not on the insured's state of mind** (emphasis added).

In relation to the change in business use, although the language of the 1994 policy contemplated the use of the premises for business purposes, this does not prevent reasonable persons from being expected to know that a change in the level of business use (which involved the stockpiling of wood) is relevant to their insurer's decision whether to accept the risk.

In relation to the receipt of threats and the occurrence of damaged property, they were serious and had the capacity to concern the insured enough to contact the other parties. Therefore, a reasonable person could be expected to know that the treats were relevant to the insurer's decision whether to accept the risk.

The 1994 policy and renewal notice did come to the Mr Wallace's attention. Even if they had not, they had come to the attention of the office administrator.

In any event, the Court considered that the requisite informing does not need to have occurred at a particular time before the contract was entered into. There was a course of dealing between the parties which started in 1987 from the time of the original policy onwards. The insured was clearly informed of his duty of disclosure by the proposal he served and by the 1987 policy.

This case emphasises the need for insured's and their brokers to be alert to the need to notify their insurers when premises or other insured property and insured on one basis and changes in circumstances mean that there may be increased risks to the insurer. The first limb of s21(1) looks only to what the insured knows. The second limb looks to what a reasonable person in the circumstances could be expected to know. While it is necessary to take into account the circumstances affecting the particular insured, the scope of the duty of disclosure ultimately turns on what could be expected of a reasonable person in those circumstances.

Case Name:

Fishwives Pty Limited v FAI General Insurance Co Limited & Ors

Citation:

[2001] NSWCA 193, NSW Supreme Court, Court of Appeal, per Mason P, Meagher and Handley JJA

Date of Judgement:

27 June 2001

Issues:

- professional indemnity insurance
- notice of circumstances
- duty of disclosure

The facts

In June 1988 Fishwives Pty Limited ***(Fishwives)*** appointed Firth Lee & Partners Pty Limited (the ***Insured)*** as its architect to design a four storey office building in Chatswood. Construction was undertaken by Prime Constructions Pty Limited ***(Prime)***. In March 1990, after the expiration of the defects liability period, granite tiles fell from the outside of the completed building onto the footpath. The Insured and Prime investigated the situation and rectification work was performed between June and September 1990. In March 1992 further granite tile delamination occurred. The Insured organised remedial works and had discussions with Prime in May 1992 as to whether the render base beneath the tiles had been applied in the proper manner, since it was missing an adhesive additive. Rectification works were continuing in September 1992 when the Insured submitted a proposal for insurance jointly underwritten by each of the three respondent insurers. Although the proposal asked whether claims had been made against the Insured in the past or whether the Insured, after enquiry, was aware of any circumstances that might give rise to a claim, the Insured did not disclose the granite tile delamination on the proposal.

In early October 1993 the Insured was served with a statement of claim filed in the District Court by Fishwives. The proceedings were undefended and Fishwives obtained judgment against the Insured in December 1996. It subsequently served a creditor's statutory demand for payment, with which the Insured did not comply.

On 16 September 1994, one of the insurers, FAI General Insurance Co Ltd ***(FAI)***, declined indemnity on the basis of non-disclosure of circumstances known to the Insured as early as March 1990.

In November 1997 Fishwives sought leave to proceed under section 6 of the Law Reform (Miscellaneous Provisions) Act 1946 against FAI. Although leave was granted by the District Court, that decision was overturned on appeal and the matter was remitted for rehearing of an application to proceed against all three co-insurers. Leave to proceed against the three insurers was refused by the District Court. Fishwives appealed this decision.

The decision

The Court of Appeal found it unnecessary to consider whether section 6 of the Law Reform (Miscellaneous Provisions) Act 1946 applied to claims made policies, for the reason that leave was properly refused because of the non-disclosure. Mason P, with whom Meagher and Handley JJA agreed, found that the trial judge was entitled to view the objective circumstances as disclosing the Insured's awareness of a significant risk that the claim might eventuate at the time of completing the proposal form. The evidence of the Insured that it had formed a view that it was not

negligent for the delamination was irrelevant since the proposal form explicitly required disclosure "whether you consider yourselves liable or not". The Court concluded that the recurrence of the delamination in 1992 must have brought home to the Insured an actual awareness of circumstances that might give rise to a claim against it.

Fishwives also argued that before the trial judge could refuse leave on the basis that the insurers were entitled to disclaim liability, section 6 required the insurers to bring proceedings to prove their entitlement to such a disclaimer. However, the Court of Appeal rejected this argument, finding that a court that was persuaded of an insurer's right to disclaim was entitled not to grant leave.

This judgment illustrates that "circumstances which may give rise to a claim" can involve an objective element for the purposes of the duty of disclosure. It will not necessarily be a defence for the insured to establish that he or she honestly believed no claim would be made. This decision should be contrasted with the decision in *Australian Hospital Care v Swinbank* reported in our 1999 Annual Review where no breach of the duty of disclosure was found where the insured honestly believed no claim would be made. One distinguishing feature of this case was the question in the proposal form.

This case also illustrates that insurers can raise exclusions or non-disclosure issues to defeat applications for leave brought by third parties under section 6 of the Law Reform (Miscellaneous Provisions) Act 1946.

Marine insurance – when does suspicion and rumour affecting the security of an insured vessel give rise to a duty to disclose?

Case Name:

"The Elena G" – Decorum Investments Ltd v Atkin

Citation:

Lloyd's Law Reports [2001] Volume 2 at 378 Queen's Bench Division (Commercial Court) per Steel J

Date of Judgment:

26 January 2001

Issues:

- marine insurance
- utmost good faith
- non-disclosure of insured's political connection

This case concerns the insured's obligation at common law to make a fair presentation of the risk. This obligation arises from the duty of utmost good faith as examined by the House of Lords in *Pan Atlantic v Pine Top*. In Australia, the decision is of relevance to marine insurance and in other contexts where the Insurance Contracts Act does not apply.

The facts

The claimant – Decorum Investments Limited (the insured) was the registered owner of the motor yacht Elena G, and the defendant was the representative underwriter of Lloyds syndicate 1183.

The Elena G was berthed at a marina in Sotogrande, Spain. This was a purpose built resort whichpurpose-built resort included security arrangements for the benefits of residents.

In the early hours of 18 April 1999, a fire broke out on board the vessel while she was moored at the marina. The local fire brigade was called and they sank the vessel to put out the fire. Although she was subsequently raised, the damage was so extensive that she was rendered a constructive total loss. While the precise cause of the fire was unknown, it was common ground that the vessel was treated as having been lost by an accidental cause and there was no evidence of malicious attack by any third party.

The insured claimed under the policy. Underwriters denied liability on grounds of an alleged material non-disclosure by the insured of the fact that Mr Goussinski, a Russian magnate of some notoriety, controlled the insured and used the boat. The underwriters asserted that the following facts were material and called for disclosure:

(a) the identity of the ultimate beneficiary of the policy, Mr Goussinsky;Goussinski;
(b) the fact that Mr GoussinskyGoussinski and his family were security risks, in that their lives and their property waswere in danger;
(c) the existence of extensive security arrangements at Sotogrande.

The decision

In finding for the insured, Steel J held:

1. that it was for the underwriters to demonstrate that there were facts or circumstances known to the insured (other than mere speculation or vague rumours) which would establish a real risk that an enemy of Mr Goussinski would seek to damage or destroy his yacht, or that it would be destroyed or damaged in the course of an attempt to kill or attack Mr Goussinski or his

family. Any threat that had been made to Mr Goussinski rather than his property, and was made in Russia in circumstances where he had moved to Spain (albeit out of concern for the safety of himself and his family).

2. Mr Goussinski's obligations were restricted to disclosing facts and circumstances material to the assessment of a risk that would be unknown to the underwriters. The underwriters expressly disclaimed any reliance on Mr Goussinski's failure to disclose the fact that he was a Russian business magnate or any other facts or circumstances emerging from his residence in Spain and the use by him of the yacht in and out of Sotogrande.
3. On the facts and the evidence, Mr Goussinski was not exposed to any sensible risk to his personal well-being or to damage to his property from any political sources notwithstanding that he was a controversial figure with a high profile of challenging powerful political institutions in Russia.
4. While there were particular risks that were relevant to Mr Goussinski and his property in Russia, the experts concurred that the risks were very low and stemmed from features endemic in Russian business life rather than circumstances peculiar or specific to Mr Goussinski.
5. As to the issue of security arrangements at Sotogrande, Mr Goussinski's motive in establishing additional security protection in Spain was to protect his children from the risks of abduction and not to protect his property. These precautions added nothing to the protection otherwise afforded to the vessel in Sotogrande, and if anything decreased the risk.

This case demonstrates that the burden is on the underwriter to establish that an assured failed to disclose material circumstances known to him. The insured must disclose facts known to him which a prudent underwriter would regard as material to the risk. Facts and circumstances pertaining specifically to the assured as opposed to facts and circumstances that relate generally to the assured are more likely to be material. The case highlights the need for insurer's to make their own enquiries regarding ownership interests where the insured is a corporation.

Where formation of an opinion is a precondition to liability under the policy – insurer must act honestly and reasonably

Case Name:

McArthur v Mercantile Mutual Life Insurance Company Ltd

Citation:

[2001] QCA 317; (2001) 11 ANZ Insurance Cases 61-501
Supreme Court of Queensland, Court of Appeal per McMurdo P, McPherson JA, Muir J

Date of Judgment:

10 August 2001

Issues:

- total and permanent disability
- where cover dependant on opinion of insurer
- where insurer forms opinion applying incorrect test

Where an insurer's opinion is wrongly formed: the court can remake the opinion with new evidence

The facts

Under a policy ***(Policy)*** issued by the Respondent ***(Insurer)***, the Appellant ***(Insured)*** was entitled to $80,000 in circumstances including if the Insured suffered Total and Permanent Disablement ***(TPD)***. TPD was defined under the Policy to require, after a period of six months' illness, that the Insurer form an opinion that, as a result of an injury or illness, the Insured was disabled to such an extent as to render the Insured likely never to be engaged in any gainful occupation for which the Insured was reasonably suited by training, experience or qualification. It followed that the policy required an opinion to be formed by the Insurer before the Insured would qualify for a TPD benefit.

The Insured was diagnosed as suffering from chronic fatigue syndrome and made a claim for the TPD benefit under the Policy. The Insurer considered various medical reports, and then wrote to the Insured rejecting the claim.

The trial judge

The trial judge found as a fact that the Insurer had not formed the requisite opinion properly because it had applied an erroneous test. The trial judge found that the correct test to apply was on the balance of probabilities. The test the Insurer had adopted was to the effect that something more was required by the word "likely". It followed from this finding that the Insurer was in breach of a duty to act reasonably, fairly and in good faith when considering the claim.

Issues on appeal

The issues to be determined on appeal included:

(a) In circumstances where the Insurer had failed to form the opinion which was a condition precedent to the Insured's entitlement, was the Insured prevented from suing and recovering?

(b) If not, could the court decide the proper opinion that the Insurer should have formed?

(c) If so, in determining the proper opinion, could the court could have regard to evidence that was not before the Insurer at the time the Insurer's opinion was formed?

The Court of Appeal also considered whether the Insured's cause of action was in debt for a liquidated sum or in contract for damages.

In separate judgments, McPherson JA and Muir J (with whom McMurdo P agreed) held that despite the absence of a valid opinion of the Insurer as a condition precedent, the Insured was nevertheless entitled to sue. This was because the absence was due to the Insurer's fault. The judges referred to the basic contractual principle that a party cannot insist on a condition if the reason for its non-fulfilment is its own fault.

McPherson JA and Muir J also held that, in the absence of a proper opinion, the court was entitled to form the opinion as required under the TPD definition.

Both judges held that in making that determination, it was proper for the court to admit evidence that was not before the Insurer at the time the Insurer's opinion was formed. McPherson JA observed that it would be wrong to limit the court's inquiry to material that was before the Insurer, because to do so would encourage Insurers to make adverse decisions on material which was inadequate, in the knowledge that no further evidence could be adduced if their opinions were later invalidated.

In forming his own opinion, the trial judge concluded that he was not satisfied that the Insured suffered TPD. On appeal, McPherson JA and Muir J held that, in light of the evidence that was before him, it was open to the trial judge to form the opinion that he did.

It followed that the Insured was not entitled to any payment under the Policy, and the Insured's appeal was dismissed with costs.

The Insured pleaded an action in debt for liquidated damages of $80,000, and alternatively in contract for general damages of $120,000, including compound interest.

Muir J held that the proper cause of action was for the Insured to sue for damages for breach of contract, based on the Insurer's breach of a contractual obligation. In relation to the alternative claim in debt, Muir J stated that there was a difficulty because the Insured's opinion was found to have miscarried and until the requisite opinion was formed, no sum could be due to the Insured.

Both McPherson JA and Muir J stated that the damages potentially available to the Insured for breach of contract in such a case were the full amount of $80,000. Neither judge addressed the question of whether compound interest would also have been recoverable.

It is not unusual for insurance policies to stipulate that the insurer's liability depends on the insurer forming an opinion as to a certain state of affairs. This case illustrates that in forming such opinions, the obligation of the Insurer is to act honestly, bona fide and reasonably. Where the insurer's opinion does not comply with these requirements, a court may determine the relevant opinion, and in doing so may have regard to new material that was not before the insurer. It the court forms the view that a different opinion ought to have been reached by the Insurer had the insurer acted in good faith, honestly and reasonably, it may award damages in favour of the insured for breach of contract.

Searching for ambiguity in plain language

Case Name:

De Vito v Commercial Union Assurance Co Limited

Citation:

(2001) 11 ANZ Insurance Cases ¶61-486, South Australian Supreme Court, Full Court, per Doyle CJ, Olsson and Bleby JJ

Date of Judgment:

14 February 2001

Issues:

- construction of policies
- where exclusion clause unambiguous

An insured cannot escape the operation of an exclusion clause based on an insurer's presumed intention when the words used have a clear meaning.

The decision of Bright J at first instance (11 ANZ Insurance Cases ¶61-470) was reviewed in our 2000 Annual Review.

The facts

The insured ran a transport depot and in October 1997 he instructed Mr Eaton, an employee, to drive one of his prime movers to Brisbane. Mr Eaton's partner, Ms Good, accompanied him and was in fact driving at the time that the truck left the road, overturned and was damaged. Although she had driven the truck previously, at the time of the accident Ms Good was not driving with the insured's approval.

The insured's policy indemnified him for loss caused to the truck on the condition that the insured notify the insurer of all drivers prior to them driving the truck. If loss occurred whilst an unapproved driver was in control, the insurer could either refuse to pay the claim if the driver did not satisfy its underwriting guidelines, or else the insurer would pay the claim and impose an additional excess.

Exclusion 8 of the general exclusions to the policy, excluded indemnity for claims where the driver had held the relevant licence for less than two years. Exclusion 10 excluded indemnity where the driver (defined as a driver approved by the insured) did not meet the insurer's guidelines. Ms Good had held her heavy transport licence for less than two years, and did not meet the insurer's guidelines. The insurer denied indemnity.

The first instance decision was determined by reference to s54 of the Insurance Contracts Act. The appeal decision, however, turned on the construction of the policy.

The insured argued that the reference to a "driver" in Exclusion 8 should be read as referring to a driver approved by the insured. The intention of the exclusions, according to the insured, was to permit the insurer to refuse to pay a claim relating to a loss caused by a driver only if the insured had approved that driver. Otherwise, the insured argued, Exclusion 8 would exclude claims for theft by unlicensed drivers.

The decision

Doyle CJ (with whom Olsson and Bleby JJ agreed) considered that, read literally, clause 8 was unambiguous and permitted the insurer to deny the claim. He did not accept that the meaning of the policy could be ascertained by presuming that it

operated in an expected way, and then interpreting specific clauses of the policy to coincide with that expectation.

Relevantly, other exclusions contained in the policy made no reference to any requisite knowledge on the part of the Insured.

Applying well established principles relating to the construction of contracts, Doyle CJ held that if the words are clear, the court must give effect to them. In the present circumstances, he found no ambiguity in the meaning of exclusion 8 nor any irrationality in its operation. The Court was not concerned about the potential anomaly that exclusion 8, interpreted literally, would exclude claims for theft by unlicensed drivers. It emphasised that that was the insured's bargain, and that a higher premium ought to have been paid if the insured did not want the policy to operate in that way.

This decision illustrates the limits which the courts will adhere to when an insured seeks to escape the operation of an exclusion clause. The insured will not be permitted to rely upon a "presumed expectation" based upon what may appear to be commercially rational where the literal meaning of the clause is clear. If the words used are unambiguous, the court will give effect to them notwithstanding the "presumed" intention of the parties.

Series of occurrences held not to extend beyond policy period

Case Name:

Pacific Dunlop Limited v Swinbank

Citation:

(2001) 11 ANZ Insurance Cases ¶61-496, Supreme Court of Victoria, Court of Appeal, per Tadgell, Charles and Chernov JJA

Date of Judgment:

29 May 2001

Issues:

- Product liability
- "Occurrence" or "series of Occurrences"
- aggregation clauses

A policy is to be interpreted according to its ordinary meaning but its words must be applied in their context. In this case, a commercial context was applied to the phrase "series of occurrences" in a product liability policy.

The decision of Mandie J at first instance (10 ANZ Insurance Cases ¶61-439) was reviewed in our 1999 Annual Review.

The facts

A subsidiary of the insured, Pacific Dunlop, produced over 40,000 coronary pacemaker leads between 1988 and 1994. In 1994 it voluntarily recalled all unimplanted leads following information that they had a potential to fracture and cause death or injury to patients. Personal injury claims were made against the insured seeking compensation for injury caused by the need to remove implanted leads.

The insured had primary insurance cover issued by Zurich and excess liability policies underwritten by a Lloyd's syndicate for the period 30 September 1992 to 30 September 1993. The primary policy defined an "occurrence" to include continued exposure to substantially the same conditions resulting in personal injury, property damage or advertising injury. It also contained an aggregation clause that provided that a "series of occurrences arising directly from a common cause" was deemed to be one occurrence that happened on the day of the first occurrence. The Lloyd's policies adopted the wording of the primary policy.

The insured was indemnified by Zurich for the personal injury claims, including those after 30 September 1993, on the basis that the "occurrence" was deemed to have occurred on the date of the first incident involving any injury to a patient, namely October 1992. Zurich also deemed as one occurrence all third parties suffering personal injury from the one common cause.

The Lloyd's syndicate, however, declined to accept the interpretation of the aggregation clause applied by Zurich. The syndicate asserted that all of the claims after 30 September 1993 were not covered under the policy. The insured and Zurich separately brought proceedings against the Lloyd's syndicate for declaratory relief.

The insured submitted that a single occurrence was deemed to have happened on the first day of the first occurrence of the series. The Lloyd's syndicate responded that no part of the definition of "occurrence" extended the cover provided by the primary policy beyond the period of insurance.

At first instance, Mandie J found in favour of the Lloyd's syndicate. He considered that if it had been intended that a series of occurrences should include occurrences after policy expiry, it would have been expressly stated in the policy. Mandie J held that the date deeming provision in the definition of "occurrence" was subject to the definition of the policy period in the contract.

On appeal, the insured submitted that, taken together, the aggregation clause and the date deeming provision meant that claims made after expiry of the period of insurance were deemed to be made within the period of the policy, and therefore covered as part of the same "occurrence" which first occurred during the period of the policy.

The decision

The Court of Appeal unanimously held that that while the policy was to be interpreted according to the ordinary and popular meaning of its words, the words were to be construed in their context. That context was, in the circumstances, a commercial one and sound business principles therefore applied. On the basis of good business sense, the Court considered that the essential nature of the policy was to afford an indemnity over a distinct, limited and finite period of time, marked out at each end to the very minute and designated as the period of insurance.

The Court held that when cover is placed on a time basis, the stated period of time is fundamental and must be given effect. The premium payable is assessed for that period, irrespective of whether the cover is defined by reference to losses occurring or claims made. The Court agreed with the argument relied upon by the Lloyd's syndicate that the meaning of the word "occurrence" in the insuring clause was governed by the temporal limitations that the insuring clause imports.

This decision illustrates the interaction between aggregation clauses and indemnity clauses. The case has significant implications for product liability insurers where a defective product leads to a series of occurrences. However, each case will turn on its own facts and require careful consideration of the policy wording in light of the relevant "occurrences".

What is the scope of a clause restricting the right of subrogation?

Case Name:

GPS Power Pty Ltd v Gardiner Willis Associates Pty Ltd

Citation:

Supreme Court of Queensland, Court of Appeal per de Jersey CJ, Pincus JA and Williams SJ

Date of Judgment:

8 December 2001

Issues:

- subrogation
- construction of clause restricting the right of subrogation
- whether a waiver of the right of subrogation is commensurate with cover under the policy

This is an appeal from a decision of Mackenzie J reported in our 2000 Annual Review

The facts

The defendant argued that because it was an insured under the policy of insurance, it was entitled to rely on the term of the policy restricting the insurer's right of subrogation.

The plaintiffs brought a claim for $476,548.30 for the alleged failure by the defendant, a consulting engineering company, to exercise reasonable care and diligence as an engineer in the design, engineering drawings and detailing of a supporting structure at the Gladstone Power Station.

Their insurers indemnified the plaintiffs for $418,716. The defendants admitted liability for loss of $40,890.65 that was unrecovered by the plaintiffs.

In relation to the indemnified amount, the defendant argued that the provisions of the subrogation clause prevented a subrogated right being exercised against it.

The relevant provisions provided:

(c) In the event of the insurers indemnifying or making a payment to any insured(s), the insurers shall not exercise any rights of subrogation against any other insured(s) hereunder.

(d) The insurers agree to waive any rights and remedies or relief to which they become entitled by subrogation against –

(ii) Any insured named or described by this policy.

The definition of "the Insured" contained in the policy excluded consultants but only in respect of such consultant's professional duty of care to other persons or parties included in the definition of "the Insured".

The defendant argued that even if it was within the exclusion as a "consultant" with respect to professional negligence it remained insured for some purposes under the policy and therefore was an insured for the purpose of the subrogation clause. It relied upon the fact that the subrogation provisions were expressed in general terms.

The trial judge

Mackenzie J considered that the professional services of the defendant were excluded from the coverage of the policy. Mackenzie J then discussed the conflicting authority on the issue of whether this would prevent the subrogation clause extending to the defendant.

In *National Oilwell (UK) Ltd v Davy Offshore Ltd* (1993) 2 Lloyds Rep 582 the waiver was held to extend only to insured losses. In contrast, in *Woodside Petroleum Development Pty Ltd v H & R–E & W Pty Ltd* (1999) 10 ANZ Ins Cases 61-430 the Court rejected the argument that waiver was commensurate with cover.

Mackenzie J concluded that the decision in *Woodside Petroleum* represented the current state of the law on the subject. Accordingly, he held that the defendant was entitled to the benefit of the subrogation clause and therefore, the subrogated claim against the defendant failed. The *Woodside Petroleum* decision is reported in our 1999 Annual Review.

The decision on appeal

The Court dismissed the appeal. It said that the waiver of subrogation clause should be given its literal or ordinary meaning. It could not be read down to achieve a "more commercial result".

> The decision in this case illustrates how the operation of a clause restricting the insurer from exercising rights of subrogation may not be limited to insured losses. The Court accepted that a clause waiving the right of subrogation can be relied on by an insured who is otherwise excluded from claiming under the policy. Insurers should be mindful of the effect of waiver of subrogation clauses which are couched in general terms.

Subrogation in contract works insurance: rights of the insured unable to be exercised against a co-insured

Case Name:

Co-Operative Retail Services Limited v Taylor Young Partnership & Ors

Citation:

[2001] Lloyds Rep Ir 122, English Court of Appeal per Gibson, Brooke and Walker LJJ

Date of Judgment:

July 2000

Issues:

- contractors all risk insurance
- subrogation
- rights against co-insured

In this case, the English Court of Appeal considered whether an insurer who had provided indemnity to an insured under a building contract works policy could exercise rights of subrogation against a co-insured.

The facts

The claimant ***(CRS)*** contracted Wimpey to build a new office. Wimpey in turn engaged Hall as electrical subcontractor.

A joint insurance policy was taken out with CGU, naming each of Wimpey, CRS and Hall. A fire occurred in the building. CRS alleged the fire was due to the negligence or breach of contract by the architects ***(TYP)*** and the mechanical engineer ***(HLP)*** (the ***appellants)***. CRS brought proceedings against the appellants. CRS having been indemnified under the joint named policy, the proceedings were being brought by CRS' insurers as a subrogated action. The appellants alleged that the fire resulted from breaches of the main contract between Wimpey, Hall and CRS. They sought contribution under the *Civil Liability (Contribution) Act* 1978 from Wimpey and/or Hall.

The trial judge in the Technology and Construction Court refused the application.

The decision – Court of Appeal

The issue as to whether Wimpey and/or Hall could be liable to make contribution to the appellants raised two issues:

1. Whether Wimpey and Hall could ever be liable to CRS in respect of "the same damage" within the meaning of the contribution legislation. It is worth noting that the UK legislation uses similar wording to that which applies in New South Wales.
2. Further, even if that were so, the principle of circuity of action prevented the appellants bringing the claim because the claim would in turn be passed on to the insurers that caused the action to be brought against the appellants.

In *Petrofina (UK) Limited v Magnaload Limited* (1984) 1 QB 127 the court invoked the principle of circuity of action to prevent an insurer from exercising rights of subrogation against a co-insured, even though the insurance policy was only expressed to cover property damage and did not purport to provide liability coverage. The Court reviewed the authorities upon which the principle in *Petrofina* was based and subsequent authorities and concluded that it appears to be based upon the presumed intention of the parties. In each case, it is necessary to examine closely the contractual agreement between the parties, and the insurance provision will not necessarily and by rule of law override any other contractual agreement.

The Court observed that the principle has also been expressed in terms that there must in appropriate circumstances be implied into a contract of insurance a term to give business efficacy that an insurer will not use rights of subrogation in order to recoup from a coinsured the indemnity which it had paid to the insured.

The court preferred to decide the matter by reference to the contractual arrangements between the parties rather than by reference to any principle of "circuity of action". Viewed in that light, the court concluded that neither Wimpey nor Hall should be regarded as persons "liable in respect of the same damage" as CRS. They, like CRS, had entered into contractual arrangements which meant that if a fire occurred, they should look to the joint insurance policy to provide the costs of restoring and repairing the fire damage. It was important to the court's reasoning that it took the view that the contractual scheme, when viewed as a whole, was intended by the parties to displace claims or cross claims based on civil liability between the parties. The court observed that in the absence of any special contractual scheme the doctrine of circuity could have no application. The general principle of English law that the incidence of insurance should be ignored in apportioning responsibility would prevail.

This case deals with the often difficult question of in what circumstances an insurer will be prevented from exercising rights of subrogation against a coinsured. In many cases, it will be appropriate to imply a term into the contract of insurance which prevents the exercise of such rights. In other cases, the contractual arrangements between the two co-insureds will suggest a term should be implied, to the effect that there will not be any claims between them which are covered by the insurance. However, in some cases the contractual arrangements between the co-insureds may not preclude claims being brought.

The scope of a waiver of subrogation clause

Case Name:

Larson-Juhl Australia LLC v Jaywest International Pty Limited

Citation:

(2000) 11 ANZ Insurance Cases ¶61-499, Supreme Court of New South Wales, Court of Appeal, per Handley, Stein JJA and IPP AJA

Date of Judgment:

8 August 2001

Issues:

- subrogation
- construction of policy
- waiver of subrogation rights against co-insured

This case concerns the interpretation of the scope of a waiver of subrogation clause and the limit on the insurer's right to proceed against a co-insured.

The decision of Macready M at first instance (11 ANZ Insurance Cases ¶61-472) was reviewed in our 2000 Annual Review.

The facts

Jaywest sold its picture framing business to Larson-Juhl. The business was carried out in leased premises and ultimately Larson-Juhl was forced to vacate the premises after the roof started to sag and the local council deemed the building unsafe. At that time, Jaywest continued to occupy part of the premises for the purpose of storing its stock. Accordingly, Jaywest's fire and business interruption policy remained in force after completion of the sale to Larson-Juhl and Larson-Juhl was added to the policy.

Following the enforced vacation of the premises, Larson-Juhl claimed under the business interruption section of the policy and the claim was met. The insurer brought a subrogated action in Larson-Juhl's name against Jaywest alleging breach of warranties in the contract of sale and misleading and deceptive conduct prior to the sale. In its defence, Jaywest sought to rely on the waiver of subrogation clause in the policy as a complete defence, despite the fact that the policy did not cover it for liabilities for breach of warranty or for misleading and deceptive conduct.

At first instance, Master Macready upheld the defence and dismissed the proceedings. He considered that the waiver of subrogation contained no express limitation either as to time, as to the nature of the cause of action, or as to the facts on which the cause of action is founded. Therefore, Jaywest could rely upon it.

The decision

On appeal, Handley JA (with whom Stein JJA and Ipp AJA agreed) agreed with the submission of the insurer that the waiver of subrogation clause was being invoked in unusual circumstances, thus distinguishing the leading cases on subrogation. However, he considered that the rights to which the insurer sought to be subrogated were also unusual, since they did not arise from conduct which caused the loss to Larson-Juhl. If the business had never been sold, the insurer would have had to compensate Jaywest.

The insurer was attempting to invoke rights that pre-dated the policy year and arose under representations that were collateral to its subject matter. Handley JA held for that reason any recovery by the insurer would be a windfall.

Rejecting submissions by the insurer that the Court import certain words into the clause in order to limit its scope, the Court considered that its duty was to construe the language of the clause fairly and simply. The clause was broadly worded, waiving "any rights and remedies or relief" and the Court found no reason to limit the generality of this expression. The appeal was dismissed.

This judgment shows that a waiver of subrogation clause may provide a benefit to the insured beyond that contemplated at the time of entering into the policy. If insurers wish to limit the scope of such waiver clauses, they will need to take care in drafting appropriate limitations to avoid the clause operating in an unintended manner.

Warranty held to arise from wording contained in slip

Case Name:

HIH Casualty and General Insurance Ltd v New Hampshire Insurance Co & Ors

Citation:

(2001) Lloyd's Rep

Date of Judgment:

4 December 2000

Issues:

- construction of policies
- slip followed by policy wording
- reinsurance – incorporation of terms into reinsurance contract

The facts

Law Debenture Trust ***(LDT)*** provided funding for Film Production to Flashpoint Ltd ***(Flashpoint)*** on condition that Pecuniary Loss Indemnity insurance be obtained to cover LDT in the event of a shortfall between the finance provided by LDT and the revenue collected from the films.

Flashpoint took out insurance through a Lloyd's broker. HIH Casualty And General Insurance Ltd ***(HIH)*** offered 100% coverage to LDT, and HIH reinsured the risk for 80% of the policy value.

The insurance slip stated the number of films to be produced pursuant to specified production sub-contracts between Flashpoint and the producers.

The slip contract stated that the conditions for both contracts of insurance were to be agreed in a Pecuniary Loss Indemnity wording. The preamble to these Pecuniary Loss Indemnity policies stated that the policies were issued in respect to a slate of films to be made by the production companies. Each policy contained a widely worded waiver clause in favour of the insured in which the insurer agreed that it was not entitled to avoid or rescind the policy, reject any claim under it, or seek redress or remedy, on the grounds of invalidity, unenforceability of its arrangements with Flashpoint or on the grounds of non-disclosure, misrepresentation by Flashpoint or any other person, or "any similar grounds".

A collateral agreement between HIH and Flashpoint also existed, in which Flashpoint warranted that it had fully and accurately disclosed all information material to the consideration of risks which were covered by the policy; and in which HIH and Flashpoint both agreed that they would act in utmost good faith in relation to the agreement.

HIH paid sums totalling US$31 million under the policy and sought to recover from the reinsurers. The reinsurers denied indemnity on the basis that:

(a) Flashpoint was in breach of a warranty as to the number of films to be produced. They asserted that the reinsurance contracts contained the same warranty.

(b) HIH was entitled to deny liability to Flashpoint, notwithstanding a very wide waiver clause.

The decision

The Court made the following findings:

1. It considered first whether the policy was comprised in the slip subject to the more formal pecuniary loss indemnity policy or only the latter. The fact that the slip was entitled "Slip Policy" was also of some significance in indicating the

parties' intentions. The Court concluded that the slip formed part of the policy. It contained some terms not in the more formal policy including a reference to the requirement that a full slate of films be made. Accordingly, it was a term of the policy that a full slate of films be made.

2. The term clearly had a material bearing on the risk and therefore must be construed as a warranty.
3. The warranty was also incorporated in the reinsurance contracts, because the interest insured in the reinsurance policy was expressed 'as original policy', and because the initial policy and the reinsurance policy were designed to operate back-to-back. HIH was fairly to be regarded as fronting the reinsurance for a pool.
4. Further, Steel J held that the contract of insurance contained a warranty that HIH would not make any material amendment to the initial contract of insurance without the reinsurers' approval. He defined 'material' as changes affecting the sense or substance of the underlying policy in a way potentially prejudicial to the reinsurer.
5. In relation to HIH's claim that it was afforded no defence to the claim by LDT by reason of the waiver clause, Steel J stated that the waiver applied only to the rights of set-off and counterclaim. HIH had not waived coverage defences. Such a waiver would be contrary to the nature of a contract of insurance and the courts would require clear wording to achieve it. Steel J held further that a breach of warranty was not in any case a 'similar ground' to invalidity or unenforceability of an agreement, or to misrepresentation or non-disclosure, since the effect of a breach of warranty would be to discharge the insurer from liability, whereas non-disclosure or misrepresentation would give rise to rights of avoidance, rescission and rejection of liability.
6. Steel J considered that the waiver clause was incorporated in the reinsurance policy, since the contract of reinsurance was subject to all terms, conditions and clause of the original. Therefore, the reinsurers should be bound by it. Further, Steel J held that the reinsurance policy made express reference to the clause (by mention of 'the cancellation clause', although it was noted that the clause might be better named the non-cancellation clause), and that this reference was sufficient to render reinsurers aware, or at least on enquiry, of the clause, so as not to inhibit its incorporation in the reinsurance clause.

   Steel J held that even if the clause was not incorporated by express reference, it was appropriate to incorporate the clause in the contract of reinsurance for several reasons:

   - the general clauses of incorporation of the reinsurance policy were designed to operate back to back;
   - the clause was material to the nature and scope of the risk insured, and therefore germane to the reinsurance;
   - with the substitution of 'reinsurers' for 'insurers' and 'assured' for 'reassured', the clause made sense in the context of reinsurance;
   - the clause did not contradict any of the express terms of the contract. It was not in some other respect inapposite;
   - in the case of a misrepresentation, the reinsurers could rely on the rights of subrogation to argue that there had been a breach of good faith in relation to the collateral agreement, so it did not inappropriately restrict them.
   - finally, although the clause was unusual in English insurance practice, it

was not unique; information was available on the clause; and it was desirable that all insurers subscribing on the same slip should contract on the same claims.

On balance, it was fair in all the circumstances to incorporate the clause.

7. Finally, Steel J considered the effect of the incorporation of the clause in the reinsurance contract. He considered that the incorporation clearly did not render reinsurers liable to follow settlements made by HIH where a defence was available to HIH. Steel J concluded that the parties intended to exclude the consequences of inadvertent concealment or misrepresentation by the insured.

Having determined these preliminary issues, Steel J reserved judgment on the claim as a whole until further submissions had been heard.

This case illustrates the principles applicable to establishing the terms of a contract of insurance, and the regard which may be had to the slip in ascertaining those terms. While, in general, a slip will be superseded by subsequent policy wording, this case illustrates how a slip may be used as an aid in construing the terms of the policy. The case also illustrates the principles applicable to ascertaining which terms are incorporated into contracts of reinsurance.

When can a reinsurer validly refuse approval of the cedent's inwards settlement?

Case Name:

Gan Insurance Co Ltd v Tai Ping Insurance Co Ltd

Citation:

[2001] EWCA Civ 1047, Court of Appeal (Civil Division) per Mance, Latham LJJ, Sir Christopher Staughton.

Date of Judgment:

3 July 2001

Issues:

- reinsurance
- construction of Claims Co-operation Clause
- whether an objective test should be implied as to the reasonableness of a reinsurer withholding consent to a settlement by the cedent
- Contra Proferentem in the London market

The facts

Tai Ping Insurance Company Ltd ***(Tai Ping)*** had a reinsurance policy with Gan Insurance Company Ltd ***(Gan)***. Gan, for its 2% line, and another reinsurer, Eagle Star, for a further 2%, underwrote the reinsurance in slip form. The claims co-operation clause ***(CCC)*** in the reinsurance contract provided as follows:

> Notwithstanding anything contained in the reinsurance agreement and/or policy wording to the contrary, it is a condition precedent to any liability under this policy that: …
>
> (c) No settlement and/or compromise shall be made and liability admitted without the prior approval of reinsurers…

The reinsurance was part of a line of 35% underwritten by Tai Ping on an erection all risks and third party liability insurance taken out by Winbond Insurance Corporation ***(Winbond)*** to cover machinery whilst in the process of erection, installation and commissioning in a building called Fab 3 at a science park in Taiwan.

A fire occurred in Fab 3, damaging the machinery during the process of its erection, installation and commissioning. Winbond pursued a claim on its policy. Tai Ping claimed to avoid the original insurance for misrepresentation and Winbond reacted by commencing proceedings against Tai Ping. Subsequent negotiations led to a settlement or compromise in writing on 30 July 1997. Gan then commenced proceedings against Tai Ping seeking a declaration of non-liability on the grounds that Tai Ping failed to co-operate in the investigation and assessment of loss and agreed a settlement of Winbond's claim and admitted policy liability without Gan's approval, contrary to the CCC.

The issues on appeal were:

1. whether, as a matter of construction, compliance by the reinsured with the CCC of the reinsurance contract was a condition precedent to the reinsurer's liability under that contract;
2. whether, as a matter of construction, a breach of sub-section (c) of the CCC was only established by showing that the reinsured both settled the insured's claim <u>and</u> admitted liability;
3. Whether a term could be implied into the slip policy that reinsurers may not withhold approval of a settlement unless there are <u>reasonable grounds</u> for withholding approval; and
4. Contra-Proferentem in the London insurance and reinsurance market

The Decision

The decision of the majority was as follows:

Condition precedent to liability

Compliance with the claims co-operation clause is a condition precedent to any form of policy liability by the reinsurer.

Breach of sub-section (c) of CCC

A breach of sub-clause (c) of the CCC was established on proof *either* that the reinsured settled and/or compromised the insured's claim, or the reinsured admitted liability.

Implied term regarding approvals to settlements

The Court considered that it was not appropriate to imply a term that reinsurers may not withhold approval of a settlement unless there are reasonable grounds for withholding approval. Gan alone had the right to withhold approval of payment of the claim by Tai Ping. The parties could not be taken to have agreed that the court could substitute its own judgment for that of the reinsurer.

Mance LJ (with whom Latham LJ agreed on this point) did accept, however, as a general qualification of the reinsurer's right to withhold approval, that any withholding of approval should take place in good faith after consideration of the facts giving rise to the particular claim, and not with reference to considerations wholly extraneous to the subject-matter of the particular reinsurance, or arbitrarily. This qualification does not arise from any principles or considerations special to the law of insurance; rather, it arises from the nature and purpose of the relevant contractual provisions. The right to withhold approval, provided for the protection of the reinsurer, must be exercised in good faith and in a businesslike manner.

Furthermore the reinsurer must, in exercising its role under the CCC, view the original claim objectively and as a whole. Just as it would be wrong for insurers to settle a claim without regard to its merits, as the burden would fall on their reinsurers, so it would be wrong for reinsurers to insist on a claim being fought regardless of its merits. This is in view of the common interest to which both reinsurers and reinsureds must be taken to have subscribed, that is, to resolve whether there should be a settlement, compromise or admission in respect of the original claim, viewing that as a whole.

Although Mance LJ therefore refused to introduce an implied term that the consent of the reinsurer cannot be unreasonably withheld, he did consider a range of examples where the refusal of the reinsurer might be in bad faith. The examples occurred in relation to a refusal of approval, not for any reason connected with the merits of the claim, but as part of an attempt:

- to influence the reinsured's attitude in an entirely separate reinsurance contract; or
- to harm the reinsured as a competitor in respect of other business; or
- to harm the reinsured in the eyes of a local regulator; or
- to prolong payment of claims for as long as possible, however obvious it might be that they would have to be met in full.

Contra proferentem

While not a central issue to the case, Mance LJ did make some remarks in relation to the principle of contra proferentem in the London market. This is the rule whereby ambiguous wordings are construed against the person who puts forward the clause for inclusion in the contract. In Mance LJ's view, there was no genuine ambiguity in this case. Mance LJ observed that there is a view that, where there is a genuine ambiguity in a London market wording, it should be construed as against the insured (or reinsured as the case may be). This is because brokers ordinarily put together the wordings for Underwriters to accept, often some time after agreement has been reached on the slip and since the broker is the agent of the insured and the insured is therefore the person "who puts forward the clause".

Contrary to this view, Mance LJ commented as follows:

... clauses such as the claims co-operation clause are standard clauses, used in a range of reinsurances, where one might expect them to receive a uniform construction whoever proposed them.

Mance LJ considered that the manner in which a particular clause is negotiated and settled upon may be different in each case but a *"standard clause"* in the market which is ambiguous should not be construed against the person proposing that wording.

This case provides useful guidance on the limits of judicial intervention, where a reinsurer refuses to indemnify on the basis of the reinsured's failure to comply with a claims co-operation clause. The reversal of the decision of Longmore J, to the effect that there is an implied term preventing the reinsurer from unreasonably withholding its consent to any settlement, will provide some relief to reinsurers and reinforces the importance of reinsured's obtaining appropriate consents before proceeding with any settlement.

Can a statutory demand be served on a recalcitrant insurer or reinsurer?

Case Name:

Odyssey Re (Bermuda) Limited (Company No. 161930) v Reinsurance Australia Corporation Limited

Citation:

Unreported, Supreme Court of New South Wales per Windeyer J

Date of Judgment:

12 April 2001

Issues:

- reinsurance
- s459E CorporationsLaw
- is a claim under a reinsurance policy a "debt"?

Windeyer J held that a statutory demand could not be served on a reinsurance company because a claim under a reinsurance policy is not a claim for a "debt".

The facts

Section 459E of the CL, which sets out the procedure for serving a statutory demand, can only be used for "debts". An important issue, given the current solvency problems of many insurers and reinsurers, is whether the statutory demand procedure can be used if an insurer or reinsurer fails to pay a claim.

The proceedings before Windeyer J concerned a reinsurance claim that arose out of an earthquake in Turkey in 1999.

A number of cases have held that a claim under an insurance contract is a claim for "unliquidated damages" and is therefore not a claim for a "debt". On this basis, a claim under an insurance policy can never be the subject of a statutory demand.

Odyssey Re argued that these earlier cases concerned claims under property insurance policies, and that a claim for a fixed sum under a reinsurance policy should be treated differently. Windeyer J declined to make this distinction. This was in spite of the fact that the reinsurance policy contained a fairly standard "follow the settlements" clause which provided that amounts falling to the share of the reinsurers shall be payable by them upon reasonable evidence of the amount paid by the reinsured. Windeyer J, having reviewed the authorities, concluded that the reinsured's claim was in the nature of a claim in contract for unliquidated damages rather than a claim for a debt due.

Windeyer J expressly noted, however, that "*any decision that the word debt in section 459E of the Corporations Law should be interpreted so as to encompass the claim in question here would need to be made by a higher court…*".

The proceedings in this case settled before the appeal could be heard. Until an appellate court rules on this issue there will remain some uncertainty as to whether claims under insurance and/or reinsurance policies can ever be the subject of statutory demands. The judgment of Windeyer J contains a useful review of the authorities on the nature of a claim for indemnity. His analysis that such claims will rarely, if ever, constitute a debt due. Accordingly, they will rarely be capable of forming the basis of a statutory demand for the purpose of winding up proceedings.

Broker not negligent for failure to insure a real estate agent's accounts receivable

Case Name:

Brooklyn Lane Pty Ltd v MIC Australia Pty Ltd

Citation:

(2001) 11 ANZ Insurance Cases 61-487 (Supreme Court of Victoria per Balmford J)

Date of Judgment:

21 February 2001

Issues:

- broker's duty of care
- failure to insure accounts receivable of real estate agent

The facts

The plaintiff real estate business sued its insurance broker, claiming breach of contract, or alternatively breach of the broker's duty of care in tort, arising out of an alleged failure to insure the plaintiff's accounts receivable.

On 7 June 1995 the plaintiff's premises were destroyed by fire. The insurer denied liability but in an earlier proceeding settled with the plaintiff for an amount of $225,000.

The plaintiff claimed as its loss the difference between the amount recovered from the insurer and the amount which it claimed would have been recovered if the broker had procured a policy of insurance in accordance with the alleged terms of its retainer.

The central issue in the case was whether the broker was liable because the plaintiff's business interruption policy did not cover loss of accounts receivable.

In discussing the broker's duty of care, Balmford J cited *Marvin Manufacturers (Aust) Pty Ltd v Chamber of Manufacturers Insurance Ltd* (1992) ANZ Insurance Cases 61-122 (VSC, Vincent J) as authority for the proposition that a broker cannot be regarded as burdened with a general duty to ensure that their client is impervious to loss or risk of loss through the absence of insurance. On this authority, the broker is not necessarily obliged to explain in detail the effect of each term of a contract of insurance. In summary, a broker's duty has to be viewed in a sensible and practical way.

In the present case, Balmford J found that the plaintiff did not at any time give instructions to the broker to procure cover for loss of accounts receivable. Balmford J also took into account that the plaintiff's general manager was an experienced business person with well-developed capacities to identify and act in his own interests. In the result, the plaintiff's claim was dismissed.

In deciding against the plaintiff, Balmford J accepted the broker's evidence that insurance of accounts receivable is regarded in the insurance industry as inappropriate for a real estate business.

> This case shows that courts may take account of an insured's own commercial experience when deciding brokers' and insureds' responsibilities in securing appropriate cover.
> The case also illustrates that well-accepted insurance products which are customarily adopted for specific industries or businesses may be appropriate cover for a broker to obtain for their client. However, this would only be appropriate in the absence of any specific requirements conveyed by the insured.

When may a broker be liable for more than the additional cover which would have been obtained but for the broker's negligence?

Case Name:

Aneco Reinsurance Underwriting Limited (In Liquidation) v Johnson & Higgins Limited

Citation:

[2001] UKHL 51, UK House of Lords per Slynn, Browne-Wilkinson, Lloyd, Steyn and Millett LJJ

Date of Judgment:

18 October 2001

Issues:

- broker's duty of care
- breach of duty
- assessment of insurer's loss

In our annual review of Insurance Law 2000 (see page 62), we reported on the English Court of Appeal's decision in this case. The House of Lords has now affirmed that decision.

The facts

In this case a reinsurance company, Aneco, only agreed to participate in a reinsurance placement on the condition that the broker, Johnson & Higgins ***(J&H)***, would first obtain retrocessional cover which was acceptable to Aneco. J&H duly did this although it later became apparent that the retrocessional cover had been obtained by a misrepresentation and that contract was later ruled to be void ab initio (both at arbitration and at first instance).

The reinsurance treaty that Aneco wrote gave rise to considerable losses for Aneco. At first instance it was held by Cresswell J that Aneco could only recover the amount of excess of loss retrocessional cover they would have had in place but for J&H's negligent placement (i.e. US$11m). It followed in Cresswell J's judgment that Aneco was unable to recover its own exposure over and above the excess of loss retrocessional treaty (which totalled a further US$24m).

The decision

On appeal in 1999, the decision was reversed. Having regard particularly to the fact that the brokers had acted in an advisory capacity in setting up the whole facility, Evans LJ (giving the majority judgment) held that Aneco could recover the full extent of their losses (i.e. US$35m).

Adopting essentially the same reasoning, the House of Lords have affirmed the decision of the Court of Appeal. As reported on page 64 of our Annual Review of Insurance Law 2000, this decision is likely to be followed in Australia if similar facts arose.

> This case sounds a warning for brokers who undertake an advisory role in relation to the whole of the placement. Where such a role is not intended to be undertaken, brokers would be well advised to review the terms of their retainer to ensure that is made clear to the insured.

No duty of care owed by a public authority for negligent misstatement

Case Name:

Tepko Pty Ltd v Water Board

Citation:

[2001] HCA 19; High Court of Australia per Gleeson CJ, Gummons, Hayne, Gaudron, Kirby, Callinan, McHugh JJ

Date of Judgment:

Issues:

- duty of care
- public authority
- negligent mis-statement

In this case, a majority of the High Court affirmed that the Water Board did not owe a duty of care to a developer to state accurately the likely cost of the provision of water to a planned subdivision.

The facts

Tepko sought to re-zone and subdivide land. It obtained approval from Penrith and Liverpool Councils, subject to the Board's agreement to supply water to the land. The Board subsequently agreed to provide the water to the land, subject to Tepko paying all connection costs. In order to comply with the requirements of its financier, Tepko asked the Board to provide a cost estimate for the water connection. The Board refused to provide a cost estimate as it was against its policy to do so, but the immediate cost for the connection was later included in a memorandum given to the Minister for Natural Resources. This cost was subsequently conveyed to Tepko. The figure turned out to be over-stated, and Tepko's financier, having been led to believe that the cost would be much smaller, exercised its power of sale over the land.

Tepko bought an action for negligence against the Board. At first instance, the Supreme Court in NSW found in favour of the Board, holding that it owed Tepko no duty of care. The Court of Appeal dismissed an appeal. Tepko then sought and obtained leave to appeal to the High Court on the issue of whether or not the Board owed Tepko a duty of care. It was accepted that the original estimate given by Tepko was negligent.

The decision

A majority of 4:3 of the High Court Justices dismissed the appeal. All 7 judges agreed that the relevant principles to be applied arose from the High Court's judgment in *Mutual Life and Citizens' Assurance Co. Ltd v Evatt* [1968] 122 CLR 556. Firstly, before the law will impose a duty of care in utterance by way of information or advice, 'the speaker must realise or the circumstances be such that he ought to have realised that the recipient intends to act upon the information or advice in respect to his property or of himself in connection with some matter of business or serious consequence'. Secondly, the circumstances must be such that it is reasonable, in all the circumstances, for the recipient to seek, or to accept, and to rely upon the utterance of the speaker'.

On the first point, the majority emphasised that no duty should be imposed on a party who has no appreciation of the implications of making an error. Here, Tepko did not inform the Board of the 'critical state' of its relationship with its financier until it was too late. Gaudron J held that it is not essential that the person making

the statement know the precise views to which the information will be put, so long as he or she knows or ought to know that it will be used for a serious purpose. In this case, the Board neither knew nor should have known that Tepko intended to act upon that costs estimate for a serious purpose. The Court found that the Board's knowledge of Tepko's financial position was limited, and it was clearly only providing immediate cost estimate.

On the second point, the majority stated that the circumstances were not such as to make it reasonable for Tepko representatives to rely on the 'ball-park' figure provided by the Board to meet the financier's demand for a cost estimate. The relationship between the Board and Tepko was one in which the Board was a 'reluctant participant', and Tepko had access to expert advice. The Board was not obliged to give cost estimates and nor was it its practice to do so. Combined with the provisional nature of the estimate, these circumstances made it unreasonable to impose a duty on the Board.

A minority of three Justices held that the Board owed Tepko a duty of care as Tepko had to deal with the Board to obtain the cost estimate, the Board had a monopoly on the information and a superior capacity to provide reliable advice. The minority considered that developers would naturally look to the Board for information concerning the cost of water supply, and Tepko trusted the Board to make the estimate. Moreover, the dealings between the parties related to a serious matter of business for Tepko. The Board knew or ought to have known of all these matters, and its lack of precise knowledge or foresight as to the use of the information provided no answer to the existence of a duty of care. When it provided the estimate in these circumstances, it owed a duty of care to do so accurately.

This case illustrates the uncertainty in the law on the question of the imposition of a duty of care for negligent misstatement. Each case must turn on its own facts, but judges may differ on whether those facts may give rise to a duty of care. A reasonable appreciation of the purpose for which the statement is to be relied upon is central to the imposition of a duty of care.

Nervous shock: where son goes missing in desert

Case Name:

Annetts v Australian Stations Pty Limited

Citation:

[2000 WASCA 357; Supreme Court of Western Australia – Full Court per Malcolm CJ, Pidgeon and Ipp JJ

Date of Judgment:

21 November 2001

Issues:

- duty of care
- psychiatric illness

Allens Arthur Robinson

This case reinforces the general rule that liability for psychiatric injuries suffered by plaintiffs exposed to traumatic events are limited to circumstances where the claimant is present at the scene of the accident or its immediate aftermath.

The facts

James, the 16-year-old son of the Annetts, went to work as a jackeroo at a cattle station owned by the Respondents. The Annetts were assured that their son would be under constant supervision and generally looked after. After a few weeks, the station manager sent James to work alone at another isolated cattle station. A few days later, around 3 December 1986, the Respondents suspected that James Annetts was in great danger of injury or death. On 6 December 1986 the Annetts were informed by telephone that their son was missing and believed to have run away.

Some months later in April 1987 the vehicle driven by James Annetts was found bogged in the Gibson Desert. It appeared he had died as a result of dehydration, exhaustion and hypothermia. Mr Annetts was shown photos of skeletal remains which he identified as his son.

The decision

The Court of Appeal of the Supreme Court of Western Australia dismissed the appeal unanimously. Ipp J delivered the leading judgment. He reiterated that before a duty of care could be imposed for nervous shock, it must be reasonably foreseeable that:

1. A plaintiff, assumed to be of *"normal fortitude"* and exhibiting normal standards of susceptibility, would develop the psychiatric illness.
2. A breach of duty of care might result in a "sudden sensory perception", both physically and temporally, by the plaintiff, of an event so distressing that they would suffer a recognisable psychiatric illness.

On both these accounts the Court of Appeal rejected the imposition of any duty of care on the Respondents in this case.

It was not reasonably foreseeable that a parent of normal fortitude might sustain a psychiatric injury from the mere fact of the death of a child. The grief of losing a loved one was an ordinary incident in life in a different class of harm to a medically recognised psychiatric injury.

Nor did the appellants satisfy the requirement of physical proximity "in the sense of space and time". A duty would not exist where the psychiatric injury arises away from the scene of the accident or its aftermath. The telephone call in December

1986 failed to meet this physical requirement and the event of April 1997 some months after could not be regarded as a "sudden sensory perception of a distressing phenomenon". The appellant must, by then, have come to appreciate the probability of his son's death.

This case reinforces the status quo in respect to the requisite duty of care for claimants of psychiatric injury. However, the subsequent decision in Hancock v Wallace by the Supreme Court of Queensland has created uncertainty in this area of the law. An appeal to the High Court is pending on this decision and awaits further clarification. In New South Wales, spouses of persons killed, injured or put in peril have a statutory right to claim for mental or nervous shock under s4 of the Law Reform (Miscellaneous Provisions) Act 1944. This case nevertheless has significant implications in New South Wales where claims are made by persons other than parents or spouses.

Case Name:

Hancock v Wallace

Citation:

[2001] QCA 227; Supreme Court of Queensland – Court of Appeal per McMurdo P, Davies JA and Byrne J

Date of Judgment:

8 June 2001

Issues:

- duty of care
- psychiatric illness

This case breaks new ground in increasing the exposure of defendants to claims of psychiatric injury where the plaintiff is not immediately present at the scene of an accident or its aftermath but reported of the event by some other means such as a telephone call some time after.

The facts

The respondent's son was killed in a motor vehicle accident on the night of 28 May 1995. The body was decapitated and identifiable only by means of dental records. The respondent was informed of the news at 9.30am the next morning by a relative over the telephone. Through the course of the day it was uncertain whether the son of the respondent or the driver of the vehicle was killed. At 2.00pm that day, it was confirmed by telephone that it was the respondent's son who had died.

The respondent sought and obtained an award for damages which included $40,000 for nervous shock. The Nominal Defendant appealed against that award.

The decision

The Court unanimously dismissed the appeal. Davies JA wrote the leading judgment and rejected the necessity for the causal requirement of 'sudden sensory perception' for psychiatric injury which comprised the two elements of temporal proximity, that is, a sudden assault on the senses, and geographical proximity, namely, a direct perception of the event or its aftermath.

Where there are close ties between the parties and the person harmed there was "no logical medical basis" for any distinction between a psychiatric injury caused by merely being told of the accident, or actually being present the scene of the accident or its aftermath.

The decisive factors here were:

- what was said to the respondent during the course of the day after the son was killed;
- the nature of the relationship between the respondent and his son; and
- medical evidence of the effect which the information had on the respondent.

A liability could be said to extend to these facts as there was an overriding "very close relationship" between the deceased and the victim of the tort.

This case significantly expands the scope of liability at common law towards sufferers of a psychiatric condition caused by the injury or death of someone close. The Supreme Court of Queensland had the benefit of the Annetts decision before it and came to the opposite conclusion. There is already legislative provision for parents and spouses in New South Wales, the Australian Territory and the Northern Territory. This decision takes the common law beyond that to apply to any "very close relationship". Consequently, the common law in this area is uncertain and awaits the outcome of the Annetts appeal before the High Court.

Case Name:

Lepore v New South Wales

Citation:

[2001] NSW CA 112

Date of Judgment:

23 April 2001

Issues:

- "non-delegable" duty of care
- school as custodian of children
- intentional abuse by teacher

The New South Wales Court of Appeal has held by a majority of 2:1 that a school authority owes a non-delegable duty of care to school pupils and employees in respect of the intentional tortious conduct of its employees.

The facts

The appellant, when aged seven or eight, had been sexually assaulted by a teacher at a State primary school. Whenever the appellant misbehaved, he was sent to a store room where his teacher instructed him to undress. On occasions, the appellant was sexually assaulted or smacked on the bare bottom with a ruler by the teacher, sometimes in the presence of other children.

The appellant commenced civil proceedings against the State of NSW (the ***State***) and the former teacher (the ***teacher***). The teacher had pleaded guilty to common assault in 1978 and chose to absent himself from the trial. The trial proceeded on the issue of liability only. The trial judge found that there had been no negligence on the part of departmental employees such as the headmistress or inspectors, none of whom had any reason to suspect the teacher of the acts alleged. On appeal, the appellant claimed that the trial judge failed to address the issue of the breach of the non-delegable duty of care by the school authority.

The issue

On the appeal, it was not contended by the appellant that the State was vicariously liable for the acts of the teacher. Rather, the appellant claimed that the State owed a non-delegable duty of care to the appellant which meant that it was legally responsible for the wrongful acts of the teacher, even though the teacher's misconduct was intentional (as opposed to negligent) and outside the course of his employment. The imposition of a "non-delegable duty of care" is in effect the imposition of strict liability on the defendant who owes that duty. The basis of the imposition of such a duty in the case of school authorities and school pupils is the degree of control assumed by the school during school hours and the need for care and supervision inherent in children. Mason P noted that the duty was similar to a contractual promise.

The decision

A majority of the Court took the view that the State's obligations to school pupils on school premises during school hours extends to ensuring that they are not injured, physically, at the hands of an employed teacher (whether acting negligently or intentionally) and whether or not in the course of his or her employment. The appellant was owed a non-delegable duty of care by the school authority, which stemmed from the entrustment of children into the exclusive care

of the school authority on school premises during school hours. The majority also referred to this duty being owed to employees in addition to school pupils but distinguished tortious injuries suffered by pupils at the hands of fellow-pupils.

Heydon JA delivered a dissenting judgment in which he rejected the proposition that a school authority owed a non-delegable duty of care. He also questioned whether, even if such duty was owed, it would be breached if a teacher, unbeknownst to the principal, committed sexual batteries in flagrant breach of his contract of employment.

This case, if followed, means that authorities responsible for teachers and others having the charge of children have an unprecedented form of strict liability for the conduct of their employees and agents (including teachers). A decision of the High Court may be required to give guidance on how far such a duty can extend.

Section 52 and causation: where a loss has multiple causes

Case Name:

Henville v Walker

Citation:

[2001] HCA 52 High Court of Australia per Gleeson CJ, Gaudron, McHugh, Gummow and Hayne JJ

Date of Judgment:

6 September 2001

Issues:

- s52 Trade Practices Act misleading and deceptive conduct
- causation
- quantification of damages

The facts

Henville was interested in purchasing properties for the development of residential units in Albany. Walker, a real estate agent, showed Henville certain properties and made representations regarding the state of the Albany market, in particular, the high demand for luxury units.

In June 1995, Walker showed Henville a property at 36 View Street, Albany and stated that it would be preferable to build three, larger, high-quality units on the property, rather than the maximum four, and that such units would sell for between $250,000 and $280,000. Henville made an offer of $190,000 for the property.

Henville then undertook a feasibility study to assess the profitability of the project, relying on his own expertise in estimating the costs and Walker's advice regarding the likely selling prices. On the basis of this study, Henville decided to go ahead with the development. The costs were substantially under-estimated, the selling prices substantially over-estimated and the project suffered various unrelated delays and setbacks.

The units were finally sold in June 1997 one for $175,000 and the other two for $185,000 each, at a substantial loss to Henville. Henville subsequently brought proceedings against Walker for misleading and deceptive conduct, in contravention of s 52 of the Act, and sought to recover his losses under s 82(1).

The decision of the High Court

The High Court unanimously found in favour of Henville, holding that Walker's representations regarding the units' likely selling prices were misleading. The main issue on appeal was the amount of damages to which Henville was entitled, in light of the fact that his own under-estimation of the project's costs contributed to the loss suffered.

Causation under s82

The only express guidance given by the legislation in relation to the causal connection required to trigger liability under s82 is that the loss must be suffered *by* contravening conduct of another person. In this case, the feasibility study was based on two factors: the cost of the project; and the likely selling price of the units. The High Court held that if either had been estimated with reasonable accuracy, the project would not have proceeded. Therefore, neither factor was the sole cause of Henville's decision to undertake the project.

The High Court considered that conduct will legally cause damage if it materially contributes to the damage, irrespective of whether the conduct alone was sufficient

to bring about the damage. Two or more causes may jointly influence a person. The fact that the making of the representation induced a person to act in a certain manner, resulting in loss or damage from the act means that act is a link, not a break, in the chain of causation.

McHugh J delivered a lengthy judgment which emphasised the public policy consideration which often lie behind questions of causation. He stated that the function of causation is to determine whether a person "should" be held responsible for some past act or omission – whether some breach of a legal norm is so significant that as a matter of common sense, it should be regarded as a cause of the damage. In this context, the fact that the representation was intended to induce the very act which it did induce was significant.

Quantification of damages under s82

The High Court held that there is no ground for reading into s82 doctrines of contributory negligence and apportionment of damages see, for example, [2001] HCA 52 at 140 (McHugh J) and 66 (Gaudron J). McHugh, Hayne and Gummow JJ held that if Henville had asked, he would have been entitled to damages for his actual loss of approximately $320,000 and not just the $205,000 identified in the appeal papers.

The Court held that the trial judge's refusal to treat the whole of the loss as related to Walker's misrepresentations was justified. However, it would unduly burden the plaintiff to prove which component of the loss was referable to the contravening conduct and such a finding would impose a gloss on the legislation to confine recoverable loss to that which is directly attributable to the conduct.

Gaudron and McHugh JJ considered that once the plaintiff had established the requisite causal connection, the defendant must bear the burden of establishing why the plaintiff must not recover its total loss. By contrast, Gleeson CJ would not support a decision whereby Walker would be required to underwrite all of Henville's losses, regardless of how they were incurred.

Apportionment under s87

No reliance was placed by either side on s87(1) of the Act, which permits ancillary or additional compensation for part of the loss or damage suffered by a victim of a s 52 contravention. It was held in *I & L Securities v HTW Valuers (**I&L Securities**)*(2000)179 ALR 89 (reported in our 2000 Annual Review), that damages awarded under s 87 could be reduced in cases where the plaintiff is partly at fault. This decision effectively establishes a defence of contributory negligence under the Act. The trial judge's approach in compensating Henville at first instance only for those losses attributable to Walker's conduct may have been more successful if the legal basis for that award had been s87 as opposed to s82 TPA. However, I & L Securities has been granted special leave to appeal to the High Court. The use of s87 as a means for apportioning damages in cases of contributory negligence may soon be reconsidered.

The decision in Henville v Walker confirms that liability for misleading and deceptive conduct can arise even where the relevant conduct did not directly cause the damage. Supervening events will not necessarily break the chain of causation. The decision also illustrates the policy considerations which underlie questions of causation. The effect of the decision is likely to be to increase insurers' exposure regarding their coverage of misleading and deceptive conduct. Insureds and their brokers might well expect a more detailed set of enquiries during the negotiations for renewal of a new policy about risk management of potentially misleading conduct.

Settlement with one joint tortfeasor did not preclude claim being pursued against another

Case Name:

Baxter v Obacelo Pty Limited

Citation:

[2001] HCA 66; High Court of Australia per Gleeson CJ, Gummow, Kirby, Hayne and Callinan JJ.

Date of Judgment:

15 November 2001.

Issues:

- settlements
- joint tortfeasors
- assessment of damages

The High Court has confirmed that where there are multiple joint tortfeasors in a proceeding in respect to the same damage, a partial settlement with one defendant does not bar the plaintiff from maintaining the action against the other defendants to recover the balance of the damages claimed.

The facts

Obacelo Pty Ltd ***(Obacelo)*** brought proceedings against Whitehead, a partner of a law firm, and his employed solicitor Baxter, for losses totalling over $430,000 incurred as a result of alleged negligent work performed by Baxter in relation to a conveyancing transaction.

In due course, Whitehead and Obacelo reached an agreement to settle and executed a deed of release for a sum of $250,000 inclusive of costs on the proviso that an amended Statement of Claim which maintained claims against Baxter and Terms of Settlement be filed at Court. All claims against Whitehead were dropped.

Some years later, Baxter applied for a summary dismissal of the case against him on the grounds that the settlement with Whitehead fully satisfied the entire claim the plaintiff had against him and any further claim against him was futile. This was unsuccessful. An appeal to the Supreme Court of New South Wales Court of Appeal was subsequently dismissed. Undaunted, Baxter then appealed to the High Court.

The findings

The High Court dismissed the appeal unanimously. It took the view that s5(1)(b) of the *Law Reform (Miscellaneous Provisions Act 1946* (NSW), which provided that, where there were multiple judgments, they could not "in the aggregate exceed the amount of the damages awarded by the judgment first given", was inapplicable to this situation. That provision dealt with multiple proceedings, as opposed to multiple tortfeasors in a single proceeding.

The second argument posed by Baxter was that to allow Obacelo to recover further sums of damages against him was to infringe the rule against "double satisfaction" which prevents plaintiffs recovering more than their actual loss.

The Court dismissed this proposition, and held:

- The release given by Obacelo did not have the effect of releasing its cause of action against Baxter as the other joint tortfeasor. On the contrary, it actually served to sever the unity of the cause of action against Baxter and Whitehead as joint tortfeasors.
- "Double satisfaction" of the plaintiff's claim does not arise since Obacelo accepted that in any damages awarded against Baxter credit would have to be

given for the recovery of the settlement sum.

- Partial satisfaction of losses by a judgment against a joint tortfeasor merely reduces the amount recoverable in any action that continues on foot against the other tortfeasors in that same proceeding.

This finding is not limited to judgments entered in court pursuant to formal assessment or settlements resulting in consent judgments, but to settlements more generally (e.g. "Tomlin orders" where agreements are made without the entry of a judgment).

There will have to be some clear intention (express or implied) between the parties to the settlement that the settlement sum was paid and received "in full satisfaction of the rights of the plaintiff against the defendant or anyone else, in relation to the loss or damage incurred" before courts will be prepared to prevent claims continuing against joint tortfeasors. The courts would not readily assume this. The decision accords with common sense and shows that the courts are loath to discourage settlements. Nevertheless, plaintiffs wishing to reserve their rights against other joint tortfeasors should expressly stipulate the reservation to avoid any potential argument. It is also important for defendants in those circumstances to obtain an appropriate indemnity for the plaintiff to cover a possible claim for contribution by the parties.

Liability of highway authorities for failing to act

Case Name:

Brodie & Anor v Singleton Shire Council

Citation:

[2001] HCA 29 High Court of Australia per Gleeson CJ, Gaudron, McHugh, Gummow, Kirby, Hayne and Callinan JJ

Date of Judgment:

31 May 2001

Issues:

- duty of care of highway authorities
- immunity of highway authorities for non-feasance under the "highway rule"

The High Court of Australia was asked to overrule the principle that a highway authority has an "immunity" from liability in relation to non-feasance in respect of the exercise of its power. The case was heard together with Ghantous v Hawkesbury Shire Council [2001] HCA 29 (see below).

The facts

In August 1992, Mr Brodie (the first applicant) drove a truck owned by the second applicant onto a bridge that had been constructed approximately 50 years earlier within the Singleton Shire (the respondent Council's locality). The bridge was designed to bear a load of 15 tonnes. The truck weighed 22 tonnes. Shortly before crossing the bridge, the applicant had driven the truck safely across another bridge on the same road, which had been signposted as having a capacity of 15 tonnes. When the applicant drove the truck across the second bridge, the timber girders failed, the bridge collapsed and the truck fell onto the creek bed below. The second applicant's truck was damaged and the first applicant suffered injuries, particularly to his back.

The Local Government Act 1919 (NSW) gave the respondent Council the power to *construct, improve, maintain, protect, repair, drain and cleanse every public road* (s240). It also gave the Council the *care, control and management of every public road* in the Shire (s249). The applicants claimed that the accident was caused by the negligence of the respondent Council in failing to repair and maintain the bridge.

At trial in the District Court, the case was held to be one of misfeasance by the respondent Council, in failing to properly repair the bridge when the Council, sometime prior to the incident, had undertaken repairs. Both applicants were awarded damages. The first applicant recovered approximately $350,000 and the second applicant recovered approximately $40,000. An appeal by the Council to the New South Wales Court of Appeal (Handley, Powell and Giles JJA) was successful. In the appeal, it was held that the case was properly characterised as one of non-feasance, as the failure of the timber girders was not related to the previous repairs undertaken by the Council, which were only to the planks on the top of the bridge, but was simply due to the lack of any maintenance of the girders whatever. This meant that the "highway rule" applied and the Council was therefore immune from liability. The applicants obtained special leave to appeal to the High Court.

The "highway rule"

Briefly stated, the *highway rule* provides that although a highway authority may incur civil liability for a negligent act of misfeasance, it incurs no civil liability in

relation to any non-feasance (i.e.failure to act), such as any neglect on its part to construct, repair or maintain a road or highway. This rule is sometimes described as a rule of *immunity*.

The decision

In this decision the High Court split 4:3 on the question of whether the respondent Council was negligent in the exercise of its duty. Gaudron, Gummow and McHugh JJ in a joint judgment and Kirby J, in a separate judgment, each found in favour of the applicants.

In their joint judgment Gaudron, Gummow and McHugh JJ came to the following conclusions:

In cases such as those giving rise to the present applications, the liability of the respondents does not turn upon the application of an "immunity" provided by the "highway rule". In so far as Buckle and Gorringe require the contrary and exclude what otherwise would be the operation of the tort of negligence, they should no longer be followed. Further, it is the law of negligence which supplies the criterion of liability in such cases; the tort of public nuisance in highway cases has been subsumed by the law of negligence.

In coming to this decision, they considered a number of factors to be relevant. These factors included that other common law jurisdictions have restricted the application of the *highway rule* and that the rule has been specifically abrogated by statute in the United Kingdom. They also considered that the application of the rule has led to *unprincipled distinctions*, such as the distinction between the highway and other infrastructure, between misfeasance and non-feasance and between road authorities and other statutory authorities. In addition, their Honours pointed out that the present state of the cases respecting the *highway rule* in Australia *neither promotes the predictability of judicial decision nor facilitates the giving of advice to settle or avoid litigation*. Finally, their Honours noted that the application of the *highway rule* leads to the absurd position that although a highway authority will escape liability if it has never attempted to repair a road or bridge, it may incur liability if it does attempt to repair it. This fact provides a strong incentive to a highway authority not to attempt repair of a danger on a roadway.

Ultimately, the majority found that where a highway authority has a statutory power, of the nature conferred by the *Local Government Act 1919* (NSW), to construct or repair roads, such authorities are obliged *to take reasonable care that their exercise or failure to exercise those powers does not create a forseeable risk of harm to a class of persons (road users) which includes the plaintiff*.

Kirby J wrote a separate judgment concurring with the judgment of Gaudron, Gummow and McHugh JJ.

Gleeson CJ, Hayne J and Callinan J each wrote separate dissenting judgments. Gleeson CJ said that the complexity of the issues involved in reforming the law in this area meant that it was the domain of Parliament and not the courts to attempt any such reform. He relied heavily on the fact that the Law Reform Commission of New South Wales had issued a report on the *Liability of Highway Authorities for Non-Repair* (1987) which, although regarding the non-feasance rule as

unsatisfactory, had demonstrated the complexity of the issues and recommended the abolition of the rule only in relation to negligence resulting in personal injury and death and not in relation to property damage.

In his dissenting judgment, Hayne J characterised the question as one of statutory interpretation. He said that the possession of *power* in a statutory authority, coupled with reasonable foresight of harm, should not of itself suffice to oblige the authority to exercise its power. He stated that to impose such a duty to act would depart from what has hitherto been accepted to be the common law, *not only in relation to highway authorities but statutory authorities generally*. Hayne J also found that in failing to observe the warning sign, the first applicant had failed to exercise due care.

Finally, Callinan J in his separate dissenting judgment found that, as a matter of statutory construction, the provisions of the *Local Government Act 1919* (NSW) did not impose any statutory obligation on the Council to keep roads and bridges within the Shire in good repair. He was not prepared to overrule the *highway rule* and, therefore in his view, the Council was not liable for its non-feasance.

The effect of the decision is that "the highway rule" has been abolished, and the liability of a public authority which has power to repair and maintain a highway falls to be determined in accordance with ordinary principles of negligence.

No negligence where pedestrian failed to keep a proper lookout

Case Name:

Ghantous v Hawkesbury City Council

Citation:

[2001] HCA 29 High Court of Australia per Gleeson CJ, Gaudron, McHugh, Gummow, Kirby, Hayne and Callinan JJ

Date of Judgment:

31 May 2001

Issues:

- duty of care of highway authorities
- immunity of highway authorities for non-feasance under the "highway rule"

This case was heard together with Brodie & Anor v Singleton Shire Council (see above) and raises similar issues.

The facts

In July 1990, Catherine Ghantous (the applicant) fell after stepping from a concrete footpath onto an earthen verge in a street in Windsor in New South Wales. On either side of the concrete footpath, traffic, wind and water had eroded the turf so that the earth and surface had subsided to a level of about 50mm below the level of the concrete strip. To allow two approaching women to pass, Ms Ghantous stepped to her right. She fell when her foot landed partly on the concrete strip and partly on the edge of the concrete over-hanging the lower earth surface. She suffered injuries in the fall and claimed damages in the District Court of New South Wales.

A footpath had first been constructed in the location of the one in question approximately 40 years earlier. No complaint had been made about the state of the footpath or of the concrete strip and verges which replaced it. In 1984 Hawkesbury City Council (the respondent), in whose local government area Windsor is situated, constructed a pedestrian mall just around the corner from the location of the applicant's fall.

At trial, the applicant also sued the architects and landscape designers who were responsible for the design of the mall as well as the respondent Council. It was argued that all three parties were negligent in failing to ensure that the design and construction of the mall were not such as to cause soil erosion of the kind that had occurred. It was argued that construction of the mall had led to increased pedestrian use of the area in question and to increased storm water run-off from the mall so as to cause erosion of the verge of the footpath where the applicant fell. The case against the architect and the landscape designer at the trial was shown to be unsustainable and judgment was entered for those defendants. However, the applicant submitted at the trial (to preserve her rights on appeal) that there was no longer, or there should no longer be, a distinction between non-feasance and mis-feasance in relation to the liability of a highway authority and the respondent Council should be liable for both.

At trial, in relation to the respondent Council, it was held that the case was one of non-feasance. This meant that the action came squarely within the "immunity" of highway authorities from liability and the applicant's action was dismissed. An appeal was dismissed by the New South Wales Court of Appeal (Handley Powell and Giles JJA). The applicant obtained special leave to appeal to the High Court of Australia.

The decision

The members of the High Court unanimously dismissed the appeal. Each of the Judges found that no case of negligence had been made out against the respondent Council. Although there was much discussion in the judgments of the members of the High Court of the "highway rule", this case was ultimately decided on the basis that the respondent Council had not been negligent in any event. The Court emphasised that the difference in height between the footpath and the grass verge was readily observable.

This case demonstrates that, although highway immunity has been abolished, the Courts will not readily infer that breach of duty on the part of the highway authority where an accident could have been averted by reasonable care on the part of the plaintiff. This will often be the case in relation to pedestrians.

Bicycle courier held to be employee not independent contractor

Case Name:

Hollis v Vabu

Citation:

High Court of Australia [2001] HCA 44 per Gleeson CJ, Gaudron, McHugh, Gummow, Kirby, Hayne and Callinan JJ

Date of Judgment:

9 August 2001

Issues:

- "employee" or "independent contractor"
- Vicarious liability for independent contractors.

The High Court held that a courier company was liable for the negligence of a bicycle courier because that courier was its employee. Two judges also considered whether the courier company could have been liable if the bicycle courier had not been an employee.

The facts

There is a considerable amount of law on whether or not a person who does work for another is an "employee". In this case 5 members of the High Court held (McHugh and Callinan J dissenting on this point), contrary to two earlier decisions of the NSW Court of Appeal, that bicycle couriers were employees (rather than independent contractors) of the courier company. The company was therefore vicariously liable for the negligent conduct of a courier.

An important consequence for insurers is that, in considering potential liabilities of a company – either to its employees or to third parties who are injured by employees – the "employees" of a company might be held by the court to extend beyond those who the company says are employees.

A second important aspect of this case was the consideration given as to whether a company could be liable for the negligence of someone who is not an employee.

The traditional approach has been for the courts to distinguish between "employees" and "independent contractors". An employer is liable for negligent acts of the former, but not the latter (unless the independent contractor is performing a "non-delegable duty"). The NSW Court of Appeal adopted this approach and held that the company was not liable for the negligence of the bicycle courier, because the courier was not an employee and there was no non-delegable duty.

As the majority held that the courier was an employee it did not consider this to be an appropriate case to consider whether employers should, in some circumstances, be liable for the negligent acts of independent contractors.

McHugh J asserted, as he has in a number of previous judgments, that there are circumstances in which a company can be liable for the negligence of an independent contractor and that this was such a case. The factors McHugh J considered important were that: the courier in this case was performing a task that the company had agreed to perform; the courier was serving the economic interests of the company (e.g. he had no independent goodwill); the business the courier was performing concerned a risk that the company had introduced into the community; the courier was subject to the company's direction and control; and the courier was acting within the scope of his authority.

McHugh J's views have not, however, received support from any other members of the High Court.

Callinan J was the only judge who would have dismissed the appeal. He held that the couriers were independent contractors rather than employees. He then looked at the established categories of "non-delegable" duties and held that any duties owed a courier company to the public were not of this type. In his view the company was therefore not liable for the negligence of the bicycle courier.

This case demonstrates that the question whether a worker is an employee is a question of substance which require an examination of the working relationships to ascertain how in practice the parties act, and in particular the degree of control exercised over the worker. It is clear the decision embodies public policy considerations. The courts will not permit employers to limit their responsibility merely by defining workers as independent contractors.

Case Name:

Alagic v Callbar Pty Ltd

Citation:

[2000] NTCA 15 per Angel, Thomas & Riley JJ

Date of Judgment:

8 December 2000

Issues:

- occupiers liability
- implied warranty of safety of commercial premises

The Northern Territory Court of Appeal in this case held that an occupier of a hotel makes a broad implied warranty as to the safety of those premises as part of its transactions with its customers.

The facts

In September 1992 Mr Alagic (the appellant) entered the Don Hotel in Darwin with his friend Mr Kantardzic. Callbar Pty Ltd ***(Callbar)*** (the respondent) was the occupier of the hotel.

Mr Kantardzic purchased drinks for himself and Mr Alagic and the pair sat at a table in the hotel to enjoy their beverages. Whilst sitting at this table what was described as a tile fell from the ceiling of the hotel and struck Mr Alagic on the head.

Mr Alagic sued Callbar in both tort and for breach of an implied warranty.

At trial no evidence was led as to what Callbar did or failed to do which caused the tile to fall, nor did Callbar lead evidence to rebut any inference of negligence on its part. There was no evidence of any history of tiles falling from the ceiling of the hotel. There was, however, evidence that an electrician had performed some work in that area of the hotel, although the nature of this work was not identified.

The Chief Justice of the Northern Territory Supreme Court rejected Mr Alagic's claim. Mr Alagic appealed to the Northern Territory Court of Appeal.

The decision

The Northern Territory Court of Appeal unanimously endorsed the following reasoning of McCardie J in *Maclenan v Segar* [1917] 2 KB 325:

Where the occupier of premises agrees for reward that a person shall have the right to enter and use them for a mutually contemplated purpose, the contract between the parties (unless it provides to the contrary) contains an implied warranty that the premises are as safe for that purpose as reasonable care and skill on the part of anyone can make them. The rule is subject to the limitation that the defendant is not to be held responsible for defects which could not have been discovered by reasonable care or skill on the part of any person concerned with the construction, alteration, repair, or maintenance of the premises... But subject to this limitation it matters not whether the lack of care or skill be that of the defendant or his servants, or that of an independent contractor or his servants, or that the negligence takes place before or after the occupation by the defendant of the premises.

The Court noted that this reasoning was adopted by the High Court in *Watson v George* (1953) 89 CLR 409.

The Northern Territory Court of Appeal rejected a line of New South Wales cases (which have their genesis in *Calvert v Stollznow* [1982] 1 NSWLR 175), which limit the above principle to circumstances where the plaintiff pays for entry into the premises. The Court of Appeal regarded the use of licensed premises as part of the consideration paid, and on that basis there was no reason to draw a distinction in this case.

The Court found it unnecessary to refer to the High Court's decisions in *Northern Sandblasting Pty Ltd v Harris* (1997) 188 CLR 313 and *Jones v Bartlett* [2000] HCA 56.

The existence of some contractual arrangement between Mr Alagic and Callbar was not contested at trial. The Court of Appeal suggested that the better view was that the contractual warranty discussed above may have been collateral to Mr Kantardzic's payment for the drinks at the bar or that Callbar impliedly gave the above warranty in consideration for Mr Alagic using the premises for their contemplated purpose. They thought that it would be artificial to view Mr Kantardzic as a contracting agent for Mr Alagic. However, their Honours considered that it was unnecessary to reach any concluded view on this point.

The Court found, without suggesting negligence on the part of Callbar, that the inference could be drawn that the ceiling was not in a reasonably fit and safe condition as a consequence of some unspecified act or omission of the electrician.

As such, it held that Callbar was liable to Mr Alagic on the basis of the implied warranty.

This decision, if accepted in other jurisdictions, could significantly broaden an occupier's potential liability to persons who come on to their premises for some commercial purpose which involves the use of those premises, even where the person does not pay for the privilege of entry alone.

In particular, the occupier would be liable even when they were not negligent if it could be shown that the premises were not as safe for the relevant purpose as reasonable care and skill on the part of "anyone" could have made them. Such potentially broad contractual liability will no doubt cause great concern for occupiers and their insurers, particularly in jurisdiction where the High Court's decision in Astley v Austrust [1999] HCA 6 is still applicable.

Occupier not liable for deliberate wrongdoing of third parties

Case Name:

Modbury Triangle Shopping Centre Pty Limited v Anzil

Citation:

[2000] HCA 61, High Court of Australia per Gleeson CJ, Gaudron, Kirby, Hayne and Callinan JJ

Date of Judgment:

23 November 2000

Issues:

- occupier's liability
- duty of care to protect against criminal acts of third parties
- causation

This case considers the extent to which an occupier of land may be liable, in an action for negligence, to a person who, whilst on the land, is injured as a result of the deliberate wrongdoing of a third party.

The facts

The appellant was the owner of a shopping centre in suburban Adelaide. The respondent was an employee of one of the lessees in the shopping centre. The shopping centre had a large outdoor car-parking area. The car park was dark at nights unless the car park lights were turned on. The car park lights were located on four lighting towers. Timing devices controlled these lighting towers. The lights were timed to go out at approximately 10pm. The appellant controlled the common property of the premises, which included the car park.

At approximately 10.30pm on 18 July 1993 the respondent was attacked and badly injured by three assailants after closing the store and leaving the premises. At the time, the car park was dark.

The respondent sought to recover damages from the appellant on the basis that:

(a) at the time of the attack the appellant was the occupier of the car park;

(b) the car park lights were off;

(c) in the circumstances of the case, the failure to leave the lights on was negligent;

(d) the risk of harm of the kind suffered was foreseeable; and

(e) that the negligence was a cause of the harm.

The decision

The majority of the High Court (Gleeson CJ, Gaudron, Hayne and Callinan JJ) found that the appellant did not owe a duty of care of the kind asserted by the respondent. Further, even if a duty of care of the kind asserted was found to exist, the harm suffered by the respondent could not be said to be caused by the breach of the duty.

There is little doubt that the appellant owes a duty of care to the respondent in relation to the physical state and condition of the car park. The point of contention is whether the appellant owed a duty of a kind relevant to the harm which befell the respondent. The respondent argued that the duty of the appellant was to take reasonable care to protect people in the position of the first respondent from conduct, including criminal conduct, of third parties.

The duty of care raised two issues. First, it was argued that there exists a duty of care to prevent harm caused by the actions of a third party. On this matter, the majority decided that previous authority only permitted such a duty to be imposed in situations where the alleged tortfeasor could exert an effective degree of control over third parties. *Dorset Yacht Co Ltd v Home Office* [1970] AC 1004 is such a case. Second, the majority had a significant degree of difficulty in reconciling the concept of "reasonable foreseeability" with the nature of criminal activity. Gleeson C J described such activity as being "both unpredictable in actual incidence, wanton and random, and, on that account, always on the cards." On that basis, it was held that the risk of injury from the criminal conduct of third parties was not such that it was sufficiently foreseeable as to give rise to a duty of care. Further, the broad reference to injury from "criminal conduct" covers an excessively broad range of activities, such that it opens the appellant to liability arising from a potentially vast range of criminal acts.

Gleeson CJ recognised that the position may be different if there was a history of recurrent, predictable criminal behaviour. There was no evidence of this in the present case.

On the issue of causation, the majority held that there was not a clear and demonstrable causal nexus between the failure of the appellant to leave the lights on and the attack on the respondent by the three assailants. In essence, it came down to differentiating between acts which may facilitate the commission of a wrong, such as the present case, and acts going towards directly causing the harm suffered by the respondent. Facilitation of the commission of criminal activity was held to be insufficient to satisfy the causation requirement. Further, Hayne J noted it was unreasonable to hold the appellant responsible for the actions of those that it could not control and then impose liability when its own acts or omissions did not contribute to the occurrence. The touchstones of tort liability were identified as being "deterrence and individual liability".

Kirby J was the only dissenting judge. He held that general principle did not automatically preclude the creation of a duty of care owed by a landlord to a tenant (and the tenant's agents and employees). In addition, both overseas authority and policy considerations suggested that a duty of care should be created in this situation.

This decision demonstrates that the courts are reluctant to impose a duty of care on a person to protect against the actions of third parties over whom he or she has no control. This approach accords with common sense. Occupiers and their insurers can take some comfort from the decision, but need to be aware that they may be exposed if there are any particular circumstances which make criminal activity reasonably foreseeable. The court has refrained from attempting to define the circumstances in which such liability may arise.

Can damages be awarded for birth of an unwanted child?

Case Name:

Melchior v Cattanach & Anor

Citation:

[2001] QCA 246; Supreme Court of Queensland per McMurdo P, Davies and Thomas JJA

Date of Judgment:

26 June 2001

Issues:

- wrongful birth claim
- failure to inform of future risk
- entitlement to recover damages
- whether pure economic loss recoverable
- relevance of Perre v Apand
- relevance of public policy

This case considers the ability of a plaintiff to recover for economic losses arising from the birth of an unwanted child against a medical practitioner who was negligent in performing a sterilisation procedure.

The facts

In 1992, the plaintiff, Mrs Melchior (the ***Patient***), decided to undergo a sterilisation procedure for financial and family planning reasons which involved the application of a clip to her fallopian tubes. The plaintiff consulted the Defendant, Dr Catannach (the ***Doctor***) and informed him that she had undergone an appendectomy in 1967 when she was 15 years old. From this, the Doctor determined that the Patient had both her right ovary and fallopian tube removed when in fact only her right ovary had been removed while her right fallopian tube remained. Accordingly, only the left fallopian tube was attended to at the sterilisation procedure in March 1992. That procedure, performed with the aid of a laparoscope, failed to reveal the right fallopian tube, which was obscured by adhesions from the earlier appendectomy.

In November 1996, the Patient discovered she was pregnant. She rejected any thought of an abortion and delivered a healthy son in May 1997.

At trial, the Patient succeeded in her claims that the Doctor was negligent in not determining the existence of the right fallopian tube. The trial judge held that the Doctor was aware or should have been aware that the Patient's recollection of surgery 24 years previously might be unreliable and her comments should have put him on notice with respect to its existence.

Furthermore, the Doctor was aware of procedures that could have been performed to ascertain the presence of the right fallopian tube, and he failed in his duty to outline risk of failure of the sterilisation due to the existence of that fallopian tube, thus denying her the option of further tests to determine if it was still present.

The issues

The following questions arose:

1. Was the Doctor liable in an action for negligence?
2. Was the Patient entitled to recover for economic loss arising from the raising of an unwanted child?
3. What factors may constrain the recovery of economic losses in these circumstances?

Was the Doctor negligent?

The majority of the Full Bench of the Court of Appeal upheld the decision of the trial judge finding that the Doctor was aware or was ought to be aware that the Patient's recollection of a surgery 24 years previously may not have been reliable. This should have put the Doctor on notice of the possible continued existence of the right fallopian tube.

It was not sufficient that the Doctor gave a general warning on the risk of failure of sterilisation, as a material difference existed between that general risk and the risk presented if the fallopian tube was still present.

A reasonable person in the position of the Patient would be likely to attach significance to the risk of a future pregnancy and the Doctor should have been aware of the fact that the Patient was likely to attach such significance, due to the nature of the procedure.

The Doctor was aware of a procedure that could have been performed, and if performed would have been likely to reveal the presence of the right fallopian tube.

The Doctor failed to outline the risks involved if the right fallopian tube was still present and the available procedure to ascertain this fact.

The Patient, were she aware of the risk, would have had any tests necessary to ensure the sterilisation had been effective.

The negligence was a material cause of the pregnancy and the birth of the child.

Was the Patient entitled to recover for economic loss?

The majority of the Full Bench of the Court of Appeal, with Thomas JA dissenting, upheld the decision of the trial judge, finding that the decision of the High Court in *Perre v Apand* (1999) 73 ALJR 1190, setting out the relevant considerations to determining the existence and scope of a duty of care in pure economic loss cases, supported that Patient's position.

According to McMurdo P, "...[t]he law imposes a duty of care upon a medical practitioner to avoid the foreseeable risk of the cost of raising a child conceived through negligence in the context of a failed sterilisation performed for socio-economic reasons, subject to any appropriate limiting control mechanisms."

McMurdo P considered that the English case of *McFarlane v Tayside Health Board* (1999) 4 All ER 961, in which the Court found that recovery for the pure economic cost of the raising of a healthy child was not recoverable, was not a persuasive authority in Australia following the High Court's decision in *Perre v Apand*.

What factors may constrain the recovery of economic losses in these circumstances?

McMurdo P stated that in today's Australian society children are not regarded as an economic asset, but rather for many years they are a financial liability. "Children are not universally regarded as a blessing. Contraception and sterilisation are readily available to individuals and couples wishing to control their fertility and society accepts these measures as a responsible exercise of free choice".

Davies JA supported this view by holding that "...[f]or those who choose sterilisation, the birth of a child or a further child is not a blessing...".

Thomas JA, in his dissenting judgment was more heavily influenced by the public policy argument that the benefit offered by a healthy child to a family is substantial and agreed with the position established by the *McFarlane Case*. He drew a distinction between a healthy and a disabled child.

Cases referred to in the Australian jurisdiction vary in their outcome and the High Court has not yet deliberated on this issue. In *Dahl v Purnell* 15 QLR 33 Judge Pratt QC allowed damages for the moderate reasonable cost of raising a healthy child born, with a 25% set-off for the intangible benefit of a healthy child, following a negligently performed vasectomy. He followed the reasoning of *Emeh v Kensington & Chelsea & Westminster Area Health Authority* [1985] 1 QB 1013, now overturned by the decision in the *McFarlane Case*.

This case is authority for the view that pure economic loss may be recoverable where the damage arises from the raising of a healthy child born as the result of a failed medical procedure, or a failure to warn to the risks inherent in the procedure.

Pure economic loss may also be recovered where the damage is the result of a misdiagnosis resulting in a loss of opportunity of lawful termination where the child is born with a disability.

Case Name:

Rosenberg v Percival

Citation:

[2001] HCA 18; High Court of Australia per Gleeson CJ, McHugh, Gummow, Kirby and Callinan JJ

Date of Judgment:

5 April 2001

Issues:

- duty of care owed by medical practitioners
- failure to warn of a "material risk"
- causation

This appeal clarifies the High Court's previous decisions on the scope of the duty of care of medical practitioners to adequately warn of "material risks" of complications and other adverse outcomes which result from surgical procedures.

The facts

The Appellant, Dr Rosenberg, was a dental surgeon. The patient, Dr Percival, was a lecturer in nursing with a PhD who consulted Dr Rosenberg in 1993 with a worsening condition of malocclusion (misalignment of the jaw) which required surgical correction. The patient underwent a sagittal split osteotomy which involved her jaw being broken and realigned. This was a relatively radical form of procedure but the patient had stressed that she wanted the best result.

After the operation, the patient developed complications in the joint where the upper and lower jaws meet, resulting in chronic pain, muscle spasms and loss of control of her mouth muscles. She underwent further procedures to no avail.

The patient brought proceedings in the District Court of Western Australia in negligence claiming that she would not have consented to the surgery if she had been appropriately warned of the risks of complications. Expert evidence revealed that the complications were quite rare. The trial judge held that there was no negligence as causation was lacking, that is, the patient would have proceeded with the surgery anyway.

The patient appealed and was successful before a Full Court of the Supreme Court of Western Australia. Dr Rosenberg was held to be in breach of his duty of care due to his failure to warn of a material risk. Wallmark J in his leading judgment stated that "materiality" was evident where the risk is generally known to the medical profession.

The decision

The High Court unanimously overturned the findings of the Full Court and reinstated the trial judge's decision. Only three of the judges addressed the duty of care question, with Gleeson CJ and McHugh J basing their findings solely on a lack of causation. Gummow J took the position that causation and duty of care were so interrelated that both had to be considered.

According to Gummow J, it was insufficient to suggest that once a risk is generally known, there is a duty to warn. The first step is ascertaining if a reasonable practitioner should have foreseen the risk of some kind of complication. It must then make a further inquiry to determine the *content* of that risk in deciding "materiality".

The test for "materiality" laid down in the Court's seminal decision of *Rogers v Whittaker* consisted of two limbs:

1. Should the medical practitioner have been aware that the particular patient, if warned of the risk, would attach significance to it ("subjective test")?
2. In the circumstances, would a reasonable person in the patient's position (ie. taking into account her background and education), if warned of the risk, be likely to attach significance to it ("objective test")?

Since the patient in this case failed to ask questions to indicate she was concerned about the surgery, and there were no physical or mental characteristics to indicate "substantial fears", only the objective test needed to be applied, namely whether the reasonable person in the patient's position would be likely to attach any significance to the risk. Gummow J noted however that this subjective fear was not limited in its manifestation to the asking of questions.

To determine the content of the risk, other factors needed to be addressed:

- magnitude of the risk; and
- probability of occurrence.

However this needed to be balanced against other countervailing factors:

- the expense, difficulty and inconvenience of taking alleviating action; and
- other conflicting responsibilities that the defendant doctor may have.

Based on the facts in this case, it was found that there was no breach of duty due to the following:

- the patient was a senior and highly qualified nurse who would have been aware of the risks inherent in any surgery;
- the patient had received advice from a number of sources indicating that she should proceed with the treatment;
- the extreme unlikelihood of the occurrence of the risk which in fact eventuated – the potential harm of complications was only temporary, and pain was only mild. Of these complications there was only a 10 per cent chance of it arising; and
- finally, the expressed desire to obtain the "best result" for her condition and the osteotomy would have provided the most effective remedy, contrary to her claim that she would not have undergone the procedure had she been warned of the risk.

The patient here failed on the basis of being unable to establish a causal link between the failure to warn and her claim that she would not have undergone the surgery if she had been aware of the risk.

This decision reinforces the High Court's previous position that the ultimate responsibility for informing patients of risks lies with the medical practitioner despite the failure of the plaintiff in this case on grounds of credibility and causation. Factors such as the patient's background are relevant in assessing whether there has been a breach of the duty to warn.

Record award of damages for medical negligence

Case Name:

Simpson v Diamond & Anor

Citation:

[2001] NSWSC 925

Date of Judgment:

5 November 2001

Issues:

- Medical Negligence
- Assessment of Damages

The damages awarded to the plaintiff in this case are a record payout for medical negligence in New South Wales. Cerebral Palsy sufferer Calandre Simpson sued her mother's obstetrician claiming that a competent doctor would have been able to deliver her uninjured with forceps. She was awarded $13 million in compensation. The case focuses on the assessment of damages.

The facts

The plaintiff was born on 5 July 1979. Due to complications at birth she was severely disabled by Athetoid Cerebral Palsy. Whilst the plaintiff suffers extreme physical disabilities, she is of average to above average intelligence and describes herself as "a person inside a body which does not work". She was 21 at the time of the trial.

The first defendant was Mrs Simpson's obstetrician ***(Diamond)***. The plaintiff claims that as a result of the methods adopted by Diamond during the delivery, the plaintiff suffered hypoxia and was born with a damaged brain, which resulted in cerebral palsy and her present substantial disabilities. Diamond made numerous attempts at forceps delivery with three different instruments and failed. A decision was then made to deliver the plaintiff by caesarean section. There was however a delay of some 30 minutes before the emergency caesarean was in a fact performed during which time it was determined that on the balance of probabilities the plaintiff was starved of oxygen and suffered severe brain damage. The second defendant was the private hospital at which the plaintiff was born. The plaintiff's claims against the hospital were discontinued when Diamond admitted liability to the plaintiff at the commencement of the hearing.

Diamond filed a cross claim against the hospital alleging that:

- the hospital nursing staff had given Mrs Simpson an excessive dose of Syntocinon in order to induce her labour;
- thestaff hospital's staff failed to monitor the wellbeing of the foetus or the progress of the labour after administering Syntocinon.

The plaintiff suffers from severe and multiple disabilities and requires assistance and care on a 24 hour a day basis.

The Decision

1. Assessment of Loss

The plaintiff was awarded almost $13 million plus $2 million in costs. In his final remarks, Whealy J commented that:

The plaintiff's life was substantially altered at birth by the defendant's negligence. Her disabilities and losses are life long. They commenced on the day she was born and they will endure until the day she dies. Calandre is likely to lead a long life, although less than the remaining years of a normal young woman. The purpose of damages in the present situation is to award such a sum of money as will, as nearly as possible, put the plaintiff in the same position as if she had not been injured by the defendant's negligence.

(a) Plaintiff's Life Expectancy

Consideration of the plaintiff's life expectancy is an issue which bears upon all heads of damages. In most cases, life expectancy is determined by reference to the Australian Life Tables. Often, expert medical opinion is then gathered in order to adjust the life expectancy in light of the individual characteristics and conditions of the plaintiff.

In assessing the plaintiffs remaining years, Whealy J had regard to both the statistical and medical evidence before him. After consideration of all the evidence his honour decided that the probable span of the plaintiff's life is a further 51 years from age 22. This figure is considerably lower than the life expectancy of a 22-year-old female according to the life expectancy tables. However, it gave credit to the fact that the plaintiff had some exceptional qualities which posit a longer life expectancy than many cerebral palsy sufferers with her range of disabilities and impairments.

(b) Damages

Whealy J commented that the plaintiff "has never personally known, has never had and will never have the ability and capacity to enjoy life to the full as normal able bodied people do". In awarding a generous sum for general damages, Whealy J placed emphasis on the fact that Calandre had no realistic prospects of normal married life or motherhood. She had and always will depend on others for assistance in every aspect of her daily life. As a result of this dependence, damages were awarded in order that she had some measure of financial security and is able to secure good and adequate care in the future. The fact that the plaintiff is of normal intelligence and fully aware of her disabilities was a factor considered important in the award of general damages. Whealy J described her as a "person who is imprisoned in her own body", commenting that "this acute awareness of her plight makes her suffering markedly greater than if she had no consciousness of it". Interest on the general damages was calculated from the date of the plaintiff's birth to the date of judgment (22.33 years) at a rate of 2%.

After an assessment of general damages, there were 31 contested heads of damages. The amount awarded under a number of these heads is outlined in the table below.

Head of Damage	Amount ($)
General Damages	390,000
Interest on past General Damages	174,174
Past Loss of Earning Capacity	50,880
Interest on Past Loss of Earnings	20,000
Future Loss of Earning Capacity	720,169
Past Loss of Employer Superannuation	2,100
Future Loss of Employer Superannuation	84,700
Long Service Leave	5,000
Past Gratuitous Service	119,730
Interest on Past Gratuitous Services	310,880
Future Gratuitous Services	25,000
Future Attendant Care	6,518,098
Home building and architectural costs	502,322
Hydrotherapy	95,467
Home maintenance and running costs	390,606
Therapeutic aids, appliances and equipment	427,980
Maintenance on aids, appliances and equipment	25,916
Computer	292,679
Educational Tutoring	171,628
Motor Vehicle Expenses	161,623
Future Medical Treatment	125,564
Future Paramedical costs	476,625
Future Pharmaceutical costs	16,569
Additional Holiday Costs	330,000
Case Manager	371,812
Out of Pocket Expenses	1,122,957
TOTAL	**12,932,479**

The case contains a detailed consideration of the approach, which should be taken in qualifying each head of damage, including the examination of relevant expert evidence. It provides a review of relevant case law and is a useful reference for cases in which similar heads of damage are claimed.

Approximately 50% of the entire award of damages were awarded for future attendant care. A total of $6,518,098 was awarded to the plaintiff for this expense. Whealy J concluded that the plaintiff requires "high calibre care, structured in a regime designed to serve her particular needs, and provided by well qualified, experienced and vigilant carers". The plaintiff relies on the assistance of employed carers for assistance in all aspects of daily life. The severity of the plaintiff's incapacity means that the burdens placed on her carers are considerable. In assessing this head of damage, a number of proposed care arrangements were considered. These care arrangements range between $2,400 and $7,000 per week. Whealy J awarded $4,656 per week for the remainder of the plaintiff's life.

2. Apportionment of Blame

The essence of Diamond's argument on the cross claim was that, while the use of the forceps contributed to the complications, the foetus was predisposed to this injury due to the effect of Syntocinon and the failure of hospital staff to monitor its effects in the early stages of the labour.

Whealy J concluded that Calandre was not harmed by Syntocinon. He found against Diamond in all his claims against the hospital. He was satisfied that there were no signs of foetal distress until the forceps were first employed. Whealy J concluded that any damage Calandre suffered was due to Diamond's negligent use of forceps, the absence of full dilation and the misdiagnosed position of the baby's head. As a result, apportionment was not considered as Diamond was held solely responsible.

This case involves no significant development in the law, but illustrates how the law is being applied in a way that benefits plaintiffs in medical negligence cases. It has wide-reaching implications for the insurance of medical practitioners. The most immediate impact will be on premiums. In the year 2000 insurance premiums for obstetricians doubled.

From 1 July 2002, general insurers will be subject to a new regulatory framework with revised prudential requirements and in which APRA has greater powers in setting, monitoring and enforcing those requirements. Under the transitional provisions of the General Insurance Reform Act 2001, general insurers should have already commenced discussions with APRA in order to be authorised under the new regime if they intend to carry on general insurance business on and after 1 July 2002.

The General Insurance Reform Act 2001 was assented to on 19 September 2001 and amends the Insurance Act 1973 (the ***Act***) to create the following three tier regulatory framework for general insurers:

- The first tier is the Act, which sets out the high order principles of the regime – namely, to protect the interests of policyholders by:
  - restricting who can carry on general insurance business in Australia and imposing a fitness and propriety test on directors and senior management;
  - placing the primary responsibility for protecting policyholders' interests on the insurer's Board and senior management; and
  - setting various prudential tests (such as capital adequacy, reinsurance and risk management).
- These prudential tests will be set by APRA as subordinate legislation in the form of General Prudential Standards (***Prudential Standards***) and these Prudential Standards form the second tier of the new regulatory framework. Except in certain circumstances, APRA must consult those general insurers who will be affected before making or varying a Prudential Standard.
- The third tier is the guidance notes issued by APRA to explain its interpretation of the Prudential Standards.

Two important effects of the amended Act are firstly, from 1 July 2002, general insurers will be required to meet the revised prudential tests and secondly, APRA will receive greater powers to set, monitor and enforce these new tests.

Revised Prudential Tests and Prudential Standards

As at 11 December 2001, APRA had issued the following Prudential Standards in respect of the revised prudential tests:

- Prudential Standard 110 – Capital Adequacy of Insurers. This requires general insurers to maintain, at all times, a Minimum Capital Requirement (***MCR***) of either $5 million or such other amount as calculated using a formula approved

by APRA, whichever is the higher. The formula used can be either one developed by the insurer and approved by APRA or the one prescribed in the Prudential Standard. If the prescribed formula is used, the MCR must factor in the following risks:

- Insurance Risk – the risk that the true value of the insurer's net liabilities is greater than that valued under Prudential Standard 210 (see below);
- Investment Risk – the risk of an adverse movement in the value of an insurer's assets; and
- Concentration Risk – the risk associated with the exposure to a single catastrophic event.

- Prudential Standard 120 – Assets in Australia. An insurer is required under the Act to maintain sufficient assets in Australia to meet its Australian liabilities. This Prudential Standard identifies when an asset will be considered to be held by the insurer "in Australia". Generally, to be considered as "in Australia", tangible assets must be located in Australia and have legal title held by an insurer incorporated in Australia or an insurer's Australian agent. Certain intangible assets, such as goodwill, future income tax benefits and assets under a charge or security will not be considered as assets "in Australia".
- Prudential Standard 210 – Liability Valuation. This describes how an insurer should value its liabilities for the purposes of satisfying the revised prudential tests. Prudential Standard 210 requires most insurers to appoint an actuary to value its liabilities, taking into account the insurer's class of business. The ultimate responsibility to assign a value to liabilities, however, rests with the insurer's Board and senior management. An insurer must notify APRA in the event it assigns a value to a liability inconsistent with the appointed actuary's advice.
- Prudential Standard 220 – Risk Management. This requires an insurer's Board and senior management to ensure that the company has in place a suitable system for identifying, monitoring and managing risks. This includes directors and senior management satisfying a fitness and propriety test as prescribed by APRA and appointing an auditor and actuary who satisfies APRA's eligibility criteria. The Prudential Standard also imposes various reporting requirements on the insurer (to APRA) and requires an insurer to maintain and submit to APRA a risk management strategy.
- Prudential Standard 230 – Reinsurance Arrangements. This requires insurers to have in place suitable reinsurance arrangements and requires the Board and senior management to maintain a reinsurance management strategy ***(RMS)*** approved by APRA. The RMS must be appropriate to the size, business mix and complexity of the insurer's operations and cover the worldwide operations of the insurer.
- Prudential Standard 410 – Transfer and Amalgamation of insurers. This expands on the procedural requirements already set out in the Act and in the Insurance Acquisitions and Takeovers Act 1991 for insurers wishing to transfer or amalgamate insurance businesses. It also ensures that affected policyholders and other interested members of the public are informed about any such transfer or amalgamation.

APRA's Powers

As seen above, in issuing the Prudential Standards, APRA's powers in defining the new regulatory framework have increased. APRA's other powers under the amended Act include:

- limiting shareholders' representation on a general insurer's board – i.e. shareholders with a shareholding of less than 15% must not have more than one representative in a board of six;
- broader powers to commence investigations. Prior to the amended Act, APRA could only commence an investigation about an insurer when it appeared to APRA that the insurer was or was likely to become insolvent. Under the amended Act, APRA may start an investigation or request information from an insurer if it appears to APRA that there is, or there may be:
  - a risk to the security of the insurer's assets; or
  - a sudden deterioration in the insurer's financial condition;
- requesting information from any past or present auditor or actuary of the insurer;
- revoking an insurer's licence under the amended Act;
- directing certain provisions to be made to an insurer's accounts;
- removing directors, senior managers and appointed actuaries and appointed auditors;
- receiving undertakings from persons in relation to APRA's functions under the Act and enforcing these via the Federal Court; and
- directing insurers to comply with the Prudential Standards within a specified time.

The amended Act also imposes a "whistle-blowing" role on a general insurer's appointed actuary and auditor. Under the amended Act, the appointed actuary or auditor must disclose information to APRA at any time if they have reasonable grounds that the insurer:

- is or has significant risk of insolvency;
- has failed to comply with the Prudential Standards; or
- is in a state of affairs which may materially prejudice the interests of policyholders.

To ensure that this obligation is complied with, the amended Act:

- protects the appointed actuary or auditor from any claims which may be brought against them by any other person in respect of carrying out this obligation in good faith and without negligence; and
- denies the actuary or auditor the right to be excused from complying with this obligation on the grounds that it would tend to incriminate themselves; and
- ensures that the information given in compliance with this obligation is not admissible in evidence against the actuary or auditor in a criminal proceeding, if that auditor or actuary claims that giving such information would tend to incriminate them, and the giving of that information does in fact tend to incriminate them.

Transitional Provisions

The new capital adequacy tests do not commence until 1 July 2002. However, in order to carry on a general insurance business in Australia from 1 July 2002, general insurers will need to be authorised under the amended Act. Accordingly, transitional provisions allow those sections of the amended Act relating to the licensing of insurers to commence immediately, giving insurers the opportunity to apply to APRA for authorisation under the new regime well before the new regime's commencement date of 1 July 2002.

The Privacy Amendment (Private Sector) Act 2000 expands the application of the Privacy Act 1988 on and from 21 December 2001. From that date, the Privacy Act extends to the private sector, including most entities operating in the insurance industry.

It establishes a national scheme to regulate private sector organisations by providing a minimum standard for handling personal information.

The expanded act is designed to bring Australia into line with international standards for handling personal information. The National Privacy Principles ***(NPPs)*** set the minimum standard.

In basic terms, the NPPs are 10 principles that set a minimum standard for organisations that handle *personal information*. The NPPs cover collection, use and disclosure, data quality, data security, openness, access and correction, unique identifiers, anonymity, transborder data flows and sensitive information.

The NPPs apply to *personal information*. Basically, personal information means information or opinion about an individual, whether true or not and whether recorded in a material form or not. Particular restrictions apply to the handling, use and collection of *sensitive information*. This includes information relating to race, membership of organisations, sexual orientation, various personal beliefs, health information and criminal records.

The insurance industry, being an industry which deals with personal information, will be significantly affected by the act. It will be necessary for the industry to change business practices to accommodate the expanded privacy legislation.

The privacy legislation is complex. It is also somewhat unclear in its application in a number of material respects.

Much of the information which insurers need to have in order to underwrite and to deal with claims falls within the category of sensitive information. There is much tighter control over collection, use and disclosure of sensitive information than in relation to general personal information. The legislation restricts the use to which information may be put to uses which are legitimate. This may be a somewhat grey area and there may well be challenges to insurers' use and handling of personal information under the new regime. The new regime facilitates rights of access to information and restricts the degree to which personal information may be maintained on databases for future use, especially in relation to claims and the interchange of information between industry members and industry bodies charged with the collection of data.

There are obvious opportunities in the context of contested claims for claimants to

make use of the legislation to advance their interests and to damage the interests of insurance companies and brokers who may have come into possession of personal and/or sensitive information. Disgruntled claimants and their lawyers have a potential mechanism, via the act, to use breaches or potential breaches of the privacy legislation to their advantage particularly in the contested claims arena. The privacy legislation may become a standard weapon of choice in the claimants' armoury, in much the same way that s52 of the Trade Practices Act has become a standard plea in commercial litigation.

The challenge for the industry is to identify, understand and deal with the complex issues which the act raises.

That may be achieved in part by the adoption of appropriate industry codes of practice. The adoption of an approved code, failing which an organisation will be subject to the default NPPs, is a central plank of the legislation. Clearly, the industry will need to adopt appropriate compliance procedures otherwise face breaching the legislation. However, the adoption of an approved code and putting in place appropriate compliance procedures will not address all of the issues raised in the act.

Whilst the industry has generally tried to deal with most of the issues by way of obtaining consents from individuals to obtain and receive their personal information, obtaining consents will not be possible in a number of situations. For example, in a claims situation it may not be possible to obtain consents from third parties whose interests may be adverse to those of the insurer. How is the insurer to obtain information about a third party (e.g. a key witness) which might assist it to defend a claim? Also, the legislation imposes restrictions on the flow of information overseas. The industry is a global industry and involves the transfer across borders of a great deal of personal information. Is the industry aware of those restrictions? These are just some of the practical and legal issues which need to be addressed.

We believe that the expanded legislation gives rise to a number of operational and systems issues for insurers and brokers. The problem is particularly acute where the information held is sensitive information.

One way in which the industry may be able to obtain legal protection in respect of likely or actual breaches of the legislation is to seek permanent or temporary public interest determinations from the Privacy Commissioner. Determinations can be granted, after a public consultation process, if the public interest in allowing the breach outweighs the detriment in not allowing the conduct to occur. It is likely that determinations will be issued sparingly. Nevertheless, the industry should carefully consider its practises in order to identify possible breaches. To the extent that they cannot be varied to avoid breach and are necessary, then practises should be reviewed to consider whether it is appropriate to seek a determination from the Privacy Commissioner.

After a long wait, the FSRA is now law, and will commence on 11 March 2002.

In our 2000 Annual Review we discussed the significant legislative developments embodied in the draft Financial Services Reform Bill, and the impact those developments would have on the insurance industry.

In 2001, the Financial Services Reform Bill was tabled, debated, amended, passed and received assent (and nearly commenced) all within six months – quite astonishing for a bill of over 600 pages.

The Financial Services Reform Act 2001 (the FSR Act) is the sixth stage of the Corporate Law Economic Reform Program announced by the Treasurer in March 1997 arising from the recommendations of the Wallis Report.

The aims of the FSR Act relevant to the insurance industry are:

- firstly, that insurance products will be subject to uniform regulation that applies equally to other financial products such as securities;
- secondly, that providers of financial products will be subject to the same licensing procedures; and
- thirdly, that the same disclosure standards will apply to similar products.

1. Regulation

One of the key elements in the regime relevant to the insurance industry is the regulation of the provision of financial products and services. Three types of insurance products fall within the definition of *financial product* in the FSR Act: general insurance products, life insurance products and investment life insurance products.

The legislation distinguishes between retail and wholesale clients, providing additional protection to retail clients in areas including product disclosure, compensation and complaints handling. If an individual is provided with general insurance, he or she is deemed to be a retail client. Alternatively, the type of insurance being provided may deem the client to be a retail client. This applies in the case of motor vehicle, home building and contents, sickness and accident, consumer credit, travel, personal property and small business insurance.

2. Licensing

The new licensing regime will replace the existing licensing schemes for different types of financial product and service providers. Brokers will no longer be registered under the Insurance (Agents and Brokers) Act, which is repealed by the FSR Act. For insurers, however, the new regime supplements, not replaces, the

APRA authorisation requirements under the Insurance Act 1973 or the Life Insurance Act 1995.

The objective of the new regime is to provide investors with the same consumer protection irrespective of who is providing their financial services. Generally, the licensing requirements apply whether the licensee's clients are retail or wholesale, although insurers licensed by APRA who provide services to wholesale clients only need not be licensed under the FSR Act.

The FS licence is provided by ASIC after the applicant completes a stringent application process and ASIC may impose conditions on the licence. A licence holder will have extensive obligations in relation to dispute resolution, professional indemnity insurance, and the training and supervision of representatives.

In some respects, there are similarities between the new and existing regimes for insurance agents and brokers that will assist the transition for those in the insurance industry, for example in relation to the responsibility for the acts of a representative.

However, s992A should be of particular concern to insurers and brokers. Section 992A prohibits anyone from offering a financial product (and this includes general insurance products) for sale during the course of, or because of, an unsolicited meeting. It also prohibits such offers during or because of unsolicited personal contact such as telemarketing, unless prescribed procedures are followed. Although the two year transition period in the FSR Act originally included s992A, later amendments reduced the transition period for s992A from two years to just one day. The prohibitions in s992A apply equally whether the offer is made to a person who is a retail, wholesale, new or existing customer. The exact scope of this prohibition is far from clear, but it is clear that its application is extremely wide. There is no legislative guidance on the extent to which a sale might be made "because of" an unsolicited meeting. All insurers and agents currently involved in direct marketing must review their practices to ensure compliance with these new restrictions. Further, all members of the general insurance industry should consider the potential for s992A to affect their operations and the effect that it will have on their current distribution methods from 11 March 2002

3. Disclosure

The FSR Act imposes new disclosure requirements that apply whenever products or services are provided to retail clients. The objective is to allow consumers to have access to standard information that will allow them to compare different products.

The main requirements are the provision of a financial services guide ***(FSG)*** when offering services; a statement of advice ***(SoA)*** when providing advice; and a product disclosure statement ***(PDS)*** when recommending or offering a product.

The FSG contains information, such as the source of the service provider's remuneration and relationships with issuers of financial products, which might reasonably be expected to influence the service provider. The SoA discloses benefits and obligations that might reasonably be expected to be capable of influencing the service provider. The PDS must include information about significant benefits and risks associated with the product, including mandatory and voluntary cooling-off periods.

There are other aspects to the new disclosure regime that require ongoing disclosure requirements, periodic reporting and require insurers to provide, on request, additional information that might reasonably influence a consumer's decision to acquire an insurance product.

There are two further aspects to the new regime of which insurers should be particularly aware.

Firstly, the requirement to provide confirmation of transactions to consumers applies to all financial products. Therefore, when an insurance policy is due for renewal, the insurer will need to provide the insured with a renewal notice to comply with the Insurance Contracts Act, and also to confirm the transaction as soon as practicable after the insurance has been renewed. To avoid the costs associated with direct mail, insurers may take advantage of the standing facility contemplated by the FSR Act whereby insureds are provided with details of a facility through which they may confirm the details of the policy that they have purchased.

Secondly, the provisions of the new regime relating to cooling-off periods will require insurers who do not presently offer such a facility to make significant changes to their distribution models. A 14 day cooling off period is mandatory for all risk insurance products (general and life) and does not commence until the transaction acquiring the product has been confirmed (or 5 days later, whichever occurs earlier). Following industry consultation, exceptions to the general rule have been made available to insurers, such as in the case of travel insurance or cover notes, where the insured has had the benefit of the product before the expiration of the cooling-off period.

Our dedicated FSR website at http://www.aar.com.au/fsr/ contains further detailed information about how the legislation will affect the Australian insurance industry.

From 1 July 2001, a tax of $65 million per year has been imposed on all general insurance premiums relating to New South Wales risks. All insurers issuing such policies must be registered under the Insurance Protection Tax Act 2001 (NSW). Those persons who have taken out policies of general insurance in respect of risks occurring in New South Wales with unauthorised insurers will be subject to a tax of 1% on all such premiums paid. Taxes collected under this Act will be used to meet claims under home building and third party motor accident insurance policies of declared insolvent insurers. The critical issue for the industry is the prohibition on passing through the tax to policyholders.

The Insurance Protection Act 2001 (NSW) (the ***Act)*** was assented to on 29 June 2001 and amended by the Insurance (Policyholders Protection) Legislation Amendment Act 2001 and the Insurance Protection Tax Amendment Act 2001. The Act commenced on 1 July 2001.

Premiums Received by Authorised Insurers

From 1 July 2001, a tax will be imposed on all premiums received by an insurer authorised under the Insurance Act 1973 (or its authorised agent) in respect of general insurance policies insuring:

- property in NSW;
- a risk, contingency or event that, in the normal course of events, may occur within or partly within NSW; or
- insurance that is effected by a third party policy within the meaning of the Motor Accident Compensation Act 1999.

All authorised insurers writing the above policies must be registered under this Act.

However, the tax is not imposed on policies of life insurance or "exempt insurance", the latter of which includes workers compensation policies, reinsurance policies and policies issued to charitable organisations.

Where the policy insures both a risk in NSW and a risk outside of NSW, the Act allows the premiums received in respect of that policy to be appropriately apportioned.

The total amount of this tax for the 2001-2002 financial year will be $65 million. The amount raised during subsequent years may be reduced below $65 million if recommended by the Treasurer and determined by the Governor.

The amount payable each year by each participating insurer will be apportioned by the Chief Commissioner of State Revenue according to that insurer's share of the total premium income of all participating insurers for that year.

Policies of General Insurance with Unauthorised Insurers

The Act imposes a tax at the rate of 1% on persons who take out general insurance (as defined above) with an unauthorised insurer. Those persons must, within 21 days after the end of the month in which a premium is paid in respect of such a policy:

- lodge with the Chief Commissioner a return in the approved form; and
- pay to the Chief Commissioner a tax equal to 1% of that premium.

Use of Tax Collected

All amounts collected under this Act will be placed into the Policyholders Protection Fund (the ***Fund***) and must be applied to meet the following expenses:

- expenditure from the Building Insurers' Guarantee Fund in connection with insurance contracts of declared insolvent insurers; and
- expenditure from the Nominal Defendant's Fund in connection with third party policies issued by declared insolvent insurers.

The amount of any such payments out of the Fund are to be determined by the Treasurer.

Goods and Services Tax ruling GSTR 2001/4 – GST consequences of court ordersand out of court settlements

Insurers should note this GST ruling, as it will affect settlement payments made to policyholders and out-of-court settlements. Under the Ruling, whether an out of court settlement, or a payment made under court order, constitutes a taxable supply for GST purposes depends on the underlying "supply" being made. Payments ordered by the Court, such as damages or costs, will not be considered as "taxable supplies".

In Australia, a goods and services tax ***(GST)*** is imposed on all "taxable supplies". A "taxable supply" is defined under the *A New Tax System (Goods and Services Tax) Act 1999* (the ***GST Act)*** as a supply that is:

- made for consideration;
- made in the course or furtherance of an enterprise carried on by the supplier;
- connected with Australia;
- made by a person who is registered or required to be registered for GST under the GST Act; and
- is neither GST-free nor input taxed, as defined in the GST Act.

GSTR 2001/4 (the ***Ruling)*** clarifies when out-of-court settlements and payments made under a court order will be considered as a "taxable supply" for GST purposes. The Ruling applies on and from 1 July 2001.

Effect of Ruling – Look at Underlying Supply

Under the Ruling, the GST consequence of a supply made during an out-of court settlement or as a result of a court order depends on the GST status of the underlying supply. According to the Ruling, the underlying supply is either an earlier supply or a current supply:

1. Earlier Supplies

   If the settlement or court order relates to an earlier supply, then the GST treatment of the settlement or court order depends on the GST status of that earlier supply.

   For example, A sells goods to B but B claims that the goods are defective. A and B reach an out-of-court settlement whereby A makes a payment to B. The underlying supply for the payment from A to B is the original sale of goods by A to B. If that original sale was a taxable supply, then the settlement payment will also be a taxable supply and attract GST.

2. Current Supplies

   If the settlement or court order gives rise to a current supply, it will be subject to GST if the other requirements of a taxable supply (as set out above) are met.

For example, A and B enter into a trade name dispute resulting in the court ruling that B may use A's trademarked name in the future in return for a payment. That payment is therefore in respect of a current supply (the right to use A's trademarked name) and will be in respect of a "taxable supply" if the other requirements of a "taxable supply" are met. Note that as a taxable supply has been made, A may need to issue a tax invoice to B.

Adjustment Events

When a settlement adjusts the original consideration for an earlier taxable supply (eg. a partial refund), then an adjustment event occurs. For example, assume A sold goods to B for $1,000 (plus GST). Because the goods were defective, a settlement was reached whereby A refunded B $500. This settlement is an adjustment event. A would have previously paid GST to the ATO on the original $1,000 price and is now entitled to a refund to reflect the fact that the price is now $500. B would have previously claimed an input tax credit based on the $1,000 price but must now refund part of the input tax credit to the ATO to reflect the reduced price.

The net GST effect for both parties is the same as if A was paying B for a taxable supply made by B. Wording in the settlement agreement requiring A to pay B $500 plus any applicable GST, however, may not be wide enough to make A pay $550. This is because the payment from A to B is not a payment for a taxable supply but rather, an adjustment event. To protect B's position, therefore, the settlement agreement should set the settlement sum as the gross amount ($550) or have an adjustment event gross up clause in addition to the standard GST gross up clause.

Discontinuance Supply – Must Still Satisfy Definition of "Taxable Supply"

A court order or reaching an out-of-court settlement invariably results in one party surrendering its right to sue the other (a ***Discontinuance Supply***). For example, A sells defective goods to B. A and B reach a settlement whereby A pays a sum of money to B and B agrees to end the dispute there. B has just made a Discontinuance Supply.

The Ruling confirms that a Discontinuance Supply is a supply for the purposes of the GST Act but will generally *not* constitute a "taxable supply", because surrendering the right to sue is no more than part of the mechanics of settlement and any payment given in such cases is generally in respect of an earlier supply, current supply or is not a supply at all (see the section on damages and costs below). There is generally an insufficient nexus between a Discontinuance Supply and the consideration given as part of a settlement or resulting from a court order.

The fact that a settlement agreement states that a party does not acknowledge liability or fault does not automatically mean that any payment made is made for a Discontinuance Supply. A payment will only be considered as referable to a Discontinuance Supply if there is overwhelming evidence that the dispute is in respect of a claim which is so lacking in substance that the payment could only have been made for the Discontinuance Supply.

Under the Ruling, even if the payment is in respect of the Discontinuance Supply,

the other criteria of a "Taxable Supply" must still be met before the Discontinuance Supply will attract GST.

Damages and Costs

Damages are ordered by the Court in order to compensate a party who has suffered a loss or to punish the wrongdoer. For example, compensatory damages for negligence resulting in property damage or punitive damages for extraordinary behaviour by the wrongdoer. The Ruling confirms that damages are not subject to GST as there has not been a supply for consideration.

The Ruling states that costs, awarded by a court or as agreed between the parties as part of an out-of-court settlement, are not subject to GST as there has not been a supply for consideration. Rather, payments of costs are another form of compensation (ie. damages) and are treated as such for the purposes of GST.

Apportionment

If a payment or consideration under a court order, or as part of an out-of-court settlement, relates to more than one type of supply, then the Ruling requires that consideration to be apportioned before calculating any applicable GST.

Summary

Insurers will need to understand the GST consequences of any settlements entered into by it or its policyholders as well as the GST consequences of any payments ordered by the court as this may:

- affect the GST consequences of any payments made under its policies;
- require a gross up clause in the settlement agreement; and
- result in other GST consequences, such as the person making the supply being required to issue a tax invoice.

Summary of the Health Care Liability Act 2001

The *Health Care Liability Act* (NSW) 2001 was assented to on 5 July 2001. The Act introduces a legislative reform package that will regulate claims for personal injuries arising from the provision of medical and hospital care. Parts 1 and 2 of the Act are deemed to have commenced on the date of assent, however Part 3 of the Act has not yet commenced.

The Act will apply to claims for injuries sustained prior to the date of assent. However, the Act will not apply to proceedings that have commenced, or damages that have been awarded, prior to the date of assent, nor will it apply to certain classes of damages excluded by regulation.

Part 2

Part 2 of the Act limits the quantum of damages that may be awarded to claimants, and thereby seeks to reduce the indemnity costs of providers of certain hospital and medical services and their insurers. It sets out the following requirements:

(a) the maximum weekly rate for damages for loss of earnings is set at a net amount of $2,603. This rate will be indexed in line with the motor accidents scheme;

(b) future loss of earnings claims will be determined strictly in accordance with the most likely future prospects of the particular claimant prior to the injury;

(c) the discount rate on lump sum damages for medical and hospital claims is set at 5%;

(d) domestic, nursing and other gratuitous attendant care services will not be compensable unless the court is satisfied that they are reasonably necessary, that the need for them has arisen solely because of the injury, and that they would not have been provided to the claimant but for the injury to which the claim relates;

(e) non-economic loss will be assessed in accordance with the table in the Motor Accidents Act 1988. Non-economic loss damages for the most serious cases is capped at $350,000. No interest is payable on non-economic loss damages;

(f) damages may be reduced if the claimant has been guilty of contributory negligence; and

(g) exemplary and punitive damages for health care claims are abolished.

Part 3

Part 3 of the Act contains information that is most relevant to insurers of medical and other health care practitioners. It requires registered medical practitioners to be covered by approved Professional Indemnity Insurance, unless they fall within the exemptions listed in the Act or the Regulations. The Act provides that the Medical Board will have the power to suspend a doctor if it is satisfied that he or

she does not have Professional Indemnity Insurance. Doctors who will be exempted from obtaining such insurance include those who are employed in the public health system, and those who practice in an area with no risk of a personal injuries claim.

Professional Indemnity Insurance will be approved by ministerial order published in the *Government Gazette*. Professional Indemnity Insurance will only be approved if it is adequate to cover claims for severe injuries, and if it provides sufficient run-off cover for practitioners who retire, or who cease to practise in NSW. The Act also imposes mandatory risk management obligations on medical indemnity insurers, and provides that other conditions may be imposed on insurers under ministerial order.

A medical indemnity provider who fails to comply with the requirements of an insurance regulation order may be excluded from the NSW medical indemnity insurance market for a specified period. A prohibition order may prohibit an insurer from providing approved insurance at all, or alternatively, it may prohibit an insurer from providing cover to newcomers, but will not prevent it from renewing cover for existing customers.

Allens Arthur Robinson