

**Annual Review of
Insurance Law**

2002

Allens Arthur Robinson 

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We would very much like your feedback on this Review: there's a short questionnaire on our website.

If you would like further information about our monthly Forums on Insurance Law please contact: Natasha Scott on +61 2 9230 4426.

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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

The Allens Arthur Robinson Annual Review of Insurance Law 2002 is the culmination of the efforts of many people in the AAR Insurance Practice Group in monitoring, reviewing and developing an understanding of cases, legislation and regulatory developments affecting the insurance industry over the past year. There has been a record number of contributors to this year's review, and the quality of the contributions this year has been particularly high, reflecting the breadth and depth of experience the firm has built up in the insurance area. The firm's insurance practice continues to thrive and it is pleasing to see that it has attracted, and continues to attract, many outstanding lawyers.

The past year has been a challenging one for the insurance industry. The lessons to be learned from the collapse of HIH and heavy losses experienced throughout the industry on particular lines of business, in turn impacting upon reinsurers, have inevitably led to very substantial increases in premiums and/or changes in policy wordings aimed at limiting coverage. Many insurers have consolidated with other insurers through mergers and acquisitions. Significant legislative reforms in the area of civil liability are aimed at ensuring that claims are kept to a reasonable level and insurance remains affordable across the community.

Ultimately, the cost of insurance in any field of activity reflects the risks of engaging in such activity. Recent events have forced participants to look at ways of either curtailing these costs or reducing those risks. An example of the latter is the efforts of many auditing firms to improve the independence of their auditors, following the collapse of Arthur Anderson. This often involves a two-way process between insureds and insurers and requires each to achieve a greater understanding of each other's business. In the field of directors' and officers' liability, many insurers have focused on the financial stability of the relevant corporations and have sought to curtail the unsustainable influx of claims by excluding coverage for claims arising out of insolvency. Where insured directors are able to demonstrate that the company's financial position is sound, they are often able to negotiate for the removal of such exclusions.

The changes that are occurring are necessary to the long-term survival of the industry. The changes in turn provide a stimulus for insureds and insurers alike to achieve a better understanding of each other's business. By reporting on legal developments of relevance to the industry as a whole, among its other uses, this publication may assist in that process.

The feedback from last year's publication and publications of previous years has been tremendous. It is encouraging to see that a diverse range of readers find the publication useful. I trust readers will find this year's publication both useful and interesting. I wish to thank all those who have contributed to the publication and I welcome any comments from readers, including any suggestions as to how the publication may be improved.



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CONTENTS

General insurance law

1.	Rights of subrogation held to be paramount and able to be exercised against third party liable under a contractual indemnity	9
	<i>Caledonian Oil Sea Limited v British Telecommunications PLC (Scotland) & Ors</i>	
2.	Contract works insurance – rights of subrogation unable to be exercised against beneficiary of contractual obligation to insure	11
	<i>Co-operative Retail Services Limited v Taylor Young Partnership & Ors</i>	
3.	Section 35 – Supreme Court adopts narrow interpretation of insurer’s obligation to inform	13
	<i>Hams v CGU Insurance Ltd</i>	
4.	Section 54 unable to assist an insured who has failed to exercise the right conferred by section 40	15
	<i>Gosford City Council v GIO General Ltd</i>	
5.	Section 51 – ‘the insured’ must be a party to the contract of insurance	17
	<i>Ripper & Ors v Gatenby & Ors</i>	
6.	Claims, notifications and joining a defendant’s insurer	18
	<i>Hellyer & Anor v AMP General Insurance Limited</i>	
7.	Availability of preliminary discovery to identify an insurer	20
	<i>Perpetual Trustee Co Ltd v Wilkins</i>	
8.	No leave to proceed against insurer where exclusion clause operates	22
	<i>New South Wales v AXA Insurance Australia Ltd</i>	
9.	More than one proximate cause of loss under an ISR policy	24
	<i>PMB Australia Limited v MMI General Insurance Limited</i>	
10.	Total and permanent disability benefit – the role of the Superannuation Complaints Tribunal	26
	<i>Alcoa of Australia Retirement Plan Ltd v Thomson</i>	
11.	Whether an insured’s admission caused or contributed to the loss	27
	<i>Hugo trading as Hugo Auto Services v AMP General Insurance (NZ) Limited</i>	
12.	Further restrictions on public liability claims in Western Australia	29
	<i>Hewitt v Benale Pty Ltd; WMC Resources Ltd v Koljibabic</i>	

Duty of disclosure

13.	What must an insurer do to inform the insured of their duty of disclosure?	31
	<i>RACV Insurance Pty Ltd v Alam</i>	
14.	When will insurer be unable to avoid in the case of fraudulent non-disclosure	33
	<i>Sherry v FAI General Insurance Company Limited (in liquidation)</i>	
15.	Remedies for misrepresentation and non-disclosure – discharging the onus of proving what the insurer would have done	35
	<i>McNeill & Ors trading as The Front Row & Anor v O’Kane</i>	
16.	Duty of disclosure – what matters are known to an insurer?	36
	<i>General Accident Insurance Asia Ltd v Sakr & Anor</i>	
17.	Construction of exclusion clauses – knowledge and the duty of disclosure	39
	<i>Hammer Waste Pty Ltd v QBE Mercantile Mutual Limited & Anor</i>	

Construction of policies

- | | |
|---|-----------|
| 18. Issue of writ does not constitute making of a claim | 41 |
| <i>King v McKean & Park and Ors</i> | |
| 19. What conduct is a professional indemnity policy intended to cover? | 42 |
| <i>Pioneer Road Services Pty Limited v QBE Insurance Limited & Anor</i> | |
| 20. What is the consequence of breaching an obligation to take out insurance in the name of another party? | 45 |
| <i>Thiess Contractors Pty Ltd v Norcon Pty Ltd</i> | |
| 21. Exclusion clauses, cross-liability clauses and election | 47 |
| <i>Transfield Pty Limited v National Vulcan Engineering Insurance Group Limited & Ors; Connell Wagner Pty Ltd v National Vulcan Engineering Insurance Group Ltd & Ors</i> | |
| 22. Group public liability policies – possible gaps in coverage | 49 |
| <i>Toomey v Scolaro's Concrete Constructions Pty Ltd & Ors</i> | |
| 23. The meaning of 'subsidiary' and the contra proferentem rule | 51 |
| <i>Independent Timber Importers (Aust) Pty Ltd v Mercantile Mutual Insurance (Australia) Limited</i> | |
| 24. No indemnity available where derelict building damaged | 52 |
| <i>Bakerland Pty Ltd v Coleridge</i> | |
| 25. Extension of cover to riot – burden of proof that loss not due to insurrection | 54 |
| <i>Grell-Taurel v Caribbean Home Ins & Ors</i> | |
| 26. Insurer able to deny liability where insured failed to comply with regulatory regime in carrying out work | 56 |
| <i>Kim & Anor v Cole & Ors</i> | |
| 27. No general obligation on insurer to indemnify insured for legal costs if no express clause and where costs not incurred for insurer benefit | 58 |
| <i>Royal Sun Alliance Insurance Australia Ltd v Mihailoff & Anor</i> | |

Reinsurance

- | | |
|---|-----------|
| 28. Reinsurance – establishing breach of claims cooperation clause | 60 |
| <i>Gan Insurance Co Ltd v Tai Ping Insurance Co Ltd (No 3)</i> | |

Broker's duties

- | | |
|---|-----------|
| 29. Broker's duty to advise about flood exclusion | 63 |
| <i>Eliade Pty Ltd v Nonpareil Pty Ltd & CIC Insurance Limited</i> | |

Duty of care, Trade Practices Act and common law liability

- | | |
|--|-----------|
| 30. High Court considers duty of care of statutory authorities | 65 |
| <i>Graham Barclay Oysters Pty Ltd v Ryan</i> | |
| 31. A stockbroker's flagrant breach of duty – exemplary damages awarded | 69 |
| <i>Ali v Hartley Poynton Ltd</i> | |

32.	No extension of liability in favour of subsequent purchasers of commercial dwellings <i>Woolcock Street Investments Pty Ltd v CDG Pty Ltd & John Cameron Johnson</i>	73
33.	Degree of control necessary to found direct or vicarious liability <i>Frost v Warner</i>	75
34.	Hotelier's duty of care towards an intoxicated patron <i>South Tweed Heads Rugby League Football Club Ltd v Cole</i>	77
35.	Display of warning signs required? <i>Burns v Hoyts Pty Ltd</i>	79
36.	Reasonable foreseeability of the risk of injury and the borderline between liability and non-liability <i>New South Wales Land & Housing Corp v Watkins</i>	81
37.	Duty of care and reasonable foreseeability of sporting injuries <i>Woods v Multi-Sport Holdings Pty Ltd</i>	83
38.	Occupier's liability – multiple-use sporting venue <i>Canterbury Municipal Council v Taylor</i>	85
39.	Negligence and occupier's liability <i>Gondoline Pty Ltd v Janice Rose Hansford</i>	87
40.	When is risk of injury far-fetched and fanciful? <i>Hakoah Club Ltd v Green</i>	89
41.	Nervous shock – what limits remain? <i>Tame v New South Wales; Annetts v Australian Stations Pty Limited</i>	91
42.	High Court abolishes discounting of damages for prospect of remarriage <i>De Sales v Ingrilli</i>	95
43.	High Court rejects reduction of damages award under Trade Practices Act for contributory negligence <i>I&L Securities Pty Ltd v HTW Valuers (Brisbane) Pty Ltd</i>	97
44.	Equitable contribution arising out of different causes of action <i>Burke v LFOT Pty Ltd</i>	99
45.	What law should be applied to an action in respect of torts committed outside Australia? <i>Regie National des Usines Renault SA v Zhang</i>	101
46.	Duties and responsibilities of the expert witness <i>Makita (Australia) Pty Ltd v Sprowles</i>	103

Legislative and regulatory developments

47.	Tort law reforms	105
48.	Financial services reform	115
49.	Not-for-profit pool	128
50.	Terrorism Insurance Bill 2002	129
51.	Anti-terrorism funding legislation	132

Rights of subrogation held to be paramount and able to be exercised against third party liable under a contractual indemnity

Case Name:

Caledonian Oil Sea Limited v British Telecommunications PLC (Scotland) & Ors

Citation:

[2002] UK House of Lords per Lords Bingham, Mackay, Nicholls, Hoffmann and Scott

Date of Judgment:

7 February 2002

Issues:

- Subrogation
- Third party contractual indemnity

In this decision, the House of Lords confirmed the decision of the Court of Sessions (Scotland) that an insurer could exercise a right of subrogation to enforce a contractual right of indemnity held by the insured.

The facts

This case arose out of an explosion on the 'Pipa Alpha' Oil Platform in 1988 in the North Sea. The explosion killed 165 people. Those people were employed either by the operator of the platform or various sub-contractors. Insurers of the operators indemnified them in respect of their liability to compensate the victims. They then sought to exercise rights of subrogation against the contractors, relying upon a contractual right of indemnity under the contract between the operators and the contractors.

Decision at first instance

The original judgment in *Elf Caledonie Limited v London Bridge Engineering & Ors*, delivered by the Outer House of the Court of Sessions in September 1997, was to the effect that the insurers to the operators and the contractors had coordinate liabilities to indemnify. Since the operators had already been indemnified by the insurers, they had suffered no loss that could be the subject of a claim for indemnity against the contractors. The only claim the insurers had against the contractors was a claim for contribution. However, this was statute-barred by the time the judgment was handed down.

The effect of this treatment of insurers and contractors as co-obligors is to prevent recovery by insurers exercising their rights of subrogation. The first instance decision was overturned by the Inner Court of Sessions (as reported in our *Annual Review of Insurance Law 2000*, p.29). In essence, the court found that the indemnity obligations of the contractors were 'primary obligations', while the indemnity provided by the operator's insurers was secondary.

The House of Lords upheld the decision of the Inner Court of Sessions. In doing so, it cited with approval the decision of the Supreme Court of Western Australia in *Speno Rail Maintenance Australia Pty Limited v Hamersley Iron Pty Limited* (2000) 20 WAR 291, in which the court held that a contractual right of indemnity and a liability to indemnify arising out of the contract of insurance are intrinsically different and not coordinate. The decision in *Speno Rail Maintenance* is reported in the *AAR Annual Review of Insurance Law 2001* (p.35).

Although this decision is not binding authority in Australia, it is likely to be followed and should provide comfort for insurers seeking to exercise rights of subrogation to enforce contractual rights of indemnity. This is of particular importance to insurers in the mining and construction industries.

Contract works insurance – rights of subrogation unable to be exercised against beneficiary of contractual obligation to insure

Case Name:

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

Citation:

[2002] Lloyds Rep Ir UK House of Lords per Lords Bingham, Mackay, Steyn, Hope and Rodger

Date of Judgment:

25 April 2002

Issues:

- Contractors' all-risk insurance
- Subrogation
- Rights against co-insured

In this case, the UK House of Lords 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 decision of the English Court of Appeal is reported in the *AAR Annual Review of Insurance Law 2001*¹.

The facts

The claimant (**CRS**) contracted Wimpey to build a new office under a standard-form building contract. Wimpey, in turn, engaged Hall as electrical subcontractor.

Clause 22A in the standard-form contract required Wimpey to take out joint-names insurance, covering itself and sub-contractors, such as Hall, for all risks of damage.

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 was indemnified under the joint named policy, therefore the proceedings were brought by CRS' insurers as a subrogated action.

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

The decision – Court of Appeal

The issue was whether Wimpey and/or Hall were liable to make contribution to the appellants and, if so, whether the insurers could exercise rights of subrogation to enforce such liability.

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 appeared to be based upon the presumed intention of the parties. The court observed that the principle had 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 co-insured the indemnity that it had paid to the insured.

¹ See page 64

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 could be liable to 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.

The decision of the House of Lords

The House of Lords upheld the decision of the English Court of Appeal. They considered that the effect of clause 22A was to exclude Wimpey's liability to CRS in the event of damage that was the subject of Wimpey's obligation to insure. The intent of the parties was that CRS would look to the joint-names insurance policy. It was not envisaged that Wimpey would be sued for damages by CRS, nor would CRS be relieved from its obligation to pay the full contract price to Wimpey.

It follows that the court considered that the contractual scheme displaced whatever rights of action would have existed at common law. There was no need to consider the difficult question of whether, and in what circumstances, rights of subrogation could be exercised against a co-insured under a joint-names policy. Once it was determined that Wimpey and Hall had no liability to CRS, no question of subrogation could arise.

Of interest are obiter remarks made as to the proper basis for the rule in *Petrofina* that insurers can never sue one co-insured in the name of another. Lord Hope (with whom a number of the other judges agreed) supported the view of the Court of Appeal that circuity of action is not the explanation, but the true basis for the rule is an implied term in the contract between the parties.

This case deals with the often difficult question: 'in what circumstances will an insurer be prevented from exercising rights of subrogation against a co-insured?' In the case of contract works insurance, the contractual arrangements between the two co-insureds will often suggest a term should be implied to the effect that there will not be any claims between them for losses that are covered by the insurance. However, in some cases the contractual arrangements between the co-insureds may not preclude claims being brought. In such cases, there may nevertheless be an implied term in the contract of insurance preventing the exercise of rights of subrogation against a co-insured.

Section 35 – Supreme Court adopts narrow interpretation of insurer’s obligation to inform

Case Name:

Hams v CGU Insurance Ltd

Citation:

[2002] NSWSC 273 per Einstein J

Date of Judgment:

12 April 2002

Issues:

- Section 35 of the *Insurance Contracts Act 1984*
- Meaning of ‘flood’ exclusion
- Wayne Tank principle

This case discusses the ambit of section 35 of the *Insurance Contracts Act 1984 (Cth)* (the *ICA*), namely what an insurer must do to satisfy its obligation to clearly inform the insured in writing of the limitations of the policy terms.

The facts

Mr and Mrs Hams were leaseholders of a sheep station located within a geographical depression in New South Wales, described as a valley with an uneven floor that creates three sumps where water collects after heavy rainfall. In February 2000, exceptionally heavy rain fell and the Hams’ homestead was inundated with water when the water level within the depression rose. The Hams made a claim under their insurance policy, which was issued by CGU Insurance Ltd (**CGU**).

The insurance policy excluded flood damage and ‘flood’ was defined as:

inundation following the escape of water from the normal confines of any lake, reservoir, dam, river, creek or navigable canal, as the result of a natural phenomenon which has some element of violence, suddenness or largeness about it but does not mean inundation by water from fixed apparatus, fixed tanks, fixed pipes or run-off of surface water from surrounding areas.

CGU denied liability on the basis that the damage to the Hams’ property was caused wholly or partly by flood and therefore excluded from cover. By virtue of the principle laid down in *Wayne Tank & Pump Co Ltd v Employers Liability Assurance Corp Ltd* [1974] QB 57, if a loss has two or more proximate causes and at least one cause is excluded from cover, the insurer is not liable. If CGU could prove, therefore, that at least one proximate cause of the damage was flood, it was entitled to deny liability entirely.

The Hams argued that the source of the water was the rain-filled sump and a sump is not a lake with ‘normal confines’ and so does not fall within the flood exclusion. Alternatively, they argued that CGU was precluded from relying on the flood exclusion because it had not clearly informed them in writing either that the policy excluded destruction, loss or damage caused by flood or about the Wayne Tank principle, as required by s35 of the ICA.

Section 35 requires insurers of ‘prescribed contracts’ to provide the level of cover specified in the regulations, unless it proves that it clearly informed the insured, in writing, ‘whether by providing the insured with a document containing the provisions, or relevant provisions, of the proposed contract, or otherwise’, that cover was more limited. ‘Prescribed contracts’ include motor vehicle, home building, home contents, sickness and accident, consumer credit and travel insurance.

As this was the first time that a court had considered the effect of s35, ASIC decided to intervene and make submissions.

The decision

Justice Einstein decided that a body of water could not be properly described as a lake if it did not have normal confines, particularly as there could not be an 'escape' of water as required by the policy. Accordingly, the insured's claim for indemnity hinged on whether it could establish that the insurer had failed to comply with s35.

When considering the wording of s35, Justice Einstein accepted ASIC's submissions that merely supplying an insured with a document containing the relevant provisions may not be sufficient to discharge the insurer's obligations to clearly inform. He said that there may be circumstances where the complexity of or confusions within the document are such that the mere provision of the policy did not establish that the insurer had effectively informed the insured of relevant limitations. However, the judge decided that, in these circumstances, the Hams had been clearly informed about the nature and extent of the flood exclusion by merely being provided with the policy.

In addition, Justice Einstein said that it could not be the intention of s35 to require an insurer to provide a text on the principles of insurance law that underpin the construction of policy provisions, and so he decided that CGU were not obliged to inform the Hams about the operation of the Wayne Tank principle.

Accordingly, the judge ordered that the Hams were not entitled to an indemnity under the policy for the damage sustained.

This decision provides some comfort to insurers and indicates that, in many cases, an insurer can satisfy its obligation to inform its insured of the limitations of the policy by merely providing a copy of the policy terms and conditions. However, to be successful, an insurer must show that the policy terms are not complex and there is no opportunity for confusion in the way they have been written. It will be important that any exclusions are written in plain English.

Section 54 unable to assist an insured who has failed to exercise the right conferred by section 40

Case Name:

Gosford City Council v GIO General Ltd

Citation:

[2002] NSWSC 511; [2002] 12 ANZ INS CAS 61-527

Date of Judgment:

13 June 2002

Issues:

- Sections 54 and 40 of the *Insurance Contracts Act 1984*
- Claims made policies lacking 'deemed claims' or 'occurrences notified' clause
- Effect of failure to give notice of occurrences within the policy period

This case considers the ability of an insured to rely on section 54 to provide relief for a failure to notify the insurer of occurrences under s40(3).

The facts

GIO General Limited (**GIO**) issued a 'claims made' professional indemnity insurance policy (the **policy**) to Gosford City Council (the **council**) for the period 30 June 1998 to 13 December 1991. The policy was a claims made policy that lacked an 'occurrence notified' clause. In May 1991, the council notified its broker, Jardine Lloyd Thompson (the **broker**), about a potential claim by the Central Coast Leagues Club (the **club**) against the council regarding an allegedly negligent approval of building plans in 1986 and 1987. The broker failed to pass this information on to GIO.

In July 1994, the club commenced legal proceedings against the council. Those proceedings were ultimately settled. Following settlement, the council sought indemnification under the policy for its legal costs not included in the settlement. GIO denied indemnity on the basis that the claim was not notified during the period of insurance.

The council submitted that s40(3) of the *Insurance Contracts Act 1984* (Cth) (the **ICA**) either implied a term into the policy that operated similarly to an 'occurrences notified' clause and that s54 of the ICA operated to relieve the council from its failure to notify the relevant occurrence. GIO submitted that ss40(3) and 54 could not be relied on to relieve a failure to notify the relevant occurrences and sought to distinguish this case from *FAI General Insurance Company Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641 (**Australian Hospital Care**), where s54 relieved an insured's failure to notify occurrences giving rise to a claim in circumstances where the relevant policy included an 'occurrences notified' clause.

The decision

Justice Bergin rejected the council's submission and, in doing so, endorsed the decision of Justice Chesterman in *CA and MEC McInally Nominees Pty Ltd & Ors v HTW Valuers (Brisbane) Pty Ltd & Ors* (2001) 11 ANZ INS CAS 61-507 that s54 had no application to an insured's failure to exercise the right conferred on it under s40(3), as the latter section did not imply a term in insurance contracts to the same effect as 'occurrences notified' clauses. As Justice Chesterman stated, if s40(3) implied a term into contracts it would do so clearly. Further, if s54 relieved an insured from exercising the right conferred on it by s40(3), clear reference would have been made to this within s40(3). In any event, Justice Bergin found that GIO would not have been liable even if s40(3) did imply a term into the policy

as indemnity was denied on the basis that the claim was not for a demand of the kind dealt with by the policy because it was not a demand by a third party within the period of cover.

This case provides further comfort to insurers in its support for the position that s54 will not operate to excuse a failure to notify in the policy period in cases of professional indemnity policies that do not contain an 'occurrences notified' clause. This ruling supports the decision of Justice Chesterman in *CA and MEC McNally Nominees Pty Ltd & Ors v HTW Valuers (Brisbane) Pty Ltd & Ors*, reported in the *AAR Annual Review of Insurance Law 2001* (p.17). As stated in the 2001 Review, the final resolution of this issue must await a decision of the High Court. In the meantime, insurers may consider it prudent to remove 'occurrences notified' clauses from their policies, if they are commercially able to do so.

Section 51 – ‘the insured’ must be a party to the contract of insurance

Case Name:

Ripper & Ors v Gatenby & Ors

Citation:

[2002] TASSC 45 (11 July 2002) per Blow J (Tasmanian Supreme Court)

Date of Judgment:

11 July 2002

Issues:

- Section 51 of the *Insurance Contracts Act 1984*
- ‘The insured’

This case supports the proposition that ‘the insured’ for the purpose of section 51 of the *Insurance Contracts Act 1984* (Cth) (the *ICA*) is confined to a party to the contract of insurance and does not extend to third party beneficiaries.

The facts

The pilot and passenger of a light aircraft died in a crash.

The widow and daughter of the passenger (together, the *plaintiffs*) sought damages under the *Fatal Accidents Act 1934* (Tas) (the *FAA*) from the pilot’s estate (the *defendant*), alleging that the negligence of the pilot caused the death of the passenger (the *negligence proceedings*).

The defendant instituted third party proceedings seeking an indemnity under an insurance policy issued by the insurer to the Tasmanian Aero Club, under which the pilot was insured but to which he was not a party (the *policy*).

Subsequently, the plaintiffs commenced a separate action against the insurer, relying on s51 of the ICA (the *ICA proceeding*), which provides that a third party may recover directly from an insurer where the insured has died.

While the case raised a number of issues, the most important point was the finding of Justice Blow that the plaintiffs had no right to proceed against the insurer under s51 of the ICA in the ICA proceedings, as the pilot was not a party to the policy and, therefore, the pilot was not ‘the insured’ for the purposes of s51.

Claims, notifications and joining a defendant's insurer

Case Name:

Hellyer & Anor v AMP General Insurance Limited

Citation:

[2002] NSWSC 866 per Smart AJ

Date of Judgment:

20 September 2002

Issues:

- Meaning of 'claim'
- What can be notified as a circumstance likely to give rise to a claim?
- Is there room for the operation of the *Insurance Contracts Act 1984* where a plaintiff seeks leave to sue a defendant's insurer?

Informing a person of injuries suffered while under their care is not a 'claim' but can be a circumstance that might give rise to a claim. A plaintiff cannot rely on the remedial provisions of the *Insurance Contracts Act 1984* (Cth) when seeking leave to sue a defendant's insurer under section 6 of the *Law Reform (Miscellaneous Provisions) Act 1946* (NSW).

The facts

In May 1994, the plaintiffs suffered decompression illness during a course on scuba diving provided by Mr Andrew Gunst in Cairns. The plaintiffs saw a doctor on their return to Canberra and were both treated in a decompression chamber.

Shortly afterwards, one of the plaintiffs telephoned Mr Gunst. She informed him that she and her boyfriend had been diagnosed with 'the bends' and were being treated at a decompression chamber on HMAS Penguin.

At that time, Mr Gunst was insured with AMP General Insurance Limited (**AMPG**).

Mr Gunst died on 8 November 1996. AMPG first became aware of possible claims by the plaintiffs in April 1999.

The plaintiffs sought leave to commence proceedings against AMPG under s6 of the *Law Reform (Miscellaneous Provisions) Act 1946* (NSW).

Section 6 entitles a plaintiff (in limited circumstances) to bring proceedings directly against a defendant's insurer where, for example, the defendant has died. It also provides, however that:

Leave shall not be granted in any case where the court is satisfied that the insurer is entitled under the terms of the contract of insurance to disclaim liability ...

The plaintiffs argued that they should be entitled to leave to proceed against AMPG as:

1. During the period of insurance, either:
 - (a) the plaintiffs made a claim against Mr Gunst; or
 - (b) Mr Gunst became aware of circumstances that might give rise to a claim; and
2. The failure by Mr Gunst to notify AMPG of the claim or, alternatively, of circumstances that might give rise to a claim, could be excused under s54 of the *Insurance Contracts Act 1984* (Cth) (the **ICA**).

The decision

Was a claim made against Mr Gunst during the period of insurance?

Acting Justice Smart held that no claim was made against Mr Gunst during the policy period. Although the plaintiffs informed Mr Gunst that they suffered decompression illness, Acting Justice Smart held that this fell 'marginally short of a claim'. The authorities referred to by Acting Justice Smart suggest that a claim requires an assertion of a present entitlement to compensation. The conversation between the plaintiffs and Mr Gunst did not go this far.

Was Mr Gunst aware of circumstances that might subsequently give rise to a claim?

Acting Justice Smart held that Mr Gunst was aware of circumstances that might give rise to a claim. He held that Mr Gunst was aware that a claim was likely to be made once he had been informed that two of his students had suffered decompression illness. He therefore further held that Mr Gunst should have notified AMPG that two of his students had suffered decompression illness and that a claim might be made against him.

Should leave be granted to the plaintiffs?

The failure of Mr Gunst to inform AMPG of the circumstances that might give rise to a claim meant that, looking solely at the contract between him and AMPG, he was not entitled to indemnity. This failure would arguably be excused, however, under s54 of the ICA.

Section 6 provides that a court shall not grant leave to plaintiffs to proceed against an insurer where the insurer is entitled to disclaim liability *under the terms of the contract of insurance*. The issue for Acting Justice Smart, therefore, was whether the effect of the ICA should be considered in deciding whether an insurer can disclaim liability under the contract of insurance. Acting Justice Smart referred to the decision of the NSW Court of Appeal (which was binding on him) in *FAI General Insurance v Jarvis* (1999) 46 NSWLR1 (reported in our *Annual Review of Insurance Law 1999*, p.27), in which the court held that the failure of an insured to comply with certain policy provisions (including provisions requiring prompt notification of occurrences) prevented a court granting leave under s6, notwithstanding s54 of the ICA.

Acting Justice Smart was therefore bound to refuse leave to the plaintiffs to bring proceedings against AMPG. The plaintiffs did reserve their right during this case, however, to argue before the NSW Court of Appeal that *FAI v Jarvis* was wrongly decided.

This case confirms that a 'claim' requires the assertion of a legal right. It takes a relatively broad view on what constitutes a 'circumstance' that might give rise to a claim. Most importantly, perhaps, this case confirms that plaintiffs cannot rely on the ICA in seeking leave to bring proceedings directly against an insurer.

Availability of preliminary discovery to identify an insurer

Case Name:

Perpetual Trustee Co Ltd v Wilkins

Citation:

(2002) 12 ANZ Insurance Cases 90-111 per Santow J

Date of Judgment:

21 December 2001

Issues:

- Third party claim
- Preliminary discovery of identity of insurer

This case considers the issue of whether preliminary discovery will be granted in order to enable a third party contemplating an action under section 6 of the *Law Reform (Miscellaneous Provisions) Act 1946* (NSW) from ascertaining the name of any relevant insurer.

The facts

Perpetual Trustee Co Ltd (*Perpetual*) and AGP Management Limited (*AGPM*) were the current trustee and manager respectively of the Global Property Funds Trust (the *trust*). AGPM commenced investigations into the previous management of the trust by Tyndall Funds Limited (*TFL*). Between May 1994 and late 1997, TFL invested substantial funds from the trust in the Mandarin Centre Development (the *development*), resulting in a loss of more than \$10 million by the trust. Perpetual considered the investment of trust funds in the development was inappropriate, speculative and in breach of the terms of the trust deed.

Proceedings were commenced by Perpetual against TFL and certain of its directors for restoration of trust assets and damages arising from breaches of duty, breaches of the terms of the trust deed and breach of fiduciary duty. However, TFL was insolvent and would be unable to satisfy a judgment in the proposed claim. Therefore, Perpetual sought to join any insurer that was a party to a policy of insurance with TFL as a defendant in the proceedings, under s6 of the *Law Reform (Miscellaneous Provisions) Act 1946* (NSW) (the *Act*). Section 6 enables third parties (in this case, Perpetual), with the leave of the court, to proceed against any insurers who entered into a contract of insurance by which another party (TFL) is indemnified against liability to pay any damages or compensation to the third party.

Perpetual wished to determine whether TFL had a policy that may cover its claim. It submitted that, because TFL has or may have either knowledge of facts or documents in its possession, custody or control that would assist in ascertaining the identity of any relevant contracts of insurance and any relevant insurer, an order for preliminary discovery should be made under Part 3 rule 1 of the NSW Supreme Court Rules.

The decision

Under s6, the plaintiff was required to:

1. seek leave to proceed against the insurer; and
2. establish that it had at least an arguable case against TFL.

Justice Santow acknowledged that, in general, leave to proceed against an insurer should be refused wherever the insured is a viable defendant. However, the court will generally provide direct access to an insurance fund where the insured is not solvent with liquid assets, and enforcement will be frustrated without direct access, as was the case in *Kinzett v McCourt* (1999) 32 NSWLR 32, reported in our *Annual Review of Insurance Law 1999* (p.25).

Justice Santow made it clear that leave of the court would be granted if Perpetual had lead sufficient evidence to demonstrate that there was a serious question to be tried. However, Perpetual did not establish that it had a reasonable prospect of succeeding in an action against TFL: *Stewart v Miller* [1979] 2 NSWLR 128.

This case demonstrates that an order for preliminary discovery to ascertain the identity of an insurer will only be made in favour of a claimant if (1) the insured is insolvent; and (2) an arguable case is established against the insured.

No leave to proceed against insurer where exclusion clause operates

Case Name:

New South Wales v AXA Insurance Australia Ltd

Citation:

[2002] NSWCA 63 per Mason P, Giles JA and Ipp AJA

Date of Judgment:

7 March 2002; 18 March 2002

Issues:

- Section 6(4) *Law Reform (Miscellaneous Provisions) Act 1946*
- Cause of injury
- Defective design exclusion

This case involved an application for leave to proceed against the insurer under the *Law Reform (Miscellaneous Provisions) Act 1946 (NSW)*. The insurer claimed that leave should not be granted because the policy would not respond to the insured's claim for indemnity because of a defective design exclusion.

The facts

Eight-year-old student Matthew James Poidevin (**Matthew**) was playing soccer in a school playground when a 'porcupine ball' (a ball covered in rubber protrusions resembling spikes) struck him in the eye and rendered it virtually blind. New South Wales (**NSW**) had purchased the porcupine ball from Australian Sports Factory Pty Ltd (**ASF**). Matthew brought a claim against NSW, which in turn brought a cross-claim against ASF. After an arbitrator found both NSW and ASF liable, Matthew settled his claim against NSW for \$160,000 and judgment was entered against NSW for this amount, and also against ASF in favour of NSW. ASF became insolvent and NSW sought leave under section 6(4) of the *Law Reform (Miscellaneous Provisions) Act 1946 (NSW)* to proceed against AXA, ASF's insurer.

The decision

The trial judge refused leave to appeal on two grounds. Firstly, he was not satisfied that NSW had made an appropriate attempt to recover the debt from ASF. Secondly, he held that the injuries caused to Matthew were a design defect in the ball, and, therefore, an exemption clause in the policy in relation to defects in design applied. Consequently, AXA was not liable to indemnify ASF for its liability to NSW.

The issue on appeal was whether the trial judge was correct in determining that the injury to Matthew was caused by a design defect in the ball.

Although there had previously been a finding of negligence on the part of ASF in an arbitration, Justice Ipp noted that:

...an injury may be caused by separate causes, one being negligence in use, the other defective design. The two causes are not mutually exclusive.

Justice Ipp determined that the shape of the surface configuration of the porcupine ball was an important part of its design. He held that the protrusions gave the porcupine ball a distinctive and unusual – if not unique – configuration and appearance.

In determining whether the injury was caused by a design defect in the ball, he noted that ASF sold the ball to NSW on the basis that it was suitable for



unrestricted use in the playground. He also noted that each protrusion on the surface of the ball was significantly smaller than the socket of a young child's eye. Accordingly, he held that the design of the ball was not fit for the purpose for which the ball was being sold, namely unrestricted use by young children in the playground, and therefore the design of the ball was defective.

This case demonstrates that there can be more than one cause of an injury but where one cause is the subject of an exclusion in the policy, coverage may be denied. In order to establish that a design defect was a cause of injury, it may assist to show that the design was not fit for the purpose for which the product was being sold.

More than one proximate cause of loss under an ISR policy

Case Name:

PMB Australia Limited v MMI General Insurance Limited

Citation:

(2002) 12 ANZ Insurance Cases 61-537 per de Jersey CJ, Jerrard JA & White J

Date of Judgment:

20 September 2002

Issues:

- Industrial special risks policies
- Whether an insured event was a proximate cause of business interruption
- Entitlement to indemnity for more than one proximate cause

This decision is an appeal of a decision that appeared in our *Annual Review of Insurance Law 2000*². It considers the issue of the proper construction of industrial special risk policies, which provide cover for business interruption, where there is more than one proximate cause of a loss.

The facts

Between March and June 1996, an outbreak of the salmonella virus was traced to peanut butter made from peanuts sold by PMB to Kraft. PMB's operations were immediately affected by shutdown and cleaning of its plant. It resumed operations in July 1996 subject to government monitoring. Full production for Kraft was not resumed until October 1996, and the final stage of monitoring conditions began in November 1996.

PMB claimed \$4,795,000 under its industrial special risks policy for business interruption. The insurers admitted that the contamination interrupted PMB's business and paid \$700,000 but rejected the balance of PMB's claim, stating that, once the plant reopened in July 1996, the proximate cause of any further business interruption was due to PMB's new appreciation of the risk of salmonella and the taking of steps to reduce that risk, and not the initial outbreak.

The decision

At first instance, Justice Mullins found that, after the resumption of business in July, the initial outbreak continued to contribute to the disruption of PMB's business. Both the initial outbreak and PMB's new knowledge of the risk of contamination were proximate causes of the ongoing loss. Accordingly, PMB was entitled to indemnity for part of its loss until the end of the peanut season, at which time other unrelated factors had an effect on PMB's business.

On appeal, PMB argued that it was entitled to an indemnity for all losses, regardless of whether it was caused by the initial outbreak or its 'new awareness'. Its policy indemnified it for all loss '*directly resulting from interruption ... in consequence of*' its plant closure. The insurers responded that there was more than one cause and that PMB had failed to apportion its loss.

Chief Justice de Jersey, with whom Justices Jerrard and White agreed, approved of Justice Mullins' finding that the indemnifiable losses should be limited to those specifically referable to contamination. Although there were two proximate causes, these led to respective losses that PMB had elected to combine at the trial rather than to identify individually.

On the issue of which party bore the onus of proof, Chief Justice de Jersey rejected PMB's argument that it was up to the insurers to disentangle the respective losses, ruling that the trial judge was correct in finding that the onus rested with PMB because it had not established a prima facie entitlement to the whole of the loss. An additional argument by PMB that it was entitled to the cost of mitigating its loss under an implied term of the policy was also rejected.

This case demonstrates that a business interruption insurance policy will not necessarily indemnify an insured for the whole of its loss where the insured incurs costs because of its new-found knowledge arising from the initial loss. The insured bears the onus of proof in establishing an entitlement to the whole of its loss where there is more than one cause, and it is not for the insurers to disentangle the claim.

Total and permanent disability benefit – the role of the Superannuation Complaints Tribunal

Case Name:

Alcoa of Australia Retirement Plan Ltd v Thomson

Citation:

[2002] FCA 256, Federal Court of Australia per Nicholson J

Date of Judgment:

15 March 2002

Issues:

- Superannuation Complaints Tribunal
- Total and permanent disability benefit
- Section 37(6) of the *Superannuation (Resolution of Complaints) Act 1993*

In this case, a successful appeal was made by the trustee of a superannuation fund against a decision by the Superannuation Complaints Tribunal entitling a member of the fund to a total and permanent disability benefit.

The facts

Alcoa of Australia Retirement Plan Ltd (**Alcoa**) was the trustee of an employee superannuation plan (the **plan**) for Alcoa of Australia Pty Ltd. The respondent was a member of the plan from 1984 to 1998. In October 1999, the respondent lodged a claim for a total and permanent disability benefit (**TPD benefit**) under the terms of the trust deed. Alcoa rejected the respondent's claim and the respondent appealed against the decision to the Superannuation Complaints Tribunal (the **Tribunal**).

Section 37(6) of the *Superannuation (Resolution of Complaints) Act 1993* (Cth) (the **Act**), requires the Tribunal to affirm a trustee's decision if satisfied that it was 'fair and reasonable in the circumstances'. The Tribunal found that the decision made by Alcoa was not fair and reasonable. The Tribunal held that, while the medical evidence indicated that some sort of limited (but not full-time work) may be a possibility in the future, the respondent's ability to perform part-time work did not mean that he was not totally and permanently disabled (**TPD**).

The decision

Alcoa appealed against this determination on the basis that, among other things, the Tribunal did not address the correct question and did not take into account relevant considerations. Alcoa was successful on appeal and the matter was remitted to the Tribunal for reconsideration.

On appeal, Alcoa argued that the Tribunal erred in not asking whether the decision complained of was 'fair and reasonable in the circumstances', and confining themselves to the more narrow question of 'whether in its opinion the respondent was TPD'.

Rather, the Tribunal should have focused on whether the decision was fair and reasonable and, in so doing, should not have confined itself to the medical evidence.

In summary, when reviewing a decision of a trustee, the Tribunal must consider whether the decision was fair and reasonable in all the circumstances. This would include consideration of the terms of any relevant policy and is not confined to evidence that went before the trustee.



Whether an insured's admission caused or contributed to the loss

Case Name:

Hugo trading as Hugo Auto Services v AMP General Insurance (NZ) Limited

Citation:

(2002) 12 ANZ Insurance Cases ¶161-529 per Panckhurst J of the High Court of New Zealand

Date of Judgment:

4 June 2002

Issues:

- Admissions of liability by insured
- Whether loss caused or contributed by insured's statements
- Section 11 of the Insurance Law Reform Act 1977 (NZ)

The case examines whether statements by an insured constituted admissions such as to be in breach of the policy. It also considers when admissions will be considered to have caused or contributed to the loss for which the insured claims indemnity.

The facts

Mr Hugo, a mechanic, held a public liability policy with AMP General Insurance (NZ) Limited (**AMP**). In January 1996, Mr Hugo (**Hugo**) negligently repaired a truck owned by Tahuna Transport Ltd (**Tahuna**). An accident subsequently occurred in which the truck was extensively damaged. Tahuna claimed under its policy with NZI Insurance Limited (**NZI**).

Hugo made the following statements to NZI's representatives in the course of their investigation:

- he was unaware of the special tool recommended by the truck's manufacturer to conduct the vehicle repairs;
- on the day of the accident, he saw that the repaired part was not in the correct position; and
- the accident was a serious thing to happen about which he was worried after the event.

Subsequently, NZI advised Mr Hugo that it considered he was responsible for the accident. Hugo immediately notified AMP of the possibility of the claim. AMP declined indemnity. The grounds for declinature included reliance on Condition 3(c) of the policy, which provided that the insured 'must not make or give any admission, offer, promise, payment or indemnity'.

Tahuna brought proceedings against Hugo and Hugo joined AMP as a third party. At first instance, the court found that Hugo's negligence caused the accident. However, the court upheld AMP's declinature on the basis that Hugo had failed to meet the onus of showing that his statements were not material to the loss. Therefore, Hugo was denied the protection of section 11 of the Insurance Law Reform Act 1977 (NZ) (the **Act**), which otherwise would have rendered Condition 3(c) of the policy of no effect.

Section 11 of the Act provides:

Certain exclusions forbidden – Where –

- By the provisions of a contract of insurance the circumstances in which the insurer is bound to indemnify the insured against loss are so defined as to exclude or limit the liability of the insurer to indemnify the insured on the happening of certain events or on the existence of certain circumstances; and

(b) In the view of the court or arbitrator determining the claim of the insured, the liability of the insurer has been so defined because the happening of such events or the existence of such circumstances was in the view of the insurer likely to increase the risk of such loss occurring, -

the insured shall not be disentitled to be indemnified by the insurer by reason only of such provisions of the contract of insurance if the insured proves on the balance of probability that the loss in respect of which the insured seeks to be indemnified was not caused or contributed to by the happening of such events or the existence of such circumstances.

Hugo appealed the decision to allow AMP's declinature.

The decision

The issue to be decided by the NZ High Court was whether, in the context of s11 of the Act, Hugo's statements caused or contributed to the loss, being the establishment of liability by Tahuna against Hugo.

Justice Panckhurst of the New Zealand High Court held that for an event or circumstance to 'cause or contribute to the loss' in this context requires at least a meaningful contribution. Further, *actual* causation or contribution is required; the potential of an act to have that effect is not enough. The test is an objective one; the subjective view of the insurer is not determinative. However, Justice Panckhurst did find that it is for the insured to establish the absence of causation or contribution, otherwise the policy exemption applies.

In relation to the statements made by Hugo to NZI's representatives, Justice Panckhurst considered that this case is one where the likely cause of the accident was identified immediately after the accident (eg from photographs in situ and expert inspection of the wreck). Accordingly, the liability of Hugo was established by that process, not through what Hugo had said.

Further, with respect to the third statement made by Hugo, Justice Panckhurst found that, assuming that the statement was an admission, it was not one capable of causing or contributing to the loss because it was not possible to take from it anything meaningful in relation to the establishment of liability.

Accordingly, Justice Panckhurst made a declaration that Hugo was entitled to be indemnified by AMP in the terms of the policy.

This case seems to suggest that where liability of an insured can be established without recourse to any admissions by the insured, the admissions will not be considered to have caused or contributed to the loss. While this decision is based on s 11 of the Act, s 11 is similar to s54(2) of the *Insurance Contracts Act 1984* (Cth), although, in the case of the latter, the onus is on the insurer to prove the extent of its prejudice. Subject to the issue of onus of proof, this case provides guidance about the operation of s54(2) of the ICA in relation to admissions made by an insured.

Further restrictions on public liability claims in Western Australia

Case Name:

Hewitt v Benale Pty Ltd;
WMC Resources Ltd v
Koljibabic

Citation:

[2002] Western Australian
Supreme Court per Scott,
Hasluck, Heenan JJ

Date of Judgment:

19 June 2002

Issues:

- Extension of restriction on common law damages claims by employees
- Application to 'deemed employers'

This decision is of relevance to Western Australia only. It has the potential to significantly restrict common law claims arising out of work injuries in Western Australia. In this decision, the Full Court of the Supreme Court of Western Australia held that the restrictions on seeking common law damages against an employer extended to 'deemed employers', being the principals who subcontract work to contractors, where the contractor is the *actual* employer of the injured worker.

The facts

In *Hewitt v Benale*, the worker (**Hewitt**) was employed by a labour hire firm as a meat process worker. The labour hire firm directed Hewitt to work at an abattoir operated by the defendant (**Benale**). Hewitt brought a common law claim against Benale, alleging his injuries were a result of Benale's negligence.

In *WMC Resources Ltd v Koljibabic*, WMC Resources had contracted with Koljibabic's employer to perform electrical work at its premises. Koljibabic brought a common law claim against WMC Resources, alleging his injuries were a result of its negligence.

The decision

By reason of amendments to the *Workers' Compensation and Rehabilitation Act 1981* (WA) introduced in 1999, the only circumstances where a worker can bring a common law claim against an employer, or a third party can join an employer to a common law claim, are in cases of serious injury, ie where :

- it is agreed or determined that the worker's degree of disability is not less than 30%; or
- if the worker has a degree of disability between 16% and 29% and makes an election, which is required to be in the manner prescribed in the Act.

The question that arose in the above case was whether the principals (Benale and WMC Resources) being 'deemed employers' could take advantage of the above restrictions.

Meaning of deemed employer

Section 175 of the Act says:

- (1) Where a person (the principal) contracts with another person (the contractor) for the execution of any work by or under the contractor and, in the execution of the work, a worker is employed by the contractor, both the principal and the contractor are, for the purposes of this Act, deemed to be the employers of the worker.

The parties agreed that both WMC Resources and Benale were deemed employers for the purposes of s175 because of the particular fact situations. The dispute was whether the restrictions in the Act applied to deemed employers, or should be limited to apply only to the actual employer. The Full Court held unanimously that the restrictions applied to deemed employees as much as to the employers.

The application of the principles from the decision are yet to be tested in other fact situations. In other cases, it will be necessary to first establish that a party is a deemed employer as defined in s175.

In addition to s175(1) above, it is also necessary to show that the work on which the worker is employed at the time of the accident is 'directly a part or process in the trade of business of the principal', and 'on premises where the principal has undertaken to execute the work or which are otherwise under its control or management'.

Also, arguments have already been foreshadowed that if a labour hire firm is the contractor, the principal cannot be deemed to be an employer, as the work performed by the worker is not 'the execution of any work by or under the contractor' as required by s175(1). (This issue did not arise in *Hewitt v Benale* because of the particular arrangement between the defendant and the labour hire firm.)

The decision has significant implications for public liability insurers in Western Australia. Where the requirements of the statute are met, the effect of this decision is to preclude actions against deemed employers, either by the injured worker or by other parties in contribution proceedings.

The application of the decision in other fact situations remains to be seen, particularly in relation to the meaning of a 'deemed employer'.

What must an insurer do to inform the insured of their duty of disclosure?

Case Name:

RACV Insurance Pty Ltd v Alam

Citation:

[2001] VSC 503 per Balmford J

Date of Judgment:

19 December 2001

Issues:

- Section 22 of the *Insurance Contracts Act 1984*
- Sufficiency of explanation of the duty of disclosure

This case considers whether supplying the insured with a standard notice explaining the duty of disclosure is sufficient to comply with the insurer's obligations under the *Insurance Contracts Act 1984 (Cth)* (the *ICA*).

The facts

Ms Alam (the *insured*) insured her motor vehicle with RACV Insurance Pty Ltd (*RACV*). She renewed the policy with RACV for the following year. In the time between first obtaining the policy and the renewal, her brother, Mr Alam, became the subject of certain criminal penalties arising out of property offences apparently involving dishonesty, although no conviction was actually recorded. Although she knew her brother would regularly drive her vehicle, she did not disclose these criminal penalties to RACV on renewal.

When Mr Alam was subsequently involved in an accident while driving the Insured's vehicle, RACV sought to deny the claim on the grounds that the insured had breached her duty of disclosure.

In response, the insured alleged that RACV had failed to comply with its obligation under section 22 of the ICA to 'clearly inform the insured in writing of the general nature and effect of the duty of disclosure'. Compliance with that obligation was a precondition to RACV being able to deny the claim.

The documentation the insured received when she first effected the policy contained a standard notice explaining the duty of disclosure. It did not appear that any documents were given to the insured on renewal.

At first instance, the magistrate found for the insured. RACV appealed to the Supreme Court of Victoria.

Justice Balmford adopted the NSW Court of Appeal's decision in *Suncorp General Insurance Limited v Cheihk* [1999] NSWCA 238 (reported in our *Annual Review of Insurance 1999*, page 45), which emphasised that the obligation in s22 is to make the duty of disclosure 'clear' to the insured.

Justice Balmford decided that, in the circumstances, there was evidence upon which a reasonable magistrate could conclude that RACV had not clearly informed the insured of her duty of disclosure. Those circumstances included that:

- the insured had been informed by RACV that she did not need to formally notify it that her brother was to be a driver of the vehicle (and it therefore arguably followed that she would not think to disclose anything else about her brother);

- it is difficult for members of the general community to understand what matters will be relevant to the decision of an insurer to accept a risk. It was argued by the insured that this was indicated by the fact that RACV had to go so far as to produce evidence from an underwriter to prove that Mr Alam's criminal activities would be relevant;
- a statement in the policy documents that the insured needed to disclose 'everything you know which is relevant to our decision to insure you and the terms on which we insure you' did not necessarily convey to the insured that it was necessary to disclose offences that did not relate to the driving of a motor vehicle.

This case demonstrates the difficulty faced by insurers relying on standard disclosure warnings in relation to matters that may not be obvious to the general public. Many circumstances that pose a moral risk are likely to fall into this category.

When will insurer be unable to avoid in the case of fraudulent non-disclosure

Case Name:

Sherry v FAI General Insurance Company Limited (in liquidation)

Citation:

12 ANZ Ins Cas 61-516

Date of Judgment:

18 January 2002

Issues:

- Fraudulent non-disclosure
- Multiple insureds
- Section 28 of the *Insurance Contracts Act 1984*

Difficulties can arise where there is more than one insured and the material non-disclosure is made by only one insured. The majority of the High Court held in advance (NSW) *Insurance Agencies Pty Limited v Matthews* (1989) 166 CLR 606 that the remedies available to an insurer under section 28 of the *Insurance Contracts Act 1984* (Cth) (the *ICA*) apply where one co-insured has failed to disclose a material fact, notwithstanding that the other did not know of the non-disclosure.

However, the policy wording may suggest that the insurer has agreed to modify its rights to deny cover to 'innocent' insureds where there is a non-disclosure or misrepresentation by one co-insured.

The facts

In this case, the policy defined the 'insured' as the partnership Mann Judd and a number of associated companies. It contained a clause that protected the insured for claims arising by reason of fraud on the part of the insured or its partners or employees, in which case cover extended in excess of the full extent of the fraudulent partner's assets in the firm. The clause is expressed to apply even if the fraud was not disclosed by the fraudulent partner.

One partner dealt fraudulently with the estates of the plaintiffs. After Mann Judd was wound up and a liquidator appointed, the benefit of its contract of insurance was assigned to the plaintiffs. The plaintiffs sought indemnity.

The insurer denied indemnity on a number of grounds, including that it was entitled to avoid the contract of insurance on the basis of non-disclosure and misrepresentation by the fraudulent partner.

The decision

Justice DeBelle held that the policy was intended to cover innocent partners in each of the companies in which they had an interest in respect of claims for fraud or dishonesty on the part of the insured, its partners or employees. The intent of the policy was to protect the innocent partners, while denying indemnity for the fraudulent partner. The insurer's rights of avoidance were modified by the terms of the policy.

It is not unusual for a policy of professional liability insurance taken out for the benefit of multiple insured to cover innocent insureds in the case of fraud by other insureds. In such circumstances, the remedies for non-disclosure will generally be modified by the terms of the policy so that the insurer will not be able to rely upon the non-disclosure of the fraudulent party as a basis for denying indemnity.

Remedies for misrepresentation and non-disclosure – discharging the onus of proving what the insurer would have done

Case Name:

McNeill & Ors trading as The Front Row & Anor v O’Kane

Citation:

[2002] QSC 144, Supreme Court of Queensland per Holmes J

Date of Judgment:

27 May 2002

Issues:

- Remedies for non-disclosure and misrepresentation
- Section 28(3) of *Insurance Contracts Act 1984*
- Whether insurer would have accepted risk

Section 28(3) of the *Insurance Contracts Act 1984* (Cth) (the *ICA*) limits an insurer’s remedy in the case of non-fraudulent non-disclosure or misrepresentation to reducing its liability to the amount that would place the insurer in a position in which the insurer would have been if the non-disclosure or misrepresentation had not occurred. This places an onus on the insurer to demonstrate prejudice. This case illustrates how an insurer may discharge this onus.

The facts

The Oriental Hotel in Mackay was damaged by fire, which had been lit by arsonists. Prior to inception of the policy, the insured had represented that the hotel was secured by a back-to-base alarm. The insurer claimed that, if it had known that there was no back-to-base alarm, it would not have provided cover. The insurer’s underwriting guidelines stated that all metropolitan regional capital hotels must have a monitored back-to-base alarm. The insurer sought to demonstrate that its underwriting assessment criteria was ‘effectively practised and adhered to’ and its practice was to impose a variety of exclusions and go off-risk for particular types of damage. It claimed, therefore, that had it known that these circumstances fell foul of that criteria, it would not have entered into the contract on the same terms and conditions.

The decision

Justice Holmes found in favour of the insurer. In doing so, he rejected an argument by the insured that it would have installed a back-to-base alarm had the insurer required it. The insured bore the onus in relation to such matters and the evidence was not sufficient to discharge the onus.

This case illustrates the importance of evidence of what an insurer would have done, and in some cases evidence of what an insured would have done in response, for the purposes of determining remedies available to an insurer for non-disclosure and misrepresentation.

Duty of disclosure – what matters are known to an insurer?

Case Name:

General Accident Insurance Asia Ltd v Sakr & Anor

Citation:

(2001) 11 ANZ Insurance Cases ¶61-508 per Giles JA, Hodgson JA and Sperling J (New South Wales, Court of Appeal)

Date of Judgment:

15 November 2001

Issues:

- Duty of disclosure and waiver – ss21 and 28 of the *Insurance Contracts Act 1984*
- Calculation of damages and onus to prove betterment

This case considers:

1. whether, before a policy renewal, an insured is obliged to disclose information that has already been provided to the insurer during a previous policy period;
2. whether an insurer waives compliance with the duty of disclosure on a policy renewal if it fails to follow up information provided during previous policy periods;
3. the legal effect of information included in a policy renewal form, where that information is incorrect; and
4. issues associated with betterment.

The facts

In May 1994, Mr Sakr purchased two shops and an attached residence. He obtained insurance cover for loss on the buildings, loss of rent and public liability with NZI Insurance Australia Ltd (now General Accident Insurance Asia Limited) (**General**) for the period 1 June 1994 to 1 June 1995. The cover note recorded that the property was 'Occupied as hairdresser/sandwich'.

The sandwich shop and the residence became, and remained, vacant from December 1994, as did the hairdresser's shop from July 1995.

The cover was renewed annually. The trial judge found that Mr Sakr telephoned General in June 1996 and told them that the properties had been unoccupied for a long time and he no longer needed cover for public liability or loss of rent.

On 13 June 1997, a renewal invitation was sent to Mr Sakr for the period 1 June 1997 to 1 June 1998. The cover note stated: 'Additional Occupation: Sandwich Shop, Residential Dwelling'. Evidence was adduced that Mr Sakr's English was poor and that his daughter translated the documents for him. Mr Sakr paid the premium to renew the policy (the **policy**).

The policy provided that:

- General may cancel the policy if, after commencement of the contract, the premises became and remained unoccupied for 30 days or more; and
- in the basis of settlement clause, General 'may at its option pay to You the value of the Property at the time of the Damage or reinstate, replace or repair the damaged Property less a reduction for wear and tear and betterment ...'

On 27 September 1997, fire partly destroyed the residence and the shops suffered damage.

The decision

This was an appeal from the decision of District Court Judge Delaney, who awarded Mr Sakr \$104,000, being the estimated cost of repairing the damage.

The first issue on appeal was whether General validly avoided the policy or could reduce its liability to nil under the policy because of Mr Sakr's failure to comply with the duty of disclosure in relation to the occupancy of the property.

An insured is not obliged to disclose matters known to an insurer, or which an insurer ought to know in the ordinary course of its business. The court held that, as a result of the conversation in June 1996, General knew or ought to have known that the property was unoccupied. Mr Sakr did not, therefore, breach his duty of disclosure by failing to inform General of this fact before the renewal.

The court further held that the failure of General to make further enquiries about the occupancy of the property, after the absence of occupiers was brought to its attention in the phone call in June 1996, constituted a waiver of the duty of disclosure in relation to the occupancy of the premises.

The second issue on appeal was whether General could cancel the policy on the basis that the premises became, and remained, vacant for more than 30 days. The premises were in fact unoccupied when the policy commenced in June 1997 and therefore did not 'become' vacant. General therefore submitted that because the renewal invitation stated that the premises were occupied:

1. the property was taken at commencement to be occupied;
2. there was an implied term in the policy that the premises were occupied; and/or
3. Mr Sakr was estopped from asserting that the premises were vacant.

The court rejected these arguments, as they were neither pleaded nor proven.

The property had been sold unrepaired for \$45,000. The evidence of Mr Sakr suggested the value of the property if repaired would be \$153,000. The policy gave the insurer the option to pay the cost of reinstatement, replacement or repair 'less a reduction for wear and tear and betterment'.

General's third appeal point was whether the award of damages (\$104,000) was erroneous, as no allowance was made for betterment.

The court held that, in circumstances where the insured had given evidence of what the repair costs would be, the onus was on General rather than Mr Sakr to prove betterment. General did not satisfy this onus. Although it had remained unoccupied for two years, the court was not satisfied that, at the time of the fire, the property had value to Mr Sakr only as a piece of land for immediate sale. Consequently, Mr Sakr should not be limited to the difference in market value. The judgment of Justice Giles contains a useful discussion of the authorities and the principles relevant to the question of betterment.

This case demonstrates that information provided to an insurer during a policy period is information within the insurer's knowledge and, therefore, within the exception to the duty of disclosure, even in relation to subsequent renewals of the policy. Further, the failure to make further enquiries on receipt of information may lead to a waiver of the duty of disclosure in relation to that information.

Construction of exclusion clauses – knowledge and the duty of disclosure

Case Name:

Hammer Waste Pty Ltd v QBE Mercantile Mutual Limited & Anor

Citation:

[2002] NSWSC 1006, Supreme Court of New South Wales per Palmer J

Date of Judgment:

29 September 2002

Issues:

- Construing an ambiguous policy to exclude cover
- When is a matter 'known' for the duty of disclosure?

The court rejected an attempt by an insurer to exclude cover by construing an exclusion clause in a particular manner. It also considered the meaning of 'knowledge' for the purposes of the duty of disclosure.

The facts

1. The plaintiff was a garbage removalist company. In November 2000, it decided to employ a new driver. It filled in a 'Driver's Declaration Form' and sent it to its broker. The broker forwarded the form to the insurer, which subsequently informed the broker that the driver was not acceptable because of his inexperience driving trucks of the relevant class.
2. Justice Palmer held (resolving conflicting evidence) that the broker did not inform the insured of the insurer's decision.
3. The policy provided for a greater excess to apply if the driver had less than two years' experience driving the same type of vehicle (as was the case here).
4. The policy also excluded cover where the insurer had not 'received and accepted a Driver's Declaration' and one of four specified circumstances had occurred in the past five years. It was common ground that there were no such specified circumstances.
5. The policy was renewed in July 2001. In August 2001, the truck was involved in a serious accident while being driven by the new driver.
6. The insurers sought to deny cover because either:
 - (a) under the terms of the policy, cover was excluded when the truck was driven by the new driver; or
 - (b) the insured failed to disclose, at the time of the policy renewal, that it had continued to employ the new driver.

The decision

Justice Palmer held for the insured.

The insurer's first argument was that the phrase 'not received and accepted a Driver's Declaration' did not apply where a Driver's Declaration had been received but declined. It argued that the new driver should be regarded as a 'rejected driver' and therefore unable to claim under the policy. Justice Palmer rejected this argument, as there was no reference in the policy to a separate category of 'rejected' drivers. He also condemned (in general terms) attempts by insurers to deny cover by finding ambiguities in their own standard wordings. He emphasised that exclusions in an insurance policy must be expressed clearly, particularly today when 'by means of lavish advertising campaigns' insurance companies promote the virtues of insurance. He also stated that, if an insurer denied cover contrary to

the express wording of the policy, then the courts will consider awarding indemnity costs to the insured.

The insurer also sought to imply a term that cover would be excluded where a Driver's Declaration has been received but declined. As Justice Palmer rejected the distinction between 'not receiving and accepting' and 'declining', this submission failed. The courts will not imply a term that is inconsistent with an express term of the policy. In this case, the policy expressly provided the cover would be excluded if a Driver's Declaration Form had not been received and accepted *and* one of four specified circumstances had occurred in the previous five years, which was inconsistent with an implied term that cover would be excluded *only* if a Driver's Declaration Form had not been received and accepted.

Justice Palmer held that the insurer could not avoid the policy for non-disclosure, as the relevant matters were not 'known' to the insured. The primary reason for this conclusion was his finding that the insured had not been informed that the insurer had rejected the Driver's Declaration Form. Justice Palmer also emphasised that the insured is obliged only to disclose matters that are *known*, and is not obliged to disclose matters that *ought to be known*. In response to a submission that the insured could 'know' matters through its broker, Justice Palmer found that the broker did not know all of the relevant facts. This was because Justice Palmer accepted the broker's evidence that the broker had forgotten to tell the insured of the rejected driver, and the broker was not conscious of this fact at the time of renewal.

This case illustrates the difficulties faced by an insurer in relying on an exclusion clause in one of its standard policy wordings if the facts do not clearly satisfy the terms of that exclusion clause.

Issue of writ does not constitute making of a claim

Case Name:

King v McKean & Park and Ors

Citation:

(2002) 12 ANZ Insurance Cases ¶161-534, Supreme Court of Victoria per Osborn J

Date of Judgment:

23 August 2002

Issues:

- Claims made and notified policies
- When is a litigated claim 'made'?

The case considers the issue of when a claim is made for the purpose of a claims made and notified professional indemnity policy.

The facts

Mr King issued a writ in the Supreme Court of Victoria against a number of parties, including Mr McKean, a barrister. The writ was issued on 19 May 1999, but was not served on Mr McKean until 17 May 2000. Mr McKean issued a third party notice against his professional indemnity insurer, AMP General Insurance Limited. The relevant insurance policy was current when the writ was issued but had expired by the time of its service. The third party proceedings were determined separately by Justice Osborn, who was asked to decide whether the liability asserted arose from a claim made during the period of insurance.

The decision

Justice Osborn considered what constitutes the making of a claim in the context of a 'claims made and notified' policy such as that held by Mr McKean.

The court found that the institution of proceedings is not the same as the making of a claim against a person. No order can be made against a defendant named in a writ without notice of the writ having been provided.

The court considered the argument that the issue of a writ constitutes notice to the world at large of the making of the claim. However, Justice Osborn rejected that argument, citing a 1984 Canadian decision that had been approved in more recent Australian decisions. In that case, the majority held that a claim is 'made' by being notified or brought to the attention of the person against whom it is asserted.

Considering more recent decisions, Justice Osborn found in favour of the insurer's argument that no claim had been made based on the ordinary meaning of the words, on the weight of judicial authority, and on commonsense. If Mr McKean was correct, the court held, it would create a category of claims that could be made but never notified within the terms of the policy.

This case applies a commonsense approach to the interpretation of when a claim is made for the purposes of a 'claims made' policy. The commencement of proceedings is neither notice to the world at large, nor to the insured in particular, of the making of a claim.

What conduct is a professional indemnity policy intended to cover?

Case Name:

Pioneer Road Services Pty Limited v QBE Insurance Limited & Anor

Citation:

(2002) 12 ANZ Insurance Cases ¶61–520 per Wood CJ

Date of Judgment:

8 March 2002

Issues:

- Professional indemnity insurance
- Meaning of ‘design and consulting/advisory services’
- Determining the parties’ intentions
- Meaning of ‘professional services’

Pioneer’s general liability policy became worthless after the collapse of HIH. It tried to bring liability arising out of a supply and lay contract under its professional indemnity policy with QBE on the grounds that the contract involved matters of planning or decision-making.

The facts

Pioneer was sued by Miss Palmer for injuries sustained in a car accident. Miss Palmer had had an accident while driving on a section of road on which road works were being carried out by Pioneer in the Evans Shire in NSW.

Pioneer had contracted with the Evans Shire Council (the **council**) to carry out the road works.

Pioneer was held to be negligent and liable to Miss Palmer for:

1. failing to prepare and submit a traffic control plan to the council before commencing the relevant road works;
2. deciding to defer the sweeping of gravel off the road; and
3. failing to ensure that sufficient signage was erected at the site once gravel was spread on the new surface.

Pioneer cross claimed against QBE, alleging that it was entitled to be indemnified under its professional indemnity insurance policy with QBE.

QBE had issued insurance policies each year in response to a proposal from Pioneer. The proposal for the relevant year (**claim year policy**) indicated that the nature of Pioneer’s business was ‘principally the manufacture, design and construction of asphalt surfaces’. Pioneer stated that it was occasionally engaged in providing advice associated with manufacture, design and construction of road services in return for a consulting fee, and that it was this occasional, extra business for which it desired insurance from QBE.

The claim year policy and succeeding policies contained an endorsement limiting the cover to ‘design and consulting/advisory services’ only.

At the time of Miss Palmer’s accident, Pioneer held two policies of general liability insurance issued by HIH. These would have indemnified Pioneer, but were ineffective because of HIH’s collapse.

Pioneer submitted that its negligence fell within the concept of ‘design and/or advisory services’, since they involved matters of planning or decision-making about what was required for the safe execution of the work to be performed under its contract with the council.

The issues at trial were:

- Whether Pioneer's liability arose out of 'design and consulting/advisory services'.
- Whether Pioneer and QBE had intended to insure liability arising in connection with Pioneer's contract with the council.
- Whether the liability was 'incurred in the Professional Business Practice' of Pioneer, ie whether Pioneer's conduct had to be of a 'professional' nature and what that meant.

The decision

The Supreme Court of NSW, comprising Chief Judge Wood, dismissed the cross claim, denying indemnity.

'Design and consulting/advisory services'

Guidance on whether any relevant act or omission fell within the cover was to be obtained from the description of the work that Pioneer agreed to provide under its contract with the council.

Pioneer's contract was to perform road work in accordance with the design and specifications laid down by the road traffic authority. Pioneer's work was more properly to be regarded as the execution of that design, rather than the provision of design, or advisory/consulting services.

Parties' intentions

The policy was unclear as to whether Pioneer was indemnified. Where the language of a contract is ambiguous or susceptible to more than one meaning, the court can consider the circumstances surrounding the making of the contract to ascertain the parties' intentions.

As the claim year proposal formed the basis of the policy, and was incorporated into the contract, it was appropriate to have regard to it in interpreting the policy.

Normally, the court cannot consider anything done *after* the contract is made in interpreting it. However, later conduct and statements of the parties are admissible to identify the things that the contract deals with. Therefore, the subsequent proposals could also be considered.

The party's intentions needed to be understood in the context of the work Pioneer undertook, and in light of the proposals. Each proposal showed that its principal relevant source of revenue was 'contracting revenue'; and that design or consulting/advisory services occupied a small proportion of its work, arising where it was 'occasionally' called on to provide specific advice, or accepted specific responsibility for pavement design. The thrust of the proposals was that insurance was sought only in relation to the occasional, specific advice or design contracts.

Subsequent proposals did not disclose any difference in approach.

Relevance of the term 'professional business practice'

In relation to cover for tort liability, the expression 'professional business practice' was used to define the ambit of Pioneer's business, and, as such, did not confine the cover to a breach of 'professional' duty.

However, cover for a breach of contract was only available where the contract was one that was for 'professional services'.

The term 'professional', in relation to insurance contracts, is to be construed broadly. Pioneer would be covered for breach of contracts calling for the provision of design or consulting or advice services that were 'of a skilful character according to an established discipline'. This was not such a contract.

This case contains a useful illustration of the guiding principles where an insured seeks to rely on a favourable interpretation of the policy wording to expand cover beyond that which the insured and the insurer had clearly intended.

What is the consequence of breaching an obligation to take out insurance in the name of another party?

Case Name:

*Thiess Contractors Pty Ltd v
Norcon Pty Ltd*

Citation:

[2001] WASCA 364 per Murray
J, Steytler J & Templeman J

Date of Judgment:

16 November 2001

Issues:

- Breach of contract for failing to take out insurance in joint names
- Public liability insurance

A subcontractor failed to comply with a contractual term obliging it to effect public liability insurance in joint names. It argued that the other party had not in fact suffered any loss because it had its own insurance policy that covered the claim in question.

The facts

In 1995, a construction workman was injured on site when he tripped on a piece of uncapped reinforcing steel and injured his spine. He commenced proceedings against his employer for negligence. Thiess Contractors Pty Ltd (*Thiess*) and Norcon Pty Ltd (*Norcon*), respectively the main contractor and its sub-contractor, were subsequently joined as defendants.

The workman alleged that Thiess was negligent in failing either to cap the reinforcing steel or to warn the workman that it was uncapped. Thiess issued a contribution notice against Norcon on the basis that, if it was found to be liable, then so too was Norcon. Thiess also alleged that Norcon breached a contractual obligation to take out an insurance policy in their joint names covering liability for any personal injury arising in connection with the works. It was this contractual obligation that was considered by the Full Court.

Norcon pleaded that, even if it was in breach of its contract by failing to take out the requisite insurance, Thiess had not suffered any loss because it was entitled to indemnity under its own insurance policy (*the alternative defence*).

The decision

Thiess brought an application before a Deputy Registrar in the District Court to strike out the alternative defence on the grounds that it was irrelevant, for the purposes of its right to recover from Norcon, whether it had taken out its own insurance in terms wide enough to cover the claim. The Deputy Registrar agreed and struck out the alternative defence.

Norcon appealed to a judge of the District Court. It argued that Thiess had not suffered any loss, and so could not have obtained an indemnity under the Norcon insurance even if Norcon had taken out the policy. The judge upheld the appeal and the alternative defence was reinstated on the grounds that it was an arguable defence. Thiess appealed to the Full Court of the Supreme Court of Western Australia.

The court decided that the alternative defence should be struck out. In reaching its decision, it applied the underlying principle laid down in *Bradburn v The Great Western Railway* (1874) LR 10 Exch 1 that a plaintiff is entitled to recover its full measure of damages caused to it by the negligence of another party without

reference to any right of indemnity it has under an insurance policy. The court decided that the critical issue in this case was that Thiess had lost the benefit of the proposed policy and it was irrelevant that it might, by resorting to an insurance policy that it had taken out on its own initiative, recover or avoid any expense that would otherwise have followed from the loss of the benefit of the proposed policy.

The case has important implications for insurers in the construction industry seeking to exercise rights of subrogation or contribution. Had Thiess elected to claim under its policy then, subject to the terms of the policy, its insurers would be entitled to exercise rights of subrogation against Norcon to recover the full indemnity. Had Norcon taken out the relevant insurance, then a situation of dual insurance would arise and Thiess' insurer would be limited to a claim for contribution. It follows that there is potential for a 'windfall' to Thiess' insurer to arise from Norcon's breach.

This case demonstrates that, where a defendant has breached its contract by failing to effect joint insurance, damages may equate to the full value of the indemnity that would otherwise have been available, even in circumstances where the other party can claim under its own insurance policy. In contrast, if the defendant had taken out the insurance as required, not only would it have avoided potential exposure to an uninsured claim, but its insurer would arguably be able to claim contribution from the other party's insurer on the basis of dual insurance.

Exclusion clauses, cross-liability clauses and election

Case Name:

Transfield Pty Limited v National Vulcan Engineering Insurance Group Limited & Ors; Connell Wagner Pty Ltd v National Vulcan Engineering Insurance Group Ltd & Ors

Citation:

[2002] NSWSC 830, Supreme Court of New South Wales per McClellan J

Date of Judgment:

17 September 2002

Issues:

- Contract works insurance
- Effect of exclusions clause and cross-liability clause
- Election

This case considers: (i) the effect of an exclusion and a cross-liability clause where multiple entities are insured under a single policy; and (ii) whether acceptance by an insurer of a claim by an insured amounts to an election, and thereby subsequently disentitles the insurer from subsequently denying liability.

The facts

Transfield Pty Limited (*Transfield*) was the head contractor for a railway construction project. Transfield engaged four subcontractors and consultants (the *subcontractors*). Two incidents occurred at the construction site, causing damage to the property of Transfield and two of the subcontractors.

Various claims were brought by and against Transfield and the other two subcontractors (together the *plaintiffs*) for compensation for loss and damage.

The plaintiffs each sought indemnity under a policy of insurance held by Transfield Holdings Pty Limited (*THPL*), the parent company of Transfield. The policy covered THPL, all of its subsidiaries and their subcontractors for any liability for (among other things) loss of, damage to or destruction of property.

The insurers denied indemnity, relying on an exclusion (the *exclusion*) for liability for damage to property owned by 'the insured'.

The insurers argued that the expression 'the insured' means *all* parties insured under the policy. Accordingly, property owned by 'the insured' means property owned by any one or more of the insured entities, including property owned by any of the subcontractors.

The plaintiffs argued that:

1. the exclusion did not apply, as the expression 'the insured' refers not to any insured entity but to the particular entity bringing the claim. This is because the exclusion must be interpreted in light of a cross-liability clause in the policy, which stated that:

Each of the persons comprising the Insured shall...be considered as a separate and distinct unit and the words 'the Insured' shall be considered as applying to each...in the same manner as if a separate policy had been issued to each...

2. even if the exclusion applied, the insurers had conducted Transfield's defence on its behalf, required Transfield's co-operation and told Transfield that indemnity had been granted. The plaintiffs claimed that the insurers had thereby elected not to exercise their right to deny liability under the policy, and could not at a later time rely on the exclusion.

The insurer argued that the exclusion had no work to do if the insured's contentions were accepted, since there could be no question of legal liability arising from damage to one's own property. It also argued that its construction was in accordance with good business sense and the weight of authority.

The decision

In relation to the first issue, Justice McClellan considered case law relating to the interpretation of exclusion clauses in policies containing cross-liability clauses. His Honour concluded that, informed by the cross-liability clause, the phrase 'the insured' in the exclusion is a reference to the particular party that makes a claim under the policy. This was on the basis that:

- the contract must be construed with regard to the language used by the parties;
- any doubt must be resolved in favour of the insured;
- the purpose of the policy was plainly to provide insurance to all parties. Although separate policies could have been issued, this had obvious practical difficulties; and
- for the exclusion to have the operation suggested by the insurer, it would have had to read 'any insured' or 'an insured' rather than 'the insured'.

In rejecting the insurer's submission that the exclusion would have no work to do, Justice McClellan considered obligations to others may arise where one damages one's own property; for example, the property may be leased or mortgaged or others may have rights to use it.

In relation to the second issue, Justice McClellan considered the law relating to election. His Honour concluded that acceptance by an insurer of a claim by an insured to which the policy does not extend cover does not amount to an election, so as to disentitle the insurer from subsequently denying liability under the policy. In such circumstances, the insured would need to demonstrate some detriment entitling it to raise an estoppel.

This case illustrates the importance of careful policy drafting to avoid coverage in circumstances that may not have been intended by the insurer, particularly where the policy contains a cross-liability clause.

The case also provides some comfort to insurers on the issue of election. However, insurers need to be wary that once indemnity is confirmed, even if the policy does not cover the claim, it may not be able to be subsequently denied if the insured can establish detriment.

Group public liability policies – possible gaps in coverage

Case Name:

Toomey v Scolaro's Concrete Constructions Pty Ltd & Ors

Citation:

[2002] 12 ANZ Insurance Cases ¶161-519 Supreme Court of Victoria per Eames J

Date of Judgment:

7 March 2002

Issues:

- Public liability insurance
- Definition of 'the business' to which the policy applies
- Scope of the 'professional capacity' exclusion

This case illustrates how, without careful drafting, gaps in coverage may exist in group public liability policies. It also illustrates that activities conducted in a 'professional capacity' may be construed narrowly when they are the subject of an exclusion clause in a policy.

The facts

On 2 March 1996, Mr Toomey was seriously injured after falling over a defective balustrade in residential units constructed on behalf of Davidson Hughes Estates Pty Ltd (*DHE*). DHE is a wholly owned subsidiary of Hudson Conway Limited (*HCL*), as is Hudson Conway Management Limited (*HCML*). HCML provided DHE with owner's representative services during the construction of the residential units.

Mr Toomey obtained judgment against nine defendants, including DHE and HCML, primarily as the balustrade's height did not comply with the Building Code of Australia. Justice Eames found that this was known by an employee of HCML, who instructed the builder not to remedy the defect.

HCML commenced third party proceedings against Royal & Sun Alliance Insurance Australia Limited (*Royal*), seeking indemnity for its liability to Toomey under HCL's group public liability policy. Royal denied indemnity to HCML, asserting that HCML's liability:

1. did not arise in the course of a 'business' within the meaning of the policy; and
2. arose in a professional capacity and was therefore within an express exclusion within the policy.

HCL's policy wording, endorsements and replacement schedules were to be read together as one contract. The description of HCL's business contained in its proposal, being 'property investment, development, construction', was not replicated in any of the policy documents, particularly the replacement schedules where the definition of business was left blank.

The definition of 'the business' contained in the policy wording referred to the description of business in the schedule (of which there was none) and, relevantly, the ownership or occupation of property.

The professional capacity exclusion provided that Royal would not be liable for any claims arising out of any breach of duty owed in a professional capacity.

The decision

Justice Eames held that the policy did not respond to indemnify HCML for its liability to Toomey.

Despite Justice Eames' finding that it was intended that the property development activities of the HCL group be covered under the public liability policy, without any definition of 'the business' contained in any of the replacement schedules, only liability arising in relation to 'the business', as defined by the policy wording, was covered. Consequently, Justice Eames held that only liability arising from the ownership or occupation of property was properly subject to indemnity under the policy.

As HCML was not the registered proprietor or occupier of the land upon which the residential units were constructed, it, in contrast to DHE, was not entitled to indemnity.

In relation to the professional capacity exclusion, Justice Eames found that HCML's liability to Toomey arose vicariously. Consequently, HCML's liability did not arise out of a breach of any duty owed in a professional capacity. Further, Justice Eames found that, while HCML had some influence over the builder and sub-contractors, it did not have contractual control over the day-to-day work and was not providing DHE with professional services. It took the role of the interested and informed owner, checking to see that it was getting value under the contract.

In addition, Justice Eames did not consider the HCML's employee's error to have been one made 'in a professional capacity'. This required that he be providing 'advice and services of a skilful character according to an established discipline'; per Justice Kirby in *GIO General Ltd v Newcastle City Council* (1996) 38 NSWLR 558. Justice Eames noted that James had trade skills and experience in the building industry, but he was not a qualified surveyor or building inspector. In commenting on the balustrade, Justice Eames did not consider he was performing professional functions.

This case illustrates:

- (a) The importance of careful drafting when a policy is meant to cover all companies in a group of companies for liability arising out of activities conducted by any company in the group. Otherwise, if one company in the group incurs a liability by reason of the activities of another, coverage may not apply.
- (b) The narrow interpretation of an exclusion clause based on activities conducted 'in a professional capacity'.

The meaning of 'subsidiary' and the contra proferentem rule

Case Name:

Independent Timber Importers (Aust) Pty Ltd v Mercantile Mutual Insurance (Australia) Limited

Citation:

[2002] NSWCA 304, New South Wales Court of Appeal per Sheller JA, Giles JA and Gzell J

Date of Judgment:

24 September 2002

Issues:

- Whether an individual can own subsidiary companies
- The application of the contra proferentem rule

The court held that an individual cannot own a 'subsidiary company'.

The facts

Independent Timber Importers (Aust) Pty Limited (*ITI*) sought indemnity under a public liability policy that named Paul Shadbolt as the insured.

The policy provided cover to subsidiary companies of the named insured. ITI argued that it was a subsidiary company of Mr Shadbolt. The insurer argued that a company cannot be a subsidiary of an individual.

The decision

The court held that a 'subsidiary company' must be a subsidiary of another company.

ITI argued that, in construing the policy, the court should have regard to the commercial purpose of the policy, the contra proferentem rule and/or to various events subsequent to the policy, which allegedly supported its interpretation (that a company could be a subsidiary of an individual).

The court rejected these arguments as

- there was no ambiguity about the meaning of 'subsidiary company' and therefore no room for the operation of the contra proferentem rule;
- later conduct and statements of parties to a contract are not admissible to resolve an ambiguity in the meaning of the contract (although they are admissible to identify the matters with which the contract deals); and
- the evidence did not in any case justify drawing an inference that the policy was intended to apply to ITI (or that there was a separate contract to insure ITI).

This case emphasises the care that is required, before entering into an insurance policy, in stating which individuals and companies are to be insured under the policy.

No indemnity available where derelict building damaged

Case Name:

Bakerland Pty Ltd v Coleridge

Citation:

[2002] NSWCA 30 per Giles, Heydon JJA, and Groves J

Date of Judgment:

29 November 2001; 25 March 2002

Issues:

- Construction of insuring clause
- Property insurance
- Damage to derelict buildings

This case considers the issue of whether the indemnity value of a building insured under property insurance should be determined as the value of the building or considered as an item of property separate from the land.

The facts

The owners of the Coogee Palace Aquarium in Coogee, Sydney, obtained insurance on the property for the period August 1983 to August 1984 from Lloyds Underwriters. By the insuring clause in the policy, the underwriters insured the property against certain perils, including storm and tempest. The schedule in the policy listed buildings as the interest.

On 19 June 1984, the dome of the Coogee Palace Aquarium collapsed during a fierce storm. The entire roof and domed structure fell to the ground and were destroyed, together with the low-level roof structures. The insured claimed the amount of \$130,000 as an agreed value or, alternatively, as the amount necessary to provide indemnity against loss.

Reports prior to the storm revealed that the building was in a derelict state. Further, it could not be improved due to a conservation order.

The decision

The trial judge held that the contract of insurance was not for an agreed value and that there had been no loss established on an indemnity value basis in relation to the damage caused to the building, so that the insured could not recover the \$130,000 or any part of it.

On appeal, the insured submitted that the underwriters were obliged to pay the indemnity value of the building viewed alone – ie the sum of money that could be said to be the value of the building considered as an item of property separate from the land. In response to this submission, the court upheld the decision of the trial judge and reasoned that the building could not be separated from the land, and could not sensibly have a value as something separated from the land. It had a value as a building on the land, but the value came from both land and building. The policy did not look to the building alone, despite the wording in the schedule.

Further, the Court of Appeal held that, on the evidence presented to the trial judge, the insured had failed to establish that it suffered any loss from the storm and tempest and therefore the insured could not recover any amount from underwriters for property loss or damage. This was because the evidence showed that the value of the land and building after the improvements increased by an amount greater than the cost of the improvements.

This case demonstrates that in determining the indemnity value under a property insurance policy a building cannot sensibly be given a value as something separated from the land on which it stands. The court will consider the value of the land and building, before and after the event, to determine the value of the insured's indemnity.

Extension of cover to riot – burden of proof that loss not due to insurrection

Case Name:

Grell-Taurel v Caribbean Home Ins & Ors

Citation:

Court of Appeal (Trinidad and Tobago) per Sharma JA, Hamel-Smith JA and Warner JA

Date of Judgment:

11 July 2002

Issues:

- Extension of cover to riot
- Exclusion of cover for insurrection
- Reverse burden of proof clause

The case considers the operation of an exclusion for loss or damage occasioned by insurrection where the policy requires that the burden of proving the loss is not caused by insurrection lies on the insured.

The facts

On 27 July 1990, members of the Muslimeen attempted to overthrow the government of Trinidad and Tobago, bombing the police headquarters in Port of Spain and storming the parliamentary chambers. In the aftermath, a great deal of looting took place. The Commissioner of Police took the decision not to employ men to deal with the looting, and the following day a state of emergency and a curfew was declared.

At the time of the attempted overthrow, Grell-Taurel Limited (**GTL**) was engaged in the business of selling and servicing industrial equipment and machinery at premises located about two-and-a-half miles from the city centre of Port of Spain. GTL was insured with the Caribbean Home Insurance Co Limited and others (the **insurers**) under a collective fire and special risks and consequential loss insurance policy. Coverage under the policy extended to riot damage, subject to a special condition which provided that:

this insurance does not cover any loss or damage occasioned by or through or in consequence, directly or indirectly, of any of the following occurrences namely

(b) . . . insurrection . . .

(c) acts of terrorism

The special condition further provided that:

For the purposes of this condition, 'Terrorism' means the use of violence for political ends and includes any use of violence for the purpose of putting the public or any section of the public in fear.

It was accepted by the parties that, for the purposes of the action, the immediate cause of GTL's loss was 'riot' within the extension to the policy, and that the activities of the Muslimeen constituted 'terrorism' and/or 'insurrection' within the definition contained in the special condition.

The policy also provided that, in the event that the insurers alleged that by reason of the special condition that any loss or damage was not covered by the insurance, the burden of proving that the loss or damage was covered shifted to GTL.

At first instance, Justice Kangaloo dismissed GTL's application. He considered that GTL could not show from the evidence that their losses, on the balance of



probabilities, had no real immaterial connection with the insurrection, because it could not rebut the inference that the turbulence and collapse of public order caused by the insurrection led to and encouraged the acts of looting and vandalism, which were the immediate cause of the insured's losses.

The decision

In dismissing the appeal, Justice Warner, with whom Justices Sharma and Hamel-Smith agreed, referred to the decision of Justice Mustill (as he was then) in *Spinneys (1948) v Royal Insurance Company*, which GTL sought to rely on. Justice Warner noted that it was held in *Spinney's* case that as regards causation:

. . . the plaintiffs had to face the assertion that the turbulence and collapse of public order (as in the present case), attendant on the civil commotion permitted and encouraged the acts of looting and vandalism, and unless rebutted would be sufficient to establish that the loss was occasioned indirectly (if not directly), by, through or in consequence.

In reference to the drafting of the mode of proof required by the reverse burden clause, Justice Warner noted:

The draftsman must have intended to stop somewhere; and that place must be the point at which an event ceases to be a cause of the loss, and becomes merely an item of history.

In applying the reasoning in *Spinney*, Justice Warner concluded that she did not think that it could be said that the insurrection could be so far removed from time and place to the extent that it had nothing to do with looting, noting that the exclusion required only an indirect connection. Furthermore, it was not an issue whether the police had to be called to account for their failure to repress the internal disturbance or to preserve the peace, but the issue was whether the looting was connected with the insurrection.

This case demonstrates the application both of a reverse burden of proof clause and of a broadly worded exclusion clause (for losses indirectly occasioned by an insurrection).

Insurer able to deny liability where insured failed to comply with regulatory regime in carrying out work

Case Name:

Kim & Anor v Cole & Ors

Citation:

[2002] QCA 176 (24 May 2002) per McMurdo P, McPherson JA and Helman J (Supreme Court of Queensland)

Date of Judgment:

24 May 2002

Issues:

- Policy conditions – failure to comply
- Breach of regulation or by-law

This case considers whether a qualification may be read into a provision of a policy to ‘comply ... with all statutory obligations By-laws and Regulations imposed by any Public Authority’ and what is ‘a simple breach of a regulation or by-law’.

This was an appeal of a decision from the Magistrates’ Court.

The facts

Mr Hurst is a plumber and gasfitter.

Mr Hurst was engaged by the owner of a pizza shop to fix the gas oven. Mr Hurst identified a fail-safe valve as the cause of the problem.

As no fail-safe valves were immediately available and the owners of the business wished to remain open, Mr Hurst fitted a valve without a fail-safe mechanism to the oven as an interim measure after satisfying himself that the owners of the business knew how to operate it.

Subsequently, the business owners failed to switch the valve off, gas leaked and a spark caused an explosion, destroying the building and damaging surrounding properties.

On the facts of the case, Mr Hurst was liable for a portion of damages.

Mr Hurst was insured under a policy (the **policy**) with Wesfarmers Federation Insurance Limited (the **insurer**), which contained provisions *inter alia* that Mr Hurst shall:

- take all reasonable measures to prevent ...damage to property ...;
- take all reasonable precautions for the safety of property insured;
- comply ... with all statutory obligations, By-laws and Regulations imposed by any Public Authority ...

The supply of gas is governed by the *Gas Act 1965*, under which the *Gas Regulations 1989* (the **regulations**) have been made. The installation of the non-fail-safe valve was a breach of prohibition in the Act.

The trial judge construed the obligation of Mr Hurst to ‘comply...with all statutory obligations, etc’ in the policy to incorporate the words to ‘take all reasonable precautions’. On this basis, the magistrate held that Mr Hurst had not breached his obligations under the policy and, therefore, the insurer was liable to indemnify Mr Hurst.

The appeal

Justice McPherson, with whom President McMurdo and Justice Helman agreed, held that it was impermissible to import the phrase ‘take all reasonable precautions’ into sub-paragraph (c) and that it must be construed as it stands.

In installing a valve without a fail-safe mechanism, Justice McPherson found that Mr Hurst had contravened Clause 5.2.6 of the Gas Installation Code and, therefore, the statutory duty imposed under the *Gas Regulations 1989* to comply with the Code. Consequently, Justice McPherson, with whom President McMurdo and Justice Helman agreed, held that Mr Hurst lost the benefit of his cover.

Justice McPherson made reference to the decision of the Full Court in *Gold Coast Bakeries (Qld) Pty Ltd v Heat & Control Pty Ltd* [1992] 1 QdR 162, 173, which is authority for the proposition that a ‘simple breach of a regulation or by-law’ is not enough to constitute a breach of a policy provision requiring reasonable care to be taken to comply with all regulations and by-laws. Justice McPherson observed that, even if it is permissible to import such a qualification into sub-paragraph (c), the statutory provision that was contravened was intended to protect people and property that would be placed at serious risk if it were omitted and, therefore, ‘it would scarcely be correct to regard what happened as a simple breach of a regulation or by-law’.

This case will provide some comfort to insurers seeking to rely on obligations or exclusions in the policy aimed at conduct that increases the risk. It demonstrates the limits to which courts will go to import qualifications into contractual conditions. Further, a ‘simple breach of a regulation or by-law’ does not include a breach of a regulation that places people or property at serious risk. However, insurers should be mindful that, under section 54 of the *Insurance Contracts Act 1984* (Cth), the insurer seeking to rely on the breach bears the onus of proving that it has been prejudiced. This was not difficult on the facts of this case.

No general obligation on insurer to indemnify insured for legal costs if no express clause and where costs not incurred for insurer benefit

Case Name:

Royal Sun Alliance Insurance Australia Ltd v Mihailoff & Anor

Citation:

[2002] SASC 32 per Prior (dissenting), Gray and Nyland JJ

Date of Judgment:

16 April 2002

Issues:

- Statutory building works insurance
- Construction of insurance policy
- Insurer's liability to indemnify insured for legal costs where no express provision in policy
- Considerations relevant to determining when a term will be implied into a policy

The case examines the circumstances in which the courts will find an implied obligation under a policy for an insurer to indemnify the insured for legal costs incurred.

The facts

In relation to building work to be carried out on their house, Mr and Mrs Mihailoff obtained an insurance policy from Royal Sun Alliance Insurance Australia Ltd (**RSAL**) covering loss resulting from an inability to enforce or recover under a statutory warranty brought about by the builder's insolvency, death or disappearance.

A dispute arose as to whether the builder's work breached statutory warranties imposed by the *Building Work Contractors Act 1995* (SA) (the **Act**), and the Mihailoffs referred the matter to arbitration. The arbitrator found in favour of the Mihailoffs, and made awards against the builder in relation to the breach of the statutory warranties and the Mihailoffs' legal costs. The builder became insolvent and a claim was made against RSAL under the policy. RSAL accepted the claim for the award for breach of statutory warranties but rejected the claim for the award for costs.

At first instance, the magistrate held that the Mihailoffs were entitled, under the policy, to recover costs incurred in establishing the breach of the statutory warranties. A single judge of the SA Supreme Court upheld this decision, but for different reasons. RSAL appealed.

The decision

By majority, the SA Court of Appeal found that the policy did not cover the Mihailoffs' legal fees.

Justice Gray (with whom Justice Nyland agreed) found that neither the policy nor the Act (under which the policy was purportedly issued) specifically addressed whether legal costs incurred in pursuing the builder for breach of statutory warranties were covered. However, Justice Gray considered that the penal nature of the relevant sections of the Act supported a narrow construction that would exclude legal costs.

Further, Justice Gray held that there was no implied term providing cover for the insured's legal costs of pursuing the builder. He considered in detail the provisions of the Act that required the building insurance to be taken out. He said one of the aims of the Act was to minimise the number of building disputes that proceeded to court. Another purpose was to provide a measure of consumer protection. However, it was not intended to provide litigation insurance. In this case, Justice Gray found

that the Mihailoffs were not obliged to submit their dispute to arbitration and the decision to do so was undertaken for their own benefit. The fact that the policy did not require the insured to give notice of any arbitration or legal proceedings to RSAI and, therefore, RSAI could do nothing to protect its position with respect to such proceedings or any costs that might be incurred, was considered by Justice Gray as an additional reason to conclude that the policy did not contemplate indemnifying the Mihailoffs against legal costs.

The Mihailoffs argued that the subrogation provisions in the policy implied that legal costs incurred in pursuing the builder were covered. This was rejected by Justice Gray.

This case demonstrates that, in the absence of an express term in the policy, a court may be reluctant to imply a term that the insurer must indemnify the insured for costs incurred in connection with an insured loss, particularly where the costs were incurred for the benefit of the insured.

Reinsurance – establishing breach of claims cooperation clause

Case Name:

Gan Insurance Co Ltd v Tai Ping Insurance Co Ltd (No 3)

Citation:

[2002] EWCA Civ 248, English Court of Appeal per Brooke and Mance LJ and Park J

Date of Judgment:

1 March 2002

Issues:

- Reinsurance
- Settlements
- Claims cooperation clauses

In this case, a reinsurer sought to deny indemnity to the reinsured on the basis of a breach of a claims cooperation clause.

The facts

The insured sought cover against all risks of loss and damage to machinery in a Taiwanese factory. Tai Ping took a 35% line but sought 100% reinsurance. A placing broker in London placed 2% of Tai Ping's line with Gan.

Gan required a claims cooperation clause (**CCC**), stating that as a condition precedent to any liability under the policy:

- (a) the reinsured shall, upon knowledge of any circumstances that may give rise to a claim against them, advise the reinsurers immediately ...;
- (c) the reinsured shall cooperate with reinsurers ... in investigation and assessment of loss and circumstances giving rise to a loss; and
- (d) no settlement and/or compromise shall be made and liability admitted without prior approval of the reinsurers.

A fire broke out, causing damage to the insured's machinery. Gan wrote to Tai Ping's brokers, requesting that Tai Ping take immediate steps to instruct specified consulting forensic scientists to investigate and report on whether the fire precautions stated in the underwriting information were in place and serviceable, what part they played in the actual detection and containment of the fire, and whether they were properly installed and commissioned.

The letter stated that Tai Ping's failure to investigate the matters would be treated as a breach of the CCC. Tai Ping did not reply. Gan wrote again, stating that Tai Ping was in breach of the CCC.

Later, Tai Ping was sued by the insured. After negotiations, the claim was settled. Gan again requested Tai Ping to investigate matters that would go to avoiding their liability and stated that Tai Ping was in blatant breach of the CCC. Tai Ping replied, stating that the investigations that Gan sought were not relevant, as the specified consulting forensic scientists had already commissioned several reports on the fire.

Initial litigation

Preliminary issues about the meaning of the CCC were decided by Justice Longmore, who held that:

1. compliance by Tai Ping with the CCC was a condition precedent to Gan's liability;

2. breach of paragraph (c) of the CCC was established only by showing that Tai Ping both settled and/or compromised the insured's claim AND admitted liability;
3. there was an implied term in the CCC that Gan could not withhold approval of a settlement other than on reasonable grounds;
4. if there had been a breach of the CCC, Tai Ping could not recover, even if it could prove its liability to Winbond as a matter of fact and law; and
5. Gan could not avoid the reinsurance for misrepresentation or non-disclosure on the part of Tai Ping.

Following these findings, in a separate determination, Justice Smith held:

1. there was no failure by Tai Ping to cooperate with Gan in the investigation;
2. Tai Ping had not admitted liability in the settlement; and
3. there was nothing in the settlement that was not proper or businesslike.

Gan and Tai Ping both appealed. The Court of Appeal held (in a decision reported in the *AAR Annual Review of Insurance Law 2001*, p.71):

1. Justice Smith had been wrong to hold that paragraph (c) of the CCC could only be construed as applying only where there was both a settlement and an admission of liability;
2. Justice Longmore had been correct to hold that the CCC was a condition precedent to Gan's liability;
3. Justice Longmore had been correct to hold that the breach of the condition precedent created by the CCC had the effect that Tai Ping could not recover under the policy by showing that it was in fact and law liable to the insured under Taiwanese law; and
4. Justice Longmore had been wrong to hold that reinsurers were required to have reasonable grounds for withholding approval of settlement.

The decision

In this appeal, there were two remaining issues. The court was asked to assess whether Gan had any real prospect of showing that Tai Ping failed to cooperate in their investigations and assessment of loss or to act in a proper and businesslike manner in settlement of the claim.

Lord Justices Brooke and Mance and Justice Park held:

1. there was no breach of the CCC;
2. although Gan could not properly request investigations to establish whether Tai Ping was in breach of its duties of reinsurance, Gan could request whether the installation was in accordance with engineering standards, as this related to compliance by the original insured;
3. because of (2), the court had been wrong to conclude that the request by Gan was pointless, yet it was right to conclude that Gan had no real prospect of showing that the reports already commissioned did not cover all facts related to compliance;

4. paragraph (b) and (c) of the CCC should be read together to show that (b) extended to the determination of the nature, scope and amount of any loss and whether it fell within the policy cover; and
5. Gan should be granted leave to pursue its defence that Tai Ping did not act in a businesslike manner in making the settlement, as there was evidence that settlement figures perceived as maxima had been exceeded. As a matter of law, Gan bore the onus to prove this.

This case illustrates the hurdles faced by reinsurers seeking to rely upon a breach of a claims cooperation clause.

Broker's duty to advise about flood exclusion

Case Name:

Elilade Pty Ltd v Nonpareil Pty Ltd & CIC Insurance Limited

Citation:

[2002] FCA 909 Federal Court of Australia – Northern Territory District Registry per Mansfield J

Date of Judgment:

31 July 2002

Issues:

- Duty of an insurance broker to the insured
- Proximate causes of loss where one proximate cause is an exempted event under the policy

This case illustrates the duties of insurance brokers to highlight important exclusions in the coverage so that clients are able to make fully informed decisions whether or not to seek coverage for the excluded events. In cases where the broker fails in this duty, the case also illustrates the onus on insureds to prove the additional cover would be obtained.

The facts

The claim arose out of damage to Elilade's stock and plant as a result of the flow of water into its premises following severe tropical rainstorms. Water entered the premises to a depth of about 300mm during the night of 26 January 1998 (the **initial inundation**). The Katherine River subsequently broke its banks about 6am on 27 January 1998. Water from the river flowed directly into the premises to a depth of about 1.8 metres (**the second inundation**).

Elilade commenced complementary claims against:

- its insurer, CIC, for wrongfully declining indemnity under its insurance policy for the property damage; and
- its broker, Nonpareil, for breach of duty in failing to advise of the availability of flood cover and expressly advise of the flood exemption contained in the CIC policy.

Claim against CIC

Elilade argued that both the initial inundation and the second inundation were defined events under the policy to trigger indemnity. CIC accepted that the initial inundation was a defined event under the policy; however, it contended that any property damage was also caused by the second inundation. It argued that the second inundation was a 'flood', as defined in the policy to fall within the flood exclusion. Consequently, CIC argued that, as there were two proximate causes of the damage, one of which fell within an exemption under the policy, CIC was not liable to indemnify Elilade for its loss.

CIC contended in the alternative that any property damage beyond the direct damage caused by the initial inundation was because of Elilade's inability to gain access to the premises from the early hours of 27 January 1998. Such loss was not recoverable because at least one proximate cause of the damage was the flood and therefore the loss was excluded under the policy. His findings in this regard are similar to those of Justice Einstein in *Hams v CGU*, reported elsewhere in this Review (see the 'General insurance law' section).

Justice Mansfield did not agree with CIC's contention that the initial inundation and the second inundation were contemporaneous causes of Elilade's loss. His Honour found that the initial inundation, an insured event, occurred many hours before the second inundation, an exempt event. Therefore CIC was liable to indemnify Elilade for losses caused by the initial inundation, including humidity damage resulting from the premises being closed up, until the time of the second inundation, which rendered the initial inundation of no ongoing significance to the losses sustained.

Justice Mansfield went on to quantify the loss that was attributable to the initial inundation and allowed damages, including damages for the stock contained on the bottom two shelves (but not the top shelf), which would have been below the line of water.

Claim against Nonpareil

Justice Mansfield was of the view that, in order for Nonpareil to discharge its duty of care owed to Elilade, it was required to expressly raise the issue of flood insurance with Elilade, and to make it aware of the flood exclusion contained in the policy. There was a range of contributing factors leading to this conclusion, including the fact that Nonpareil was aware that the directors of Elilade were not well experienced in addressing the insurance requirements of such a business, and that the broker was aware that there was a significant risk of flood in Katherine.

Justice Mansfield found that Nonpareil had failed to discharge the duty it owed to Elilade. He then considered whether this failure had caused Elilade's loss and concluded that Elilade would not have procured flood cover had Nonpareil raised the issue of flood cover and expressly advised of the flood exemption in the policy. There were a number of factors on which Justice Mansfield based this conclusion, including the relative inexperience of the directors of Elilade in procuring business insurance and the consequent trust Elilade placed in Nonpareil; the inclination of Elilade's directors to proceed in a similar way to the previous owners of the business, who had not procured flood insurance; and the fact that Elilade's budgeted allowance for insurance was inadequate to cover the premiums had flood coverage been sought. Therefore Justice Mansfield held that Nonpareil's breach of duty did not cause Elilade's loss, as Elilade would have otherwise sustained that loss had Nonpareil not breached its duty. Hence, he dismissed Elilade's claim against Nonpareil.

This case demonstrates the importance of brokers fully advising their clients so that they are able to make informed business decisions about the level of cover. In many circumstances, it is not enough just to provide a schedule of information summarising the relevant provisions in the policy.

High Court considers duty of care of statutory authorities

Case Name:

Graham Barclay Oysters Pty Ltd v Ryan

Citation:

[2002] HCA 54, High Court of Australia per Gleeson CJ, Gaudron, McHugh, Gummow, Hayne, Kirby and Callinan JJ

Date of Judgment:

5 December 2002

Issues:

- Duty of care of statutory authorities
- Reasonable foreseeability

This case involves an appeal from a decision of the Full Federal Court, as reported in our *Annual Review of Insurance Law 2000*³.

The facts

In late 1996, there was heavy rainfall around Wallis Lake. As run-off into the lake can increase the risk of contamination from sewage and other pollutants, oyster-growers usually do not harvest oysters for a few days following heavy rain. Graham Barclay Oysters Pty Ltd (**Barclay Oysters**) waited a few days before harvesting. The standard tests were conducted: samples of oysters taken tested negative for E-coli bacteria (suggesting, but not guaranteeing, that the oysters were virus-free), and the oysters were depurated by being immersed in purified water and disinfected by ultra-violet radiation for 36 hours. This method was a useful, but not infallible method, of ensuring the purity of oysters for consumption. At the time, there was no known method of detecting the Hepatitis-A virus (**HAV**) in oysters. Despite the care taken by Barclay Oysters, it sold oysters contaminated with HAV.

Mr Ryan consumed oysters harvested from Wallis Lake. He was diagnosed with HAV after eating the oysters, in what became an epidemic. Never, in more than a century of oyster-farming at Wallis Lake, had such an outbreak occurred.

Mr Ryan launched proceedings in the Federal Court against Barclay Oysters, the NSW State Government and the local council. The claims were in negligence (and under the *Trade Practices Act 1974* (Cth) for merchantability of goods).

At first instance, Justice Wilcox found that all three defendants were liable in negligence to Mr Ryan. Barclay Oysters' duty of care was uncontested, the only issue being breach. Barclay Oysters and the authorities appealed on the negligence finding.

The Full Court of the Federal Court (Justices Lee, Lindgren and Kiefel) allowed an appeal by the local council, holding it had no relevant duty of care to oyster consumers. A differently-constituted majority (Justice Lindgren dissenting) dismissed the State's and Barclay Oysters' appeal, holding that it was open to Justice Wilcox to find a duty of care in the State, and a breach of Barclay Oysters' duty to oyster consumers.

The decision

Justices Gummow and Hayne delivered a joint judgment, with which Justice Gaudron concurred. Justice McHugh delivered a separate judgment that concurred with the orders of the joint judgment. Chief Justice Gleeson and Justices Callinan and Kirby each delivered separate judgments. The findings were unanimous as to the liability of the State and council, but split four to three (Chief Justice Gleeson and Justices Callinan and Kirby dissenting) on the question of Barclay Oysters' breach of its duty of care.

Was the State liable?

Mr Ryan argued that the State had a duty to take reasonable care to protect consumers from reasonably foreseeable risks of injury as a result of oyster consumption. The source of this duty was, it was argued, a network of statutory provisions giving the State powers over aquaculture and public health. Importantly, the State could have, but did not:

- conduct sanitary surveys to identify and remedy the sources of pollution;
- close oyster fisheries that presented an unacceptable risk to public safety, or prevent them from selling oysters during periods of danger.

Their Honours found that the existence of statutory powers does not ordinarily give rise to a duty of care to persons for whom the statutory powers were created.

A public authority has no duty to take reasonable care to protect other persons merely because the legislature has invested it with a power whose exercise could prevent harm to those persons (per McHugh J at [81]).

There is no simple test for determining when an authority will owe a duty of care to an individual. However, the court attempted to explain its method by asking whether there is 'a relationship between the authority and a class of persons that, *in all the circumstances*, displays sufficient characteristics answering the criteria for intervention by the tort of negligence' [at 146].

The 'circumstances' of which the court was speaking include the following:

- the degree and nature of control exercised by the authority over the risk of harm that eventuated;
- the degree of vulnerability of those who depended on the exercise by the authority of its powers; and
- the consistency of the asserted duty of care with the terms, scope and purpose of the relevant statute.

In this case, the State had decided, after much consultation, to adopt a self-regulation scheme for the oyster industry. Since this was fundamentally a political decision about the nature of regulation and the allocation of resources, the members of the court noted that such a question is not appropriate for the courts to rule upon [175-176]. Once such a decision is taken, the scope of any common law duty is necessarily adjusted to reflect the insusceptibility of that decision to judicial review.

The State had decided upon self-regulation. There were no reasons to conduct sanitary surveys, as HAV had never been found in Wallis Lake oysters before. Likewise, there was no reason to order a fishery closure. Thus the court unanimously found that the State had no common law duty of care towards the oyster consumers.

Was the council liable?

As with the claim against the State, the claim failed. The council had no direct control over the farming of oysters, and between it and Mr Ryan stood the entire oyster industry, each enterprise of which markets produce presenting a potential threat to the public. The control ultimately lay with the industry and its operators.

Though the council had broad statutory powers of inspection and intervention to protect the local environment, those powers did not give the council sufficient control over all risks of harm that could emanate from any commercial enterprise in the local area. Accordingly, the powers of the council were insufficient to create a duty of care to oyster consumers such as Mr Ryan.

Was Barclay Oysters liable?

The court was divided on whether Barclay Oysters had breached its undisputed duty of care to its customers. In a four to three decision, Barclay Oysters was held not to have breached its duty. In so doing, the High Court affirmed its previous decision in *Wyong Shire Council v Shirt* (1980) 146 CLR 40 that a duty of care does not extend to ensuring the safety of consumers in all circumstances, but is satisfied by doing what a 'reasonable man' would do after assessing the magnitude of the risk, the probability of its occurrence, and the expense and difficulty of alleviating the risk (at [190]).

Barclay Oysters had acted reasonably in all the circumstances: it had waited an acceptable period of time before recommencing harvesting, ensured the water's salinity levels had normalised, and used the best test available for detecting bacteria. There was no available means to eliminate the possibility of HAV contamination. Ultimately, the company had acted reasonably and fulfilled its duty of care.

Orders

The appeals by the State and the Barclay companies were allowed with costs. Mr Ryan's appeal against the Federal Court's findings in favour of the council was dismissed with costs. The court, in making such orders, was effectively upholding Justice Lindgren's findings in the Full Court of the Federal Court, who reached the same conclusion but was in a minority on the liability of the State and Barclay Oysters.

This case stands as authority for the following propositions:

1. Statutory authorities do not owe a duty of care to a class of persons merely because they possess statutory powers that could affect or protect those persons.
2. The test for determining whether an authority owes a duty of care is whether the relationship between the authority and the class of persons is sufficient 'in all the circumstances' to justify intervention by the tort of negligence.

A stockbroker's flagrant breach of duty – exemplary damages awarded

Case Name:

Ali v Hartley Poynton Ltd

Citation:

(2002) 20 ACLC 1006
[2002] VSC 113 per Smith J

Date of Judgment:

16 April 2002

Issues:

- Negligence
- Negligent representations
- Misleading and deceptive conduct
- Exemplary damages

This well-publicised case examines the scope of duties owed by a stockbroker, and highlights the duty of stockbroking organisations to monitor and supervise their brokers' activities. It also illustrates the application of exemplary damages in cases of flagrant breaches.

The facts

The facts of this case were complex and hotly disputed. The trial occupied 115 days and, overall, it took more than seven months. The trial judge, Justice Smith, described the proceedings as *'the hardest fought and most hostile civil case I have experienced as a practitioner and a Judge'*. The judgment delivered by Justice Smith runs more than 127 pages. There is also a 34-page annexure, which provides a chronology of the events.

The events that gave rise to this litigation had occurred between November 1997 and February 1999.

The plaintiff was Rahmat Ali (**Rahmat**), described as an elderly, unsophisticated man. He lived in the village of Navau in Fiji. He was a taxi proprietor and sugarcane farmer. The defendant was a firm of well-known stockbrokers, Hartley Poynton Limited (**HPL**).

Rahmat has never dealt directly with HPL. At all times, his son, Liyakat Ali (**Liyakat**) acted on his behalf as his agent. Liyakat dealt mostly with Christopher Martin (**Martin**), an employee of HPL.

There were two main aspects of Rahmat's claim.

1. **'Trading aspect'** – whereby Martin was retained by Rahmat through Liyakat to act as his broker and produce returns of 15 to 20% compounding per week (later varied to 25 to 30% compounding per month), with the trading conducted on a discretionary basis by Martin, subject to Rahmat's instructions. Rahmat made the initial investment of \$101,818.54 to be used in the trading. Further terms of the retainer in respect of the trading aspect were:

- HPL will provide \$200,000 of interest-free gearing if Rahmat provided \$100,000;
- Rahmat will be given extended settlement terms of at least 30 days.

In respect of the trading aspect, Martin was aware of the fact that the investment was to provide funds for the retirement of Rahmat, although the relevant forms designed to inform the broker of the personal information and the financial details of the investor were not completed by Liyakat. Liyakat informed Martin that the client's profile was one of a very risk-conscious client.

During the discussions between Liyakat and Martin, prior to entering the retainer agreement, Martin made the following alleged representations to Liyakat:

- Martin would not suffer losses in excess of 5% on any individual investment in a share or financial derivative;
- Rahmat would have a period of up to six to eight weeks to settle transactions;
- that trading in shares was not risky and that Rahmat would not be exposed to losses in excess of the stop loss limit (5%);
- Martin had the ability to adapt to the market as it evolved so that he could take significant advantage and be a couple of steps ahead of everyone else; and
- that Martin had come into a lot of information before the market knew about it and that this would alleviate risk for Rahmat.

Between November 1997 and February 1999, Martin traded close to \$40 million worth of shares and derivatives, earned brokerage fees of more than \$130,000, and, by the end of February 1999, accumulated trading profits of more than \$520,000. However, trading losses exceeded \$825,000. The original investment of Rahmat was depleted, and HPL was claiming more than \$67,000 in outstanding brokerage fees.

2. **'Telstra aspect'** – whereby Martin was retained by Rahmat through Liyakat to acquire for Rahmat 100,000 Telstra shares (**T1 shares**) to be held as a long-term investment to be used to build up a portfolio of blue chip shares by means of margin lending. Rahmat made the initial investment of \$195,000 to be used in establishing the portfolio.

The 100,000 T1 shares were acquired by Martin for Rahmat using applications by 13 family members of Rahmat applying for 8,000 shares each in the Telstra share offer. On 18 November 1997, Martin sold the 100,000 T1 shares, despite clear instructions to the contrary from Liyakat on behalf of Rahmat.

Martin used the proceeds of the sale of the T1 shares in trading on behalf of Rahmat, and, by the end of February 1999, the entire fund was run down.

The decision

Justice Smith held that:

- Martin was engaged to advise and conduct trading on behalf of Rahmat;
- Rahmat relied on Martin;
- the relationship between Rahmat and Martin was fiduciary in nature;
- a stockbroker's duty is to furnish the client with all the relevant knowledge that the adviser possesses, concealing nothing that might reasonably be regarded as relevant to the making of an investment decision;
- there was an implied term of the retainer that the stockbroker would, in performing its obligations under the retainer, exercise such reasonable care, skill and diligence as might be expected of a reasonably competent stockbroker;

- Martin owed to Rahmat a duty of care in accordance with the *Hedley Byrne* principle – in particular, he knew, or ought to have known, that Rahmat would rely on the skill of Martin and the exercise of care by him in what he said; and
- HPL had an obligation to supervise and control Martin's trading with reasonable care.

Justice Smith further held that:

- Martin was reckless in making the misrepresentations that he did about risks and returns;
- Martin's conduct was extraordinarily negligent considering that all brokers would, or should, know the equation between risk and return;
- Martin did not simply fail to inform Liyakat about the risks involved in trading in warrants and short-selling, but he recklessly dismissed or ignored the risks involved;
- Martin's failure to utilise well accepted systematic techniques to minimise losses, maximise returns and manage risks was negligent;
- Martin's sale of the 100,000 T1 shares was a wilful breach of contract;
- although HPL had appropriate policies in place, there was no adequate system in place to monitor compliance with those policies, rendering those policies worthless;
- the conduct on part of Martin of which HPL was aware of, separately and in combination, put HPL on notice that Martin required very close supervision and control;
- the breaches by Martin concluding various breaches of the ASX Rules occurred because of the absence of any adequate system for supervising and controlling brokers; and
- HPL had breached its obligations to supervise and control Martin's trading with reasonable care.

Justice Smith further held that there was contributory negligence on the part of Rahmat because he did not take control of the trading and did not terminate the retainer. However, Justice Smith also considered that Rahmat's failure in taking those actions was largely attributable to Martin's gross negligence, the gross negligence of other employees of HPL, Martin's deception and the persuasive manipulative pressure applied by Martin. Consequently, Rahmat's contribution was set at 15%.

Justice Smith awarded \$1,106,818.54 to Rahmat, consisting of both compensatory and exemplary damages as follows:

- \$101,818.54 – Rahmat's initial investment in the trading aspect;
- \$50,000 – the loss of opportunity arising from the misrepresentations about risks and returns, negligent advice, misleading conduct and negligent supervision by HPL;
- \$195,000 – Rahmat's initial investment in the Telstra aspect;
- \$500,000 – the loss of opportunity arising from the sale of the T1 shares in wilful breach of the retainer; and

- \$260,000 – exemplary damages (consisting of the approximately \$130,000 brokerage commission charged by the firm, and an additional \$130,000 as penalty and deterrence).

In assessing the quantum of exemplary damages, Justice Smith noted that:

- HPL ignored its public promises, and – although it publicly promoted itself to be a firm with core values that included acting with integrity and ensuring compliance with the spirit and letter of the relevant Acts, Rules and Regulations – on the evidence, nothing effective was done to meet those promises;
- HPL ignored the rights and interests of its clients and its actions reflected that, while HPL went into some trouble to address its own financial interests, it ignored whatever rights the clients might have acquired, and the financial position of its clients; and
- HPL ignored the rights and interests of Rahmat, including the closure of his accounts without consultation, constituting a conscious contumelious disregard for the rights of Rahmat.

Justice Smith allowed a counter claim of \$67,017.10 to be set off against the damages awarded for outstanding brokerage fees.

This case illustrates the importance of broking firms having appropriate guidelines (which are enforced) and operating control systems in place to supervise and control the trading activities of their brokers and to assure compliance with the relevant statutory and regulatory regimes.

No extension of liability in favour of subsequent purchasers of commercial dwellings

Case Name:

Woolcock Street Investments Pty Ltd v CDG Pty Ltd & John Cameron Johnson

Citation:

[2002] QCA 88 Queensland Court of Appeal per McMurdo P, Thomas JA and Douglas J

Date of Judgment:

21 March 2002

Issues:

- Pure economic loss
- Defective commercial premises
- Claim by subsequent owner

This case considers whether a future owner of a commercial building is owed a duty of care by the engineer responsible for its design.

The facts

In 1987, the then owner of a warehouse and offices in Townsville engaged engineers CDG Pty Ltd (**CDG**) to provide structural design and documentation for construction of a complex. In September 1992, the building was sold to Woolcock Street Investments Pty Ltd (**Woolcock**), who did not engage an engineer or building expert to provide a pre-purchase inspection report, and did not obtain any warranty that the complex was free of structural defects.

In 1994, substantial structural distress became apparent because of the settlement of the foundations. Woolcock alleged negligence by CDG and that it had suffered pure economic loss as a result, including the costs of demolishing and reconstructing parts of the premises, loss of rent during demolition and reconstruction, and diminution in the value of the property.

The decision

The Queensland Court of Appeal held that no duty of care was owed to Woolcock because:

1. The principle from the High Court decision in *Bryan v Maloney* (1995) 182 CLR 609 that a subsequent purchaser of a dwelling-house may recover pure economic loss from the negligent builder of the house is restricted to residential dwellings and is not extended to commercial premises.
2. The approach is not inconsistent with the general principles for the recovery of pure economic loss enunciated in recent High Court cases (that is, *Perre v Apand Pty Ltd* (1999) 198 CLR 180); and any extension of the present boundaries of liability beyond that recognised in *Bryan v Maloney* was a matter for the High Court or the legislature.

The court said that *Bryan v Maloney* rested quite heavily on the vulnerability of members of the public in acquiring their homes, and vulnerability was one of the relevant factors in *Perre v Apand* in determining if a category of claim for pure economic loss should be recognised.

The court noted that those engaged in commerce have capacity to protect themselves by employing expert assistance to ascertain the condition of the premises, seeking appropriate warranties and bargaining with the benefit of legal and other expert advice. This could be contrasted with an ordinary homebuyer's position, where only some, or none, of those options would be available to allow the purchaser to protect its interests.

This distinction was sufficient to find against imposing liability on builders and designers.

The case is of interest to insurers of engineers, architects and other professionals in the construction industry. It will mean that the circumstances in which subsequent owners can sue such professionals will be very limited, and, if this approach is followed, it is likely to be limited to residential premises.

Degree of control necessary to found direct or vicarious liability

Case Name:

Frost v Warner

Citation:

[2002] HCA 1 per Gleeson CJ, Gaudron J, Gummow J, Kirby J (dissenting) and Callinan J

Date of Judgment:

7 February 2002

Issues:

- Negligence
- Duty of care
- Vicarious liability

This case considers whether the requisite degree of control to found direct or vicarious liability can be conferred by a person's status as the holder of a certificate of registration.

The facts

On 8 January 1990, a 36-foot motor boat called the *N'Gluka* sank in Port Stephens. Five children, who were trapped in the front cabin when the boat sank, were drowned. The immediate family of one of the children who drowned, Amanda Frost, brought proceedings in the District Court of New South Wales against Mr and Mrs Warner, claiming damages for nervous shock suffered as a result of the accident and the death of Amanda Frost.

Mr Warner was the owner of the vessel and Mrs Warner, who had signed the certificate of registration for the vessel, was the 'registered controller' under the Water Traffic Regulations (NSW) (the **regulations**).

The decision

At first instance in the District Court, it was held that Mr and Mrs Warner were each liable to the appellants in negligence.

Subsequently, Mrs Warner (and not Mr Warner) appealed. The New South Wales Court of Appeal allowed Mrs Warner's appeal and set aside the trial judge's finding of liability against Mrs Warner.

The appellants appealed to the High Court on two grounds. The first ground was that the Court of Appeal erred in holding that Mrs Warner's status as 'registered controller' of the vessel did not make her responsible for the negligence of her husband. The second ground was that the Court of Appeal erred in holding that Mrs Warner did not owe a duty of care, which included a duty to prevent the vessel sailing while it was grossly overloaded, by reason of her status as 'registered controller'.

Chief Justice Gleeson and Justices Gummow and Callinan commented that the trial judge's finding that Mr Warner at all material times had de facto control of the vessel was not challenged. This meant that if the appellants' submissions were to succeed, the regulations would have to be construed such that they gave Mrs Warner the power to make another person's use of the vessel unlawful, thereby conferring an element of control upon her sufficient to found both direct and vicarious liability. The necessary 'control' was said to arise from the proper construction of two provisions of the regulations.

One of the regulations provided that a person 'who controls a registrable vessel' may apply for registration. Chief Justice Gleeson and Justices Gummow and Callinan found that this regulation did not confer control upon a successful applicant for registration either expressly or by implication. Rather, it operated in a negative sense to restrict the permissible class of applicants for registration to those who have the necessary control.

The appellants also relied on a regulation which provided that it was an offence for any person to navigate a registered vessel without the '*authority or consent of the holder of the certificate of registration*'. Again, the court found that this regulation did not confer a power to refuse to authorise or consent, rather, that power arises from being in control.

In the circumstances, the fact that Mrs Warner was the holder of the certificate of registration under the regulations was not sufficient to found liability either directly or vicariously.

Justice Gaudron found that the evidence that Mr Warner always exercised actual control also made it impossible to infer that Mrs Warner specifically authorised use of the vessel of the day of it sinking, or that Mr Warner was on that day navigating the boat on Mrs Warner's behalf, whether as her servant, agent or in any other capacity. As for actual negligence, in the absence of evidence that Mr Warner would not have commenced the journey if Mrs Warner had asserted her rights as registered controller of the vessel, Justice Gaudron was not able to find that Mrs Warner had any control over the situation and, that being the case, she was under no duty of care to the appellants.

Justice Kirby, in a dissenting judgment, found that Mrs Warner had the power to stop the vessel from putting to sea; she failed to exercise that power given to her by law; and that failure constituted direct evidence of negligence on her part.

This case demonstrates that, before a court will find that a person has been vicariously liable for the negligence of another person, there must be evidence that they were able to exercise control in all the circumstances. In this case, the fact that a person was the 'registered controller' under regulations that made it an offence to do something without the registered controller's consent was not sufficient in itself to result in a finding of liability either directly or vicariously. In other cases, the holder of a certificate of registration may in fact have effective control sufficient to found a basis for vicarious liability.

Hotelier's duty of care towards an intoxicated patron

Case Name:

South Tweed Heads Rugby League Football Club Ltd v Cole

Citation:

[2002] NSWCA 205 per Heydon, Santow JJA and Ipp AJA

Date of Judgment:

12 July 2002

Issues:

- Hoteliers' duty of care to intoxicated patrons

This case considers whether a hotelier owes a duty to ensure that their patrons are not injured as a result of their own intoxication. In this case, the New South Wales Court of Appeal took a different view to previous international and Australian judgments, including that of the Supreme Court of Queensland in *Johns v Cosgrove* (1999) 27 MVR 110.

The facts

Ms Cole was seriously injured when she was struck by a motor vehicle being driven by Ms Lawrence. Prior to the accident, Ms Cole had been drinking at premises operated by the South Tweed Heads Rugby League Football Club Ltd (the **club**).

Ms Cole sued both the club and the driver. The trial judge found that Ms Lawrence and the club were each 30% responsible for Ms Cole's injuries and that Ms Cole had contributed 40% to her own loss.

The decision

The New South Wales Court of Appeal unanimously upheld the club's appeal from the judgment of the trial judge.

While the Court of Appeal held that the evidence did not support a finding of liability on either the club or Ms Lawrence, it nevertheless addressed the scope of the duty of care owed by hoteliers to their patrons. Justice Ipp gave the leading judgment, with which Justices Heydon and Santow agreed. He stated that to impose a duty on a hotelier to take reasonable steps to avoid injuries to patrons caused by their own voluntary and self-induced drunkenness would involve a significant extension in the scope of the general duty of care owed by occupiers to persons lawfully entering their premises.

In the court's view, the recognition of such a duty, except in extraordinary cases, would give rise to a variety of difficulties and place the hotelier in an untenable position. Some of the practical difficulties that would face a hotelier which Justice identified were:

- determining whether a patron is intoxicated;
- preventing other patrons from buying alcohol for intoxicated ones;
- detecting patrons who arrive on the premises in an intoxicated state;
- preventing intoxicated patrons from suffering injury when the hotelier has limited control over such patrons; and
- where such a duty would end.

The court considered that the law of negligence should adopt a similar approach to that taken in contract and criminal law and recognise that adult persons must assume responsibility for their own actions while intoxicated if this intoxication results from a deliberate and voluntary decision on their part to drink to excess.

As such, the court held that the club did not owe Ms Cole any duty, other than the normal duty owed by an occupier to a lawful entrant, and was not responsible for her injuries.

Justice Ipp stated that even if such duty as contended for by Ms Cole existed, it would have been discharged by the club offering to arrange her transport home (as happened in this case).

Interestingly, the court left open the possibility that a duty of care on the part of a hotelier to protect a patron from suffering injury due to their own intoxication may arise where a patron becomes so intoxicated as to be completely incapable of any rational judgment or of looking after themselves.

Ms Cole has filed an application for special leave to appeal to the High Court.

This case is a marked departure from previous international and Australian authorities regarding the duty of care owed by hoteliers to their patrons. It also indicates a clear willingness by the NSW Court of Appeal, and perhaps other appellate courts, to place a greater emphasis on personal responsibility in the context of the law of negligence. However, this case should be contrasted with the decision in *Burns v Hoyts*, also reported in this Review.

Display of warning signs required?

Case Name:

Burns v Hoyts Pty Ltd

Citation:

[2002] NSWCA 5 per Sheller, Heydon JJA and Ipp AJA

Date of Judgment:

3 December 2001; 8 February 2002

Issues:

- Reasonably foreseeable risk
- Duty to warn

This case considers the need for warning signs when there is a reasonably foreseeable risk of injury.

The facts

The appellant had attended Hoyts Cinema in Bankstown, Sydney, in her capacity as a teacher's aide and was responsible for the welfare of a disabled child. Despite having entered the cinema when the seats were retracted, the appellant was unaware that the seats automatically retracted when unoccupied, and that, on rising to attend to the child, her seat would revert to a vertical position. She sat on her seat in the vertical position and injured her coccyx and the disks and ligaments of the lumbar spine.

The decision at first instance

At first instance, the plaintiff claimed negligence by reason of lack of a warning. Justice Gibbs, the trial judge, found for the defendant. Justice Gibbs held that the cinema seats were not inherently dangerous, and it was not unreasonable for the respondent to expect that its patrons were aware of the automatic retraction of the seats. Justice Gibbs concluded that the absence of warning signs was an irrelevant consideration, as the plaintiff would be likely to act in a similar manner even if she had known that the seats retracted automatically. Justice Gibbs found no breach of duty, nor any relevant failure to keep the premises as safe as reasonable care and skill could make them

The decision on appeal

Justices Sheller, Heydon and Ipp found for the plaintiff. The defendant accepted it owed a duty to patrons. 'The measure of the discharge of the duty is what a reasonable man would, in the circumstances, do by way of response to the foreseeable risk.'⁴ The court considered that there is an obvious risk, in a darkened cinema that if a patron is not aware that the seats retract, that on standing the patron may forget that the seat has moved position and attempt to sit without putting the seat down, which may cause injury. The chance of this occurring is slight, but the risk of injury if it does occur is substantial. No details were offered by the expert, Dr Emerson, regarding availability, cost or efficacy of design modifications. The court considered that there is an overwhelming inference that the display of a warning sign would be likely to have an effect on the thought processes of patrons. The court considered an appropriate warning sign could have been placed in the foyer so it was visible to patrons before entering the cinema.

⁴ *Hackshaw v Shaw* (1984) 155 CLR 614 at 663; *Australian Safeway Stores Pty Ltd v Zaluzna* (1987) 162 CLR 614.

The decision imposes a heavy burden on persons occupying premises for entertainment purposes, such as cinema owners. On one view, the effect of this decision is that such persons will need to consider whether warning signs are adequate to cover every foreseeable risk of injury, no matter how slight.

Reasonable foreseeability of the risk of injury and the borderline between liability and non-liability

Case Name:

New South Wales Land & Housing Corp v Watkins

Citation:

(2002) Aust Torts Reports 81-641 per Powell JA, Heydon JA & Hodgson JA

Date of Judgment:

19 February 2002

Issues:

- Scope and content of the duty of care
- Reasonable foreseeability of the risk of injury

The case considers the content of the duty of care owed by owners to occupiers, and the borderline between the liability or non-liability of a defendant based on the reasonable foreseeability of the risk of injury incurred.

The facts

Mr and Mrs Watkins leased a house owned by the New South Wales Land & Housing Corporation. Throughout the period in which they leased the house, they lodged a number of complaints about their hot water service, based on the fact that the system was prone to dangerous fluctuations in water temperature. However, the system was not repaired.

After six years of tenancy, Mrs Watkins fainted on one occasion while showering, and suffered spinal injuries from the fall. She brought an action in negligence, claiming that her lapse in consciousness and the resulting injury were caused by a substantial and sudden increase in water temperature.

The trial judge found for Mrs Watkins, accepting the argument that her injuries were the reasonably foreseeable result of the appellant's failure to maintain and repair the hot water service, and assessed damages at \$636,923. The defendant appealed this decision in relation to both liability and the quantum of damages.

The decision

Justice Heydon, with whom Justice Hodgson agreed (Justice Powell dissenting), upheld the decision of the trial judge about the liability of the applicant, but allowed the appeal on the issue of damages. The applicant advanced the following three central arguments on appeal.

First, it was argued that Mrs Watkins had not established any reasonably foreseeable possibility that failure to repair or replace the hot water system might cause injury. Justice Heydon rejected this argument, based on both the complaints that had been made by the Watkins about the service and the element of common experience of the possibility of a fall in the shower.

Secondly, the applicant argued that the trial judge had failed to apply the calculus of negligence prescribed by the High Court in *Wyong Shire Council v Shirt* (1980) 146 CLR 40 in relation to magnitude of the risk, probability of occurrence, expense and difficulty of taking alleviating action, and any conflicting responsibilities of the applicant. Justice Heydon agreed that the trial judge had failed to explicitly address this issue, but found that the argument failed because when the 'calculus' was considered, the outcome was adverse to the applicant.

Finally, the applicant argued that the damages awarded by the trial judge were excessive. This argument was upheld, and the damages awarded to the respondent were reduced by a third.

Justice Heydon noted in this case that, at first sight, it might seem surprising that Mrs Watkins could recover damages for a defect in her hot water system that is common to many residences. He explained that the reasonable foreseeability of injury depended in a large part on the complaints that had been made by the Watkins. Accordingly, Justice Heydon stated that ‘though it may be true that this case goes near the borderline between liability and non-liability, there is no sufficient reason to think that it crosses over it’ and observed that fluctuations in water temperature may have been less acute than in other cases.

This case demonstrates that the borderline between liability and non-liability of a defendant is often a fine one and will depend on the factual circumstances of the individual case. In this case, the court indicated that liability was based to a large extent not on an objective view of the reasonable foreseeability of the risk of injury, but rather on the fact that the plaintiff had complained prior to the injury occurring about this risk.

Duty of care and reasonable foreseeability of sporting injuries

Case Name:

Woods v Multi-Sport Holdings Pty Ltd

Citation:

[2002] HCA 9 High Court of Australia per Gleeson CJ, Hayne and Callinan JJ; McHugh and Kirby JJ in dissent

Date of Judgment:

7 March 2002

Issues:

- Scope of occupier's duty of care
- Failure to warn of specific risks and to provide protective equipment
- Reasonable foreseeability of damage

The High Court considers the extent of duty owed by an occupier of a sporting facility to provide protective equipment and to warn of specific risk of eye injuries in playing indoor cricket.

The facts

Mr Woods suffered a serious injury when he lost the sight in his right eye after being hit by the ball while playing a game of indoor cricket at a centre in Perth, owned and operated by Multi-Sport Holdings Pty Ltd (**Multi-Sport**).

Mr Woods was an experienced outdoor cricketer but had played indoor cricket only once before the time he was injured.

Mr Woods sued Multi-Sport and argued that it had breached its occupier's duty of care by not:

1. having suitable protective equipment, primarily a helmet with an eye guard, available to Mr Woods; and
2. displaying a suitable warning to alert Mr Woods, and players like him, of the particular dangers involved in playing indoor cricket, said to be:
 - (a) the danger of eye injury involved in playing a game in a confined space without an appropriate helmet with an eye guard; and
 - (b) the particular danger of eye injury from the ball used in an indoor cricket match penetrating the socket due to its size and malleability.

The decision

Ophthalmologist expert evidence was given at trial about the particular injuries that may result from the ball striking the eye socket in indoor cricket. There was also evidence about the then rules of the Australian Indoor Cricket Federation, which generally did not permit players to wear helmets. This was because the confined space, diving, sliding and frequent collisions between players made wearing helmets not only undesirable but hazardous.

Although Multi-Sport pleaded contributory negligence as to the stroke played by Mr Woods, the issue had no bearing on the outcome and was not pursued in the High Court.

At the District Court trial, District Court Judge French held that:

1. The scope of the standard of care owed by Multi-Sport to take all reasonable steps did not extend to the provision of helmets to protect players from injury where it had never been part of the game and was against the rules; and

2. Mr Woods was well aware when he played indoor cricket that he ran the risk of being hit by the ball in the body or the head, and there was no duty to warn of specific risks that were part of the inherent risks accepted by the player.

The Full Court of the Supreme Court of Western Australia, comprising Justice Murray, Chief Justice Malcolm and Justice Pidgeon, unanimously upheld the trial judge's decision.

In submissions to the High Court, the lower courts were criticised for relying on Justice Kirby's comment in *Romeo v Conservation Commission (NT)* (1998) 192 CLR 431 at 478 that:

where a risk is obvious to a person exercising reasonable care for his or her own safety, the notion that the occupier must warn the entrant about that risk is neither reasonable or just.

The High Court delivered five separate judgments and dismissed the appeal by majority. Chief Justice Gleeson said there was no error in referring to the observation of Justice Kirby and said that what reasonableness requires by way of warning from an occupier is a question of fact and depends on all the circumstances, including the obviousness of a risk.

Due to their conclusion, the majority did not deal with any argument about voluntary assumption of risk.

This decision demonstrates that determining the scope and standard care owed to participants in voluntary sporting activities is a finely balanced exercise and depends upon what will be considered reasonable conduct in all of the circumstances.

Justices McHugh and Kirby dissented. They considered that not only did Multi-Sport breach its duty of care by failing to provide helmets with face shields, but a warning sign should also have been put up and suggested the form it could take. Given the division of opinion in the judgments and the scope for a different result in other circumstances, at the very least, it would be prudent for indoor cricket venues (and the like) to consider a warning sign in the form suggested by Justice McHugh.

This decision should be contrasted with the decision of the New South Wales Court of Appeal in *Canterbury Municipal Council v Taylor*, reported elsewhere in this Review.

Occupier's liability – multiple-use sporting venue

Case Name:

*Canterbury Municipal Council
v Taylor*

Citation:

[2002] NSWCA 24 per
Spigelman CJ, Ipp,
Matthews AJJA

Date of Judgment:

5 March 2002

Issues:

- Occupier's liability
- Duty of care owed by local authorities
- Voluntary assumption of risk

This case considers the content of duty of care owed by an occupier of premises and examines the circumstances in which a defence of voluntary assumption of risk may succeed.

The facts

Mr Benedet (the **deceased**) suffered injuries and died when he stepped back into the path of a group of cyclists while playing touch football on the inner field of a velodrome owned and operated by Canterbury Municipal Council (the **council**). Mr Taylor (the **respondent cyclist**) suffered physical and psychological injuries as a result of the collision.

The respondent and the executrix of the deceased's estate sued the council, alleging negligence.

The respondent claimed that a duty of care arose from the council's occupation, control and management of the velodrome. He claimed that the council breached that duty of care by failing to:

- (a) provide a barricade between the track and the field;
- (b) exercise any control over or supervise the activities of the velodrome;
- (c) ensure that exclusive use of the velodrome was given to either the cyclists or the touch footballers; and/or
- (d) erect signs warning participants in the touch football game not to attempt to cross the cycle track while it was in use.

The decision

At first instance in the Supreme Court, Justice Barr held that the council was negligent in failing to sufficiently control the use of the velodrome, resulting in the injuries suffered by the respondent. Justice Barr assessed the respondent's contributory negligence at 50%.

The council appealed against Justice Barr's findings that it was negligent, and that the respondent had not voluntarily accepted the risk of injury. The respondent cross-appealed against the finding of contributory negligence against him and the amount of damages.

The Court of Appeal upheld Justice Barr's decision, except to reduce the respondent's contributory negligence from 50% to 25%, and upheld the respondent's cross-appeal to find the deceased 25% liable for the respondent's injuries.

Justice Ipp (with whom Chief Justice Spigelman and Acting Justice Matthews agreed) upheld Justice Barr's finding that the appellant owed a duty of care to the touch football players and cyclists who played and trained in the velodrome. He reasoned that because the appellant agreed to the dual use and tacitly authorised the cyclists to use the velodrome, they were under a duty to take reasonable care to avoid injury to touch football players and cyclists.

The court confirmed that the risk of injury arising out of the dual use of the velodrome was obvious and foreseeable. Justice Ipp noted that there were reasonable measures available to the council to prevent the dual usage of the velodrome. These included erecting warning signs, installing portable barriers and using council employees to monitor the use of the velodrome.

The appellant failed to establish a defence of voluntary assumption of risk because, while the respondent knew that there were risks in training while the football game was underway, he gave evidence that he did not think that those risks would eventuate.

Justice Ipp agreed with Justice Barr's finding that the respondent's participation in the cycling training session was negligent, given the obvious danger to all involved. However, he found that the deceased was negligent, having failed to keep a proper lookout, failing to keep off the cycling track while it was being used by the cyclists, and failing to keep out of the way of the cyclists.

In reaching his decision, Justice Ipp stated that:

I would regard the respondent and Mr Benedet as having been equally culpable. In my opinion, however, the primary cause of the collision (and the respondent's injuries) was the negligence of the appellant in breaching its duty to take reasonable care to avoid injury to the persons engaging in activities in the Velodrome, activities promoted and encouraged by it.

The court apportioned 50% of the responsibility for the respondent's injuries to the appellant, 25% to the deceased and 25% to the respondent.

This case illustrates that occupiers of multiple-use premises must be careful to monitor and control usage in a way that minimises risk of injury or, alternatively, take precautions that prevent any dangerous interaction between users.

Negligence and occupier's liability

Case Name:

Gondoline Pty Ltd v Janice Rose Hansford

Citation:

[2002] WASCA 214, Supreme Court of Western Australia Court of Appeal per Murray J, Wheeler J and Miller J

Date of Judgment:

14 August 2002

Issues:

- Occupier's liability
- Whether there is a breach of a duty of care due to a protruding paving stone

This case considers whether an occupier or owner of premises is liable to a person entering onto those premises if they are injured by a protruding paving stone on a pathway. Although this decision turns on its own facts, the court referred to High Court authority that places some limitation on whether a breach of the duty of care in these circumstances may be held to have occurred.

The facts

Ms Hansford sustained an injury when she fell on a pathway leading from a shop to a carpark at the Lavender and Berry Farm in Pemberton, in the south-west of Western Australia in August 1996. Ms Hansford was wearing hiking boots, which were said to be in good condition.

The trial judge accepted the evidence of Ms Hansford that there was a paver protruding from the pathway in the area where she fell, and that the protrusion was between half an inch to one inch. In addition, the trial judge found that the gradient of the pathway was of reasonable proportions, particularly where Ms Hansford sustained her fall.

The conclusion of the trial judge was that the owner of the property did not inspect the path with sufficient care and, had he done so, the protruding paver would have been seen. The trial judge held that the pathway on the day of the accident was unsafe.

The owner of the property appealed.

The decision

On appeal, the court accepted that the owner of the property owed a duty of care to Ms Hansford to ensure that the pathway leading from the carpark at the farm to the shops and other facilities was as safe for use by patrons as reasonable care could make it. The question was whether a reasonable person in the position of the owner of the property would have foreseen that the pathway, with some unevenness in the paving stones, created a risk of injury to Ms Hansford as she walked down it between the shops on the farm and the carpark.

The court endorsed the proposition that persons using steps, or footpaths, encounter everyday risks that they must avoid by taking care for their own safety. This principle was espoused by the High Court in *Brodie and Singleton Shire Council; Ghantous v Hawkesbury City Council* (2001) 75 ALJR 992, reported in the *AAR Annual Review of Insurance Law 2001* (pp 90 and 93). The court found, in Ms Hansford's circumstances, that there was no foreseeable risk of harm to persons using the pathway taking reasonable care for their own safety. The paver

was not a hazard or trap. Ms Hansford could have been expected to have exercised sufficient care in looking where she was going on the pathway to have observed any uneven paving stones. The court commented that a pathway 'is not to be criticised by the standards of a bowling green'. Here, the pathway was well laid out and, although on a gradient, relatively even.

However, the court placed significant emphasis on the fact that the accident occurred in a country or rural location. In addition, there was no evidence that complaints had been made about the pathway prior to the fall, which the court also took into account.

This case demonstrates that the courts will consider all the relevant factual circumstances in determining whether a breach of an established duty of care may have occurred. On the facts of this case, particularly given that the accident occurred in a rural location, such a breach of duty was held not to have taken place. This case illustrates the limits of occupier's liability for injury resulting from protrusions or obstructions that are inherent in the land.

When is risk of injury far-fetched and fanciful?

Case Name:

Hakoah Club Ltd v Green

Citation:

[2002] NSWCA 242 per Hodgson JA, Foster and Brownie AJJA

Date of Judgment:

22 July 2002

Issues:

- Negligence
- Foreseeability
- Occupier's duty of care

This case examined whether a particular set of factual circumstances satisfied the test laid down in respect of foreseeability by Justice Mason in *Wyong Shire Council v Shirt* (1980) 146 CLR 40.

The facts

Mr Green, the respondent, was a sound mixer hired by Mr De Oliveira, the organiser of a Brazilian Carnival. The Hakoah Club, the appellant, was the occupier of the building and hired the hall, out to Mr De Oliveira for him to conduct the Brazilian Carnival. Within the hall, there was a stage and on the stage was a grand piano. The space under the piano was filled with boxes.

During the evening's activities, Mr Green decided to tell the singers to get closer to their microphones. To avoid going between the audience and the band, Mr Green went to the rear of the stage and climbed up a flight of stairs, where he was concealed from the audience. His path was blocked by the grand piano, so he climbed on top of the piano, slid across the top and attracted the attention of the singers, who then moved closer to their microphones.

As Mr Green moved backwards across the top of the piano, sliding himself, he tried to put his feet down on the stage. He missed the edge of the stage and fell to the floor of the hall, injuring himself.

The decision

At first instance in the District Court, the trial judge held that the appellant negligently positioned the grand piano too close to the edge of the stage.

The Court of Appeal, in setting aside the judgment of the District Court, noted that the matter was conducted on the basis that the duty of care owed by the appellant to the respondent was that described by Justice Mason in *Wyong Shire Council v Shirt* (1980) 146 CLR 40, where at 47-48 he said:

. . . when we speak of a risk of injury as being 'foreseeable' we are not making any statement as to the probability or improbability of its occurrence, save that we are implicitly asserting that the risk is not one that is far-fetched or fanciful...a risk of injury which is remote in the sense that it is extremely unlikely to occur may nevertheless constitute a foreseeable risk. A risk which is not far-fetched or fanciful is real and therefore foreseeable . . .

Acting Justice Brownie, with whom Justice Hodgson and Acting Justice Foster agreed, held that, given the facts of the case, '*the risk of injury to someone in the position of the respondent was [not] foreseeable*' and that it was a '*far-fetched, fanciful or fantastic risk*'.

This case illustrates the application of the test of foreseeability as laid down by Justice Mason in *Wyong Shire Council*, and indicates the sort of risk that may be regarded as 'far-fetched or fanciful'.

Nervous shock – what limits remain?

Case Name:

Tame v New South Wales;
Annetts v Australian Stations
Pty Limited

Citation:

[2002] High Court of Australia
per Gleeson CJ, Gaudron,
McHugh, Kirby, Gummow,
Hayne and Callinan JJ

Date of Judgment:

5 September 2002

Issues:

- Duty of care
- Psychiatric injury
- Limits of liability

In these cases, the High Court considers the ‘special rules’ that apply to the cause of action known as ‘nervous shock’.

The decision of the High Court is a further development from the state of the law outlined in the case reviews of *Annetts v Australian Stations Pty Limited* and *Hancock v Wallace* in the *AAR Annual Review of Insurance Law 2001*⁵.

The facts

Tame v NSW

Mrs Tame was involved in a motor vehicle collision, in which the driver of the other vehicle had a blood alcohol reading of 0.14 and was driving on the wrong side of the road. Mrs Tame’s blood alcohol level was nil, but was mistakenly recorded on a police report as also being 0.14. The mistake was corrected, but Mrs Tame later became aware that an insurer had a copy of the incorrect report. She contacted the police, who provided a formal apology and an assurance that the mistake had been rectified. Mrs Tame, however, became obsessed with the mistake. She experienced shame, guilt, stress and depression. Her psychiatrist diagnosed her condition as psychotic depressive illness.

Annetts v Australian Stations Pty Limited

James, the 16-year-old son of the Annetts, went to work as a jackeroo at a cattle station owned by the respondent. 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. The Annetts claimed that they had suffered nervous shock after learning of the disappearance and death of their son.

The decision

This decision openly explores the policy issues underpinning the development of the elements of ‘nervous shock’. It also foreshadows the need for a more sophisticated, or more accurate, name for the cause of action.

⁵ See pages 79 and 81

While the decision does address liability control measures that the courts have put in place in previous decisions, the nature of the relationship between the plaintiff and the defendant in the two cases (as opposed to that between the defendant and an injured third party) is fundamental to the outcome.

Tame v NSW

The High Court dismissed an appeal from the New South Wales Court of Appeal, finding that Mrs Tame's action failed because the relationship between her and the police officer who made the error was not one that would give rise to liability. In fact, the relationship was one that was inconsistent with a duty of care arising. The police officer was required to complete the form as part of his duty to fully investigate the conduct in question, without having to take care to protect from possible psychiatric illness a person whose conduct was the subject of investigation and report.

Further, it was not reasonably foreseeable that a person in the position of Mrs Tame would suffer a recognisable psychiatric injury as a result of the defendant's conduct, and her particular susceptibility was a relevant factor in that assessment.

Annetts v Australian Stations Pty Limited

The Western Australian Full Court had held that the absence of the requirements of 'sudden shock', 'direct perception' of the events and 'normal fortitude' precluded any duty of care arising.

The High Court granted special leave to appeal the decision, specifically rejecting the elements of sudden shock and direct perception as being a requirement to establish a duty of care.

Sudden shock and direct perception

The court identified that the requirements of sudden shock and direct perception have operated in an arbitrary and capricious manner, operating to exclude meritorious claims.

In applying that reasoning to the particular facts, Chief Justice Gleeson stated:

The process by which the applicants became aware of their son's disappearance, and then his death, was agonisingly protracted, rather than sudden. And the death by exhaustion and starvation of someone lost in the desert is not an 'event' or 'phenomenon' likely to have many witnesses. But a rigid distinction between psychiatric injury suffered by parents in those circumstances, and similar injury suffered by parents who see their son being run down by a motor car, is indefensible.

The court preferred to rely on the general concept of the reasonable foreseeability of causing harm to one's 'neighbour'. That is, one who is so closely and directly affected by the actions of the person that he or she should be in that person's contemplation as likely to be affected by their conduct. As the Annetts had made enquiries of the respondent about the arrangements that would be made for their son's safety and, in particular, had been assured that he would be under constant supervision, there was a relationship of such a nature that a duty of care arose.

Justices Kirby and Gummow held that ‘sudden shock’ was not a settled requirement in the common law of Australia, noting that it derived from Justice Brennan’s judgment in *Jaensch v Coffey*. They also held there was no High Court authority for the ‘direct perception’ requirement to be an essential ingredient in the cause of action.

Justice Gaudron recognised that it may be that, in many cases, the risk of psychological injury will not be foreseeable in the absence of a sudden shock, but held that it was not critical to the existence of a duty of care. She saw no reason why liability should be denied to the Annetts because, instead of experiencing sudden shock, they suffered psychiatric injury as a result of uncertainty and anxiety culminating in the news of their son’s death.

Justice McHugh held the relationship between the Annetts and the respondent was almost akin to a contract, and that the special rules for the cause of action were therefore not applicable. He held that the relationship was such (as is that between employee and employer) that the defendant was already under a duty to take reasonable care to avoid injury to the plaintiff.

He reasoned that the special rules were concerned with situations where the parties had no pre-existing relationship and where, before the suffering of nervous shock, there was no duty on the defendant to take care to avoid injury to the plaintiff; the rules are concerned with the issue of whether the plaintiff was the defendant’s ‘neighbour’. Their usual application is where the duty to take care to avoid afflicting nervous shock on the plaintiff coincides with the breach of a duty owed to a third party.

Normal fortitude

The court did not dispense with the requirement of normal fortitude, although stating it could not be the sole criterion for liability. It was identified as a relevant factor in assessing whether a risk of psychiatric injury was reasonably foreseeable.

Justice Gaudron also raised the nature of the relationship in relation to normal fortitude, making the comment that there may be special relationships or special features of relationships to render the risk of psychiatric injury foreseeable, even where it would not be foreseeable in the case of persons of normal fortitude. An example of this is where the defendant has knowledge that the plaintiff is particularly susceptible to injury of that kind.

Bearer of bad tidings

Justices Kirby and Gummow held that there can be no legal duty to break bad news gently, that neither carelessness or insensitivity in presentation will found an action in negligence against the messenger. They left open the suggestion, however, that where the psychiatric injury results from being told of the event, an action may lie against the person who caused the event. This is consistent with dispensing of the requirement for direct perception. Justices Kirby and Gummow also expressly disfavoured the requirement of ‘normal fortitude’. They considered that the risk of a recognisable psychiatric illness to a person who falls outside the notion of ‘normal fortitude’ may nonetheless not be far-fetched or fanciful.

This case has dispensed with two of the special rules that previously existed to limit liability for nervous shock, namely, the requirements of 'sudden shock' and of 'direct perception'. The court rejected these rules as being too rigid, preferring the flexibility of reasonable foreseeability. It is therefore likely to expand liability for claims about nervous shock.

It should be noted that the case examined only the special rules in the context of determining whether a duty of care exists. Direct perception and sudden shock will continue to be relevant to the issues of *breach* of duty and causation.

High Court abolishes discounting of damages for prospect of remarriage

Case Name:

De Sales v Ingrilli

Citation:

[2002] HCA 52 per Gleeson CJ, Gaudron, McHugh, Gummow, Kirby, Hayne and Callinan JJ

Date of Judgment:

14 November 2002

Issues:

- Damages
- Discount for prospect of remarriage
- Vicissitudes of life

In this case, the High Court considered whether, in assessing damages to be awarded to a surviving spouse under fatal accidents legislation, any account should be taken of the chance of the surviving spouse remarrying and obtaining some financial benefit that may offset or diminish the loss. The court also considered whether such consideration should be made separately from, or included in, the discount that is made for the 'vicissitudes of life'.

The facts

Following the death of her husband in a farm accident at Mr Ingrilli's farm, Mrs De Sales commenced proceedings in the District Court of Western Australia under the *Fatal Accidents Act 1959* (WA). Mrs De Sales claimed damages under that Act on behalf of herself and her two children for the financial loss suffered as a result of Mr Ingrilli negligently causing her husband's death.

At first instance, Mr Ingrilli's liability having been established, the trial judge assessed the damages and applied a discount of 5% to the damages awarded to Mrs De Sales to reflect the chance that she would obtain financial support from remarriage in the future. On appeal, the Full Court of the Supreme Court increased the deduction made to Mrs De Sales' damages from 5% to 20% for the possibility of remarriage, and also added 5% for general contingencies.

The decision

Mrs De Sales appealed to the High Court contending that there should not have been any discount by the trial judge for the prospect of remarriage and that, if that was not accepted, the figure of 5% should not have been increased to 20% by the Full Court.

The joint decision of Justices Gaudron, Gummow and Hayne and the separate decision of Justice Kirby established:

- (a) in assessing the future benefits that would have flowed from a deceased person to his or her relatives, it is wrong to treat the prospect of remarriage or the prospect of forming some new continuing relationship as a separate item for which an identified discount must be made; and
- (b) the prospect of remarriage is also not a matter that should enlarge the discount made to damages under the general heading of the 'vicissitudes of life'.
- (c) This is not to say, however, that if there is evidence at trial that a new relationship had been formed, the trial judge cannot have regard to evidence revealing whether that relationship brought with it financial advantage or disadvantage.

Chief Justice Gleeson reached the conclusion that, in the ordinary case, the prospect of remarriage should be treated only as part of the vicissitudes of life. It would only be where there are special or unusual circumstances that indicate an unusually low or high chance of remarriage that a separate and substantial discount is warranted.

Both Justices McHugh and Callinan, for different reasons, ruled against the court abolishing the rule that a court should assess and value the chance of a surviving spouse obtaining financial support in future.

This case establishes that, in assessing the damages to be awarded under fatal accidents legislation, it will generally not be appropriate to reduce the damages award on the basis that the claimant may obtain financial support in future within a new relationship.

High Court rejects reduction of damages award under Trade Practices Act for contributory negligence

Case Name:

I&L Securities Pty Ltd v HTW Valuers (Brisbane) Pty Ltd

Citation:

[2002] HCA 41, High Court of Australia per Gleeson CJ, McHugh J, Gaudron, Gummow and Hayne JJ, Callinan J and Kirby J

Date of Judgment:

2 October 2002

Issues:

- Sections 82 and 87 of the *Trade Practices Act 1974*
- Misleading and deceptive conduct
- Contributory negligence

The High Court has overturned the decision of the Queensland Court of Appeal (reported in our *Annual Review of Insurance Law 2000*⁶). The Queensland Court of Appeal held that section 87 of the *Trade Practices Act 1974 (Cth)* (the *Act*) could be used to reduce damages awarded to a plaintiff in cases where the plaintiff was partly at fault.

Background to sections 82 and 87 of the Act

Section 82 of the Act enables a plaintiff to recover damages from a defendant contravening the Act where the plaintiff has suffered loss or damage 'by' the defendant's contravention.

Section 87 permits the court in such proceedings to make a wide range of orders and to 'make sure order or orders as it thinks appropriate against the person who engaged in the conduct or a person who is involved in the contravention . . . if the court considers that the orders will compensate the first mentioned person in whole or in part for the loss or damage or will prevent or reduce the loss or damage'.

The facts

Camworth Pty Ltd (*Camworth*) owned land that it proposed to sub-divide and develop. In early 1995, Camworth sought refinancing and obtained a valuation of its land from the respondent (*HTW*) to assist its loan application. HTW provided Camworth with a valuation of the land for \$1.576 million. Camworth used that valuation to seek and obtain a loan of \$950,000 from I&L, secured by the land.

Camworth defaulted on the loan and eventually went into liquidation. I&L realised the security and received net proceeds of \$592,367. I&L sued HTW for the difference between the loan and proceeds of sale on the basis of a negligently prepared/misleading valuation.

At first instance, the Supreme Court of Queensland awarded damages for negligence and breaching the Act. In both cases, I&L's claim for damages was reduced by a third on the basis that I&L contributed to the loss by failing to assess Camworth's ability to repay, and for not undertaking a proper risk assessment of Camworth.

I&L appealed to the Queensland Court of Appeal, which upheld the original decision but on a different basis. The Court of Appeal relied on s87 of the Act rather than s82.

I&L then appealed to the High Court raising two issues for determination:

- Can a court use s87 of the Act to reduce damages that might otherwise be awarded under s82?
- Does s82 permit an apportionment of damages where the plaintiff's failure to take reasonable care of its own interests was also a cause of the loss?

The decision

A Full Court of seven gave their judgments and allowed the appeal, with only one judge (Justice Kirby) dissenting. As to the first issue, the majority found that, as between s82 and s87, s82 was to take precedence. Chief Justice Gleeson remarked that:

There is no warrant for reading section 87 as conferring upon a Court a discretionary power to take away, or modify, the right conferred by section 82.

The majority also considered that s82 did not permit a court to divide the responsibility for a loss that is causally connected in the common law sense with a respondent's breach of Parts IV and V of the Act.

The main rationale for affording s82 such primacy over s87 was that the sections provided different remedies for different situations. As Justice McHugh stated:

Section 82 gives a specific remedy. On the other hand, section 87 is couched in general terms and gives a 'smorgasbord' of remedies. Section 87 cannot be regarded as a dominant provision to which section 82 is subject. Nor does section 87 provide the framework in which the power preferred by section 82 must be exercised. Sections 82 and 87 provide complementary but independent powers.

Justice Callinan dealt with a submission by HTW that the apportionment of damages merely reflected an analysis of what the plaintiff's conduct had actually resulted in. Despite noting the attractiveness of that argument, and the fact that it would produce a fair and just result, Justice Callinan felt bound by his analysis of s82 and its relationship to s87 to reject it.

The second issue for determination was easily disposed of with a reiteration of the views espoused by the majority in *Henville v Walker* (reported in the *AAR Annual Review of Insurance Law 2001*, p.85) that s82 does not provide for contributory negligence and apportionment of damages.

The High Court has preferred a technical and strict interpretation of the Act, which means that a claim for damages under the Act is an 'all or nothing' claim, depending upon whether causation can be established.

The law regarding contributory negligence in the context of misleading and deceptive conduct is not favourable for insurers and professional advisors. Some might agree with Justice Kirby, who said, with respect to the majority's decision in this case:

The outcome will now burden the party (the respondent) with the total loss or damage suffered by another (the appellant) although the evidence shows (and the primary judge accepted) that part only of such loss or damage was caused by the conduct of the other.

Equitable contribution arising out of different causes of action

Case Name:

Burke v LFOT Pty Ltd

Citation:

(2002) 187 ALR 612 (HC), per Gaudron ACJ, McHugh, Hayne and Callinan JJ (Kirby J dissenting)

Date of Judgment:

18 April 2002

Issues:

- Equitable contribution arising out of different causes of action
- Misleading and deceptive conduct & breach of duty
- Coordinate liability

The case considers the question of equitable contribution between wrongdoers who are liable to the innocent party for the same damage but under different causes of action.

The facts

Mr Burke (**Burke**) was a director of, and the solicitor for, Hanave Pty Ltd (**Hanave**). Hanave purchased retail premises (**premises**) from LFOT Pty Ltd (**LFOT**). Burke acted as Hanave's solicitor on the purchase.

Prior to settlement, LFOT engaged in misleading and deceptive conduct, principally by representing that a particular tenant of the premises was a high-quality tenant when it was not.

Burke negligently, and in breach of his retainer, failed to advise Hanave to make appropriate inquiries about the quality of that tenant. Had the inquiries been made, the purchase would have proceeded on different terms, or not at all.

Hanave brought proceedings in the Federal Court against LFOT claiming damages for misleading and deceptive conduct. LFOT cross-claimed against Burke, alleging that, if it was liable to pay damages to Hanave, it was entitled to equitable contribution from Burke by reason of his negligence.

The decision

At first instance, Hanave was awarded judgment against LFOT in the sum of \$750,000, being the difference between the purchase price and the true value of the premises, and Burke was ordered to pay contribution to LFOT in the sum of \$375,000.

Burke appealed against the order for contribution. His appeal to the Full Federal Court was dismissed, but his appeal to the High Court was allowed, by a majority of four to one (Justice Kirby dissenting).

Justice Callinan, applying the traditional test as to whether contribution should be ordered, held that LFOT was not entitled to contribution as the respective obligations of Burke and LFOT were not of the same nature or extent.

Justices Gaudron and Hayne gave greater emphasis to the fact that equitable contribution is founded on concepts of fairness and justice. It is these concepts that require that, if one of several persons has paid more than their proper share towards discharging a 'common obligation', they are entitled to be recompensed by those who have not. Applying these principles, they held that LFOT was not entitled to contribution because:

- it would result in LFOT profiting from its misleading conduct (any reduction in its own liability would result in it retaining an amount in excess of the true value of the premises); or, although this next reason was given less emphasis,
- Mr Burke was himself misled by LFOT.

Justice McHugh emphasised the need for ‘coordinate liabilities’ or ‘a common obligation’, and this requirement was also referred to by Justices Gaudron and Hayne. It is unclear what is meant by this. In particular, it is unclear whether a party liable at common law could ever be regarded as having a coordinate liability to a party liable for the same damage under the *Trade Practices Act*. It is unfortunate that, in spite of this decision, this issue remains uncertain. If such liability could never be coordinate, then contribution claims between such parties would be unavailable and it would be easier for a plaintiff to settle with only one defendant. In the meantime, the effect of the decision is that it is prudent to proceed on the basis that each case must turn on its own facts.

What law should be applied to an action in respect of torts committed outside Australia?

Case Name:

*Regie National des Usines
Renault SA v Zhang*

Citation:

[2002] HCA 10 per Gleeson CJ,
Gaudron, McHugh, Gummow,
Kirby (dissenting), Hayne and
Callinan (dissenting) JJ.

Date of Judgment:

14 March 2002

Issues:

- The law to be applied to foreign torts
- The meaning of 'inappropriate forum'

The case considers what law (the law of the tort or the law of the forum) should be applied by courts in Australia in determining substantive issues about 'foreign torts', ie torts committed outside Australia. It also examines the issues to be considered in determining whether a court is an 'inappropriate forum' for an action to be tried.

The facts

Mr Zhang (an Australian citizen residing in NSW) was injured while driving a rented motor vehicle in New Caledonia (a 'department' of France). He alleged that his injuries were caused by the defective design and manufacture of the Renault vehicle he was driving. He sued the Renault companies (two French companies) in tort in the Supreme Court of New South Wales on the basis that he continued to suffer damage after he returned to NSW.

As neither of the Renault companies had a presence in Australia, Mr Zhang invoked the 'long arm' jurisdiction of the Supreme Court of NSW, which provides that an originating process may be served outside of Australia in certain circumstances, including where the proceedings are for the recovery of damages in respect of 'damage suffered in the State caused by a tortious act or omission wherever occurring'. The Renault companies sought a stay of the proceedings on the basis that the Supreme Court of NSW was an 'inappropriate forum' in which to try Mr Zhang's actions against them.

At first instance, Justice Smart (Supreme Court of NSW) granted the stay. The Court of Appeal overturned that decision. The Renault companies appealed the orders made by the Court of Appeal to the High Court.

The decision

Although the question of whether the Supreme Court of NSW is an 'inappropriate forum' to try Mr Zhang's claim is a question of jurisdiction and not of choice of law, the majority considered that it was necessary to consider the law that would be applied to the substantive issues in proceedings if a court did hear a matter in determining whether that court was an 'inappropriate forum'.

Traditionally, the law to be applied by Australian courts in determining substantive issues relating to foreign torts was the law of the forum. Prior to the decision of the High Court in *Pfeiffer v Rogerson* (2000) 201 CLR 503 in June 2001, this was also the position on intranational torts.

The High Court reversed the traditional position on intranational torts in *Pfeiffer* when it held that the law to be applied by Australian courts in determining the substantive issues about torts committed in Australia, but which have an interstate element, is the law of the place of the act or omission giving rise to the plaintiff's cause of action. The court reserved the question of whether this rule should be extended to apply to foreign torts.

In this case, the court held that the rule in *Pfeiffer* should be extended to foreign torts. As a result, the law to be applied by Australian courts in determining substantive issues about foreign torts is now also the law of the place of the act or omission giving rise to the cause of action.

Having determined this issue, the court then considered whether the Supreme Court was an 'inappropriate forum' to try Mr Zhang's cause of action. The majority (Justice Kirby dissenting) held that the meaning of 'inappropriate forum' can be determined by reference to the authoritative Australian decisions on the meaning of the common law concept of 'clearly inappropriate forum'. On this basis, a court will only be an 'inappropriate forum' for trying a matter if the continuation of the proceedings in that court would be:

oppressive, in the sense of 'seriously and unfairly burdensome, prejudicial or damaging', or, vexatious, in the sense of 'productive or serious and unjustified trouble and harassment'.

The majority (Justices Kirby and Callinan dissenting) held that, on the basis of this test, the proceedings were not oppressive or vexatious and, therefore, that the Supreme Court of NSW was not an inappropriate forum to hear the matter. The majority also added that an Australian court cannot be a clearly inappropriate forum merely by virtue of the fact that a foreign law is to be applied to the substantive issues.

The majority also confirmed the abolition of the 'double actionability' requirement for founding a cause of action on a tort committed outside Australia.

This case has confirmed the law on the following issues:

- (a) the law to be applied by courts in Australia in determining substantive issues about foreign torts is the law of the place where the tort was committed;
- (b) a court will only be an 'inappropriate forum' for trying a matter if the continuation of the proceedings in that court would be oppressive or vexatious;
- (c) it will no longer be necessary for plaintiffs suing on a foreign tort to demonstrate that the tort would found a cause of action under the laws of Australia before relief will be granted. Australian courts can grant relief in circumstances allowed under foreign law.

It follows from the above that the likelihood of tort claims being brought in Australia based on a foreign law will increase.

Duties and responsibilities of the expert witness

Case Name:

Makita (Australia) Pty Ltd v Sprowles

Citation:

(2001) 52 NSWLR 705
per Priestley JA, Powell JA & Heydon JA

Date of Judgment:

14 September 2001

Issues:

- Admissibility of opinion evidence
- Duties and responsibilities of expert witnesses in giving opinion evidence in civil cases

The case considers the basis on which expert evidence is admissible both at common law and under the *Evidence Act 1995 NSW*, and the duties and responsibilities of expert witnesses in civil cases.

The facts

In June 1986, Mrs Sprowles fell at her place of employment on a flight of stairs leading from a car park on the roof of the building to the offices below, where she worked. Mrs Sprowles sued her employer, Makita (Australia) Pty Ltd (*Makita*) for negligence, and relied at trial on the evidence of an expert witness, Professor Morton. Professor Morton, a physicist who specialised in the investigation of slipping cases, gave evidence that, in his opinion, the tread of the stairs was slippery, and that this had caused Mrs Sprowles' fall. Against this evidence was the evidence of other Makita employees, who said that the stairs were frequently used, that no other person was reported to have slipped on the stairs, and that Mrs Sprowles had used the stairs probably more than 500 times prior to her fall without slipping.

The trial judge accepted the evidence of Professor Morton that the slipperiness of the stairs was the reason for the fall, found Makita liable, and awarded damages to Mrs Sprowles.

Makita appealed to the New South Wales Court of Appeal on the question of liability and quantum of damages awarded.

The decision

In upholding Makita's appeal, the NSW Court of Appeal unanimously held that the trial judge had erred in accepting the opinion of Professor Morton that the stairs were slippery, because that opinion contradicted uncontradictable facts (ie the history of incident-free use) that showed that the stairs were not slippery in the ordinary meaning of the word. The stairs did not have the characteristic that persons walking on them with ordinary care would, from time to time, slip.

Justice Heydon provided an extensive review of the authorities relating to the duties and responsibilities of the expert witness. The general principles to be derived from Justice Heydon's review are essentially that for expert opinion evidence to be admissible:

1. it must be agreed or demonstrated that there is a field of 'specialised knowledge';
2. the witness's expertise in that field must be demonstrated;

3. the opinion proffered must be wholly or substantially based on the witness's expert knowledge;
4. the facts 'observed' by the expert on which the opinion is based must be identified and admissibly proved; and
5. any assumptions must be identified and proved; and
6. the relevance of the expert's specialised knowledge to the facts assumed or observed must also be demonstrated.

The court (implicitly) found that the evidence of Professor Morton had not complied with these principles, and, on the basis of apparent internal deficiencies, should be afforded little weight. It was held that if the stairs were not slippery (as the lay evidence indicated) then Makita was not in breach of its duty of care as occupier and employer and the appeal should be allowed.

Mrs Spowles made an application for special leave to the High Court, which was refused on 31 May 2002.

This case reinforces the view that the opinion of an expert witness (even when uncontradicted) should not be relied upon by a court without question. The court has an obligation to independently assess the opinions of expert witnesses and to attribute weight to those opinions against the background of the other relevant factual material before the court.

Tort law reforms

Overview

There have been a number of initiatives at federal, state and territory levels to deal with tort law reform and associated issues.

In May 2002, the Commonwealth, in consultation with the States and Territories, agreed to jointly appoint an expert panel of eminent persons chaired by Justice Ipp (the **panel**) to examine the law of negligence, including its interaction with the *Trade Practices Act 1974*. The Panel provided its final report on 2 October 2002 (the **Ipp recommendations**).

In November 2002, the Commonwealth, States and Territories released a joint communique following the Ministerial meeting on public liability insurance. The communique sets out the national agreement on implementation of the Ipp recommendations.

In addition to the Ipp recommendations, all States and Territories have introduced a range of other legislative initiatives. The Commonwealth has also introduced some specific legislation to deal with recreational service providers and volunteers.

Ipp recommendations

Background

The premise for the Review of the Law of Negligence (the **review**), according to its terms of reference, was that awards of damages for personal injury have become unaffordable and unsustainable as the principal source of compensation for those injured through the fault of another.

The panel was instructed to examine methods for the reform of the common law that would have the effect of limiting liability and quantum of damages arising from personal injury and death.

The review reported on a range of issues including:

- professional negligence;
- reform of the *Trade Practices Act*;
- reforms to assist not-for-profit organisations;
- limitation periods;
- limiting the liability of public authorities;
- proposals to restrict the circumstances in which a person must guard against the negligence of others;
- self-assumption of risk to override common law principles;
- the replacement of joint and several liability with proportionate liability; and

- development of options to limit quantum of awards for damages.

National agreement on implementation of the Ipp recommendations

Instead of introducing a national statute to deal with the public liability crisis, the states and territories have agreed to introduce nationally consistent law. The national agreement on implementation provides that the following Ipp recommendations will be adopted in each State and Territory, and consequential amendments to the *Trade Practices Act* will be made to ensure it is unable to be used as a means of circumventing the proposed limitations on common law liability.

(a) Professional negligence

The panel recommended that a new standard of care should apply in relation to treatment by medical practitioners. The proposed test is a variation on the Bolam principle and requires the court to be satisfied that the conduct in question was in accordance with an opinion widely held by a significant number of respected practitioners in the relevant field. The recommendations also impose both proactive and reactive duties on medical practitioners to inform patients. The standard of care for other professionals was also restated by the panel.

(b) Recreational service providers

The Ipp recommendations suggest that the provider of a recreational service should not be liable for personal injury or death suffered by a voluntary participant in a recreational activity as a result of the materialisation of an 'obvious risk'. Further, a person does not breach a duty to inform by failing to give notice or warn of an 'obvious risk'.

(c) Foreseeability and causation

The Ipp recommendations propose that the principles of foreseeability and causation should be embodied in statute and outline various principles aimed at 'fine-tuning' the law of negligence in a way that is aimed at limiting the circumstances in which a duty of care will arise. Under these principles, some of the cases reported in this Annual Review may be decided differently (eg *Burns v Hoyts Pty Ltd* and, possibly, *New South Wales Land & Housing Corp v Watkins* and *Canterbury Municipal Council v Taylor*). The Ipp recommendations also set out various principles to be applied in determining causation in a way that enables policy considerations to play a part. It should be noted that the panel's terms of reference were limited to personal injury and death but some states, eg NSW, have provided that these recommendations should equally apply to claims arising from property damage and pure economic loss.

(d) Contributory negligence and assumption of risk

The Ipp recommendations provide that the test of whether a person has been contributory negligent is whether a reasonable person in the plaintiff's position would have taken precautions against the risk of harm and, for the purposes of

determining contributory negligence, the standard should be the same that is applied in determining negligence. The panel observed that, in practice, a lower standard has been applied. It is recommended that where a risk is obvious, a person is presumed to be aware of the risk, and it is not necessary for the person to be aware of its precise nature, extent or manner of occurrence.

(e) Mental harm

The Ipp recommendations include a number of principles relating to mental harm. These recommendations include that there can be no liability for pure mental harm unless the mental harm consists of a recognised psychiatric illness and the defendant ought to have foreseen that a person of normal fortitude might, in the circumstances, suffer a recognised psychiatric illness if reasonable care was not taken. The panel's report contains a detailed discussion of the effect of the High Court decisions in *Tame* and *Annetts*, reported in this Annual Review. The recommendations are aimed at imposing restrictions on the scope of any duty of care to prevent pure mental harm.

(f) Public authorities

The two key components of the Ipp recommendations relating to public authorities are the policy defence, which prevents a policy decision being used to support a finding of negligence, and the compatibility provision, which only allows a public functionary to be found liable for damages caused by the negligent exercise or non-exercise of a statutory public function if the provisions of the statute are compatible with the existence of such liability.

(g) Non-delegable duties

The panel recommended that liability for breach of a non-delegable duty should be treated as equivalent to vicarious liability.

(h) Proportionate liability

Although its terms of reference required the panel to develop proposals to replace joint and several liability with proportionate liability, the panel rejected such an approach in cases of personal injury and death, while expressly not purporting to comment in relation to cases of property damage or economic loss. The fundamental reason given was the undesirable consequence that the plaintiff would bear the risk that one of a number of multiple wrongdoers was impecunious, and the pecunious wrongdoers would be better off merely because someone else also caused the person harm. Accordingly, the panel recommended retaining the present system of joint and several liability.

The report containing further information and discussion on these recommendations is available on the Treasury website at www.treasury.gov.au.

Other State and Territory initiatives

There are a number of other initiatives that have been introduced by the various States and Territories. We note that these reforms are not necessarily uniform between the States and Territories. The reforms include:

- caps and thresholds on awards of damages for non-economic loss;

- caps and thresholds on awards of damages for gratuitous care;
- caps on legal costs recoverable; and, in New South Wales, restrictions placed on lawyers that are intended to restrict the bringing of unmeritorious claims;
- application of new discount rate;
- abolition of punitive, exemplary and aggravated damages;
- provision for structured settlements by consent;
- introduction of specific contributory negligence rules relating to intoxication, drug use and crime; and
- protection for volunteers and good samaritans.

Although not exhaustive, the legislation that has been tabled or enacted in 2002 includes the following:

New South Wales:	<i>Civil Liability Act</i> <i>Civil Liability (Personal Responsibility) Act</i>
Queensland:	<i>Personal Injuries Proceedings Act</i> <i>Personal Injuries Proceedings Amendment Act</i>
Victoria:	<i>Wrongs and Other Acts (Public Liability Insurance Reform) Act</i>
South Australia:	<i>Wrongs (Liability and Damages for Personal Injury) Amendment Act</i> <i>Recreational Services (Limitation of Liability) Act</i> <i>Statutes Amendment (Structured Settlements) Act</i> <i>Volunteers Protection Act</i>
Western Australia:	<i>Civil Liability Act</i> <i>Volunteers (Protection from Liability) Act</i>
Tasmania:	<i>Civil Liability Act</i>
Australian Capital Territory:	<i>Civil Law (Wrongs) Act</i> Civil Law (Wrongs) Amendment Bill
Northern Territory:	Personal Injuries (Liabilities and Damages Bill) Personal Injuries (Liabilities and Damages) (Conseq. Amendments) Bill

There is unfortunately little consistency between the Acts. For example, legislation enacted in five jurisdictions restricts awards of general damages for personal injury; however, those jurisdictions each impose different caps. Further, certain jurisdictions have enacted reforms not followed in any other jurisdictions, such as the Queensland claims notification procedures, the ACT requirement for insurers to provide claims data and the New South Wales proposal to introduce proportionate liability for economic loss claims.

New South Wales and Queensland were the first jurisdictions to enact civil liability reform legislation, in each case prior to the publication of the panel's recommendations. As these jurisdictions have led the push for reform of civil liability laws, the main features of the New South Wales and Queensland legislation are worthy of particular note.

(i) New South Wales

The *Civil Liability Act 2002*, which was enacted on 18 June 2002 and commenced retrospectively from 20 March 2002, is important not only for the reform of personal injury damages awards contained in its substantive provisions, but also for its amendment of the *Legal Profession Act 1987*.

The new legislation imposes thresholds and caps on awards of general damages and gratuitous care in personal injury damages cases. It also caps awards for loss of earnings in such cases. The *Civil Liability Act* also amends the *Legal Profession Act* to restrict the recovery of legal costs in personal injury damages claims up to \$100,000. Another feature of the legislation, unique to New South Wales, is that it prohibits legal practitioners providing legal services on a claim (or defence) for damages (not limited to damages for personal injury) unless they reasonably believe, based on provable facts and a reasonably arguable view of the law, that the claim (or defence) has a reasonable prospect of success. Providing legal services on a claim or defence without reasonable prospects of success may be professional misconduct or unsatisfactory professional conduct and may result in an adverse personal costs order.

On 28 November 2002, the *Civil Liability Act* was amended by the *Civil Liability (Personal Responsibility) Act 2002*. The significant provisions of the amending Act are as follows:

- it legislates the general principles to apply in determining liability for negligence, namely, that a person will not be liable for harm unless the person knew or ought to have known of the risk, the risk was not insignificant and, in the circumstances, a reasonable person in that person's position would have taken the precautions (it also legislates the concepts of factual causation and scope of liability);
- a person does not owe an injured person a duty of care to warn of obvious risks and a person is not liable in negligence for harm suffered by another person as a result of the materialisation of an inherent risk (the terms 'obvious risk' and 'inherent risk' are defined);
- a person who provides recreational services to others is protected from liability in negligence both in respect of failure to warn of obvious risks and also the materialisation of risks for which a warning has been given; and
- a modified Bolam test will determine the negligence of professionals by reference to widely accepted professional peer opinion in Australia.

The amending Act also contains provisions limiting awards for nervous shock, limiting the recovery of damages by intoxicated persons, allowing apologies without prejudice, limiting the liability of public authorities, protecting good samaritans and volunteers, and introducing a three-year limitation period for personal injury actions commencing on the 'date of discovery'.

- Three provisions of the amending Act had not commenced as at December 2002, pending the passage of complementary Commonwealth legislation. If proclaimed, these provisions will have the following effect:
 - recreational service providers will be able to contract out of the implied warranties of due care and skill in the provision of their services;
 - courts will be entitled to award structured settlements in personal injury damages cases; and

- the concept of proportionate liability will operate in economic loss claims so that a defendant will only be liable for the proportion of the loss that it has caused.

(ii) Queensland

The *Personal Injuries Proceedings Act 2002*, which came into force on 20 June 2002, is based on the provisions of the *Motor Accident Insurance Act 1994*.

Before commencing proceedings, an injured person must provide a notice of claim to those against whom proceedings are intended to be brought within nine months of the incident or within one month of consulting a lawyer about seeking damages for the injury. The Act also sets out the procedure to be followed by claimants and respondents to notices of claim including the sharing of medical reports and compulsory conferences and offers of settlement prior to commencing proceedings.

The Queensland legislation also includes other provisions that have the following effect:

- claims for loss of earnings in personal injury damages cases are capped;
- claims for gratuitous case services must exceed a threshold number of hours per week and per year;
- apologies are not admissible in any court proceedings;
- the recovery of legal costs is limited for small claims;
- courts may order structured settlements and jury trials are prohibited;
- legal practitioners are prohibited from advertising personal injury services except for limited contact details; and
- good samaritans are protected from liability.

This Act was amended by the *Personal Injuries Proceedings Amendment Act 2002*, which was proclaimed on 29 August 2002. The following amendments were introduced:

- some limits are removed from awards of personal injury damages to persons injured as a result of unlawful intentional acts done with intent to cause personal injury or sexual assault;
- multiple respondents must cooperate so that they are in a position to participate in a compulsory conference;
- it purports to state which provisions of the *Personal Injuries Proceedings Act* are substantive and which are procedural to avoid any attempted limitation or exclusion of the principles set out in the decision of the High Court in *John Pfeiffer Limited v Rogerson* (2000) 203 CLR 503.

Commonwealth initiatives

The Commonwealth Government has introduced two pieces of legislation that relate to public liability.

1. Trade Practices Amendment (Liability for Recreational Services) Bill 2002

The proposed amendment to the *Trade Practices Act* allows a contractual exclusion by the providers of certain recreational services from the implied

warranty in s74 of the *Trade Practices Act* that services will be rendered with due care and skill and that any material supplied in connection with those services will be reasonably fit for the purpose for which they are supplied.

2. Commonwealth Volunteers Protection Bill 2002

This act is directed at protecting individuals who work for the Commonwealth or a Commonwealth agency on a voluntary basis from civil liability. A volunteer will not be liable for an act done in good faith. Any liability of the individual will be transferred to the Commonwealth or the appropriate Commonwealth agency.

Medical indemnity legislation

Medical Indemnity Act 2002

Medical Indemnity (Consequential Amendments) Act 2002

Medical Indemnity (Enhanced UMP Indemnity) Act 2002

Medical Indemnity (IBNR Indemnity) Contribution Act 2002

Recent large court awards in medical negligence actions served to drive the tort law reform debate – see, for example, the case report on *Simpson v Diamond in the AAR Annual Review of Insurance Law 2001*, p.106. On 23 October 2002, Prime Minister John Howard introduced a package of further reforms in response to issues of rising medical indemnity insurance premiums and the viability of the medical indemnity insurance market. These Commonwealth Acts received Royal Assent on 19 December 2002. Once published, the new framework, contained in the above Acts, will introduce the following key reforms.

(a) Premium subsidy scheme

From January 2003, the Commonwealth will subsidise premiums payable by some medical practitioners who provide Medicare-billable procedures. The premium will be calculated by reference to the premiums paid by medical practitioners in more claims-averse areas of practice. The areas of practice that have been targeted for subsidy are obstetrics, procedural general practitioners and neurosurgeons (the latter receiving the greatest subsidy).

Subsidies will apply net of GST and State and Territory stamp duties – the Federal Government has called on States and Territories to abolish stamp duties on medical indemnity insurance premiums.

The subsidy is not unconditional, however. In order to establish an entitlement to the subsidy, practitioners will be required to participate in quality of service and safety programs, which the Federal Government hopes will protect patients and minimise the risk of injury.

(b) High cost claims scheme

The 'high cost claims scheme' is intended to have the effect of reducing medical indemnity insurance premiums by reducing the potential cost of large claims to insurers.

Where a claim is notified to a medical indemnity insurer after 1 January 2003 and the quantum of the claim exceeds \$2 million, the Commonwealth will subsidise the insurer for one-half of the cost of that portion of the claim that exceeds \$2 million. Importantly, the scheme will not provide a subsidy

in excess of the relevant policy limit. In the case of AMIL, for example, the limit of indemnity provided to practitioners was \$5 million, so that if that limit continues to apply, the maximum subsidy for any one claim will be \$1.5 million.

The scheme, which excludes public hospital services, is intended to provide greater certainty for insurers and to ensure that adequate cover is available to seriously injured patients.

The rationale for the scheme, according to the Prime Minister, is that insurers are reluctant to underwrite large and uncertain risks, as evidenced by the departure of medical indemnity insurers from the Australian and global markets in the past 12 months.

(c) The IBNR scheme

The IBNR scheme is intended, according to the media release, to provide MDOs with a 'fresh start' by removing any encumbrance of unfunded incurred-but-not-reported (**IBNR**) liabilities. An actuarial assessment commissioned by the provisional liquidator found that UMP's IBNR liabilities were between \$368.6 million and \$500 million, as at 3 May 2002. UMP had never been required to record a reserve for its IBNR liabilities in its financial statements. Under the IBNR scheme, the Commonwealth will begin funding, in early 2003, the unfunded IBNR liabilities of MDOs. The Commonwealth will then recoup the cost of this funding by imposing a levy on members of MDOs that have benefited from the IBNR scheme.

A person who was a member of an MDO on 30 June 2000, where that MDO had an unfunded IBNR liability as at 30 June 2002, will pay the levy. Some exemptions will apply, for example, members who retired before the end of 2001 will not be levied.

The levy will be tax deductible and will be proportionate to the medical indemnity insurance premium paid by the member in the financial year ended 30 June 2001. The levy will be payable in the 2003-04 financial year.

The levy is capped so that no member will pay a higher IBNR levy than the amount that they are required to pay in the first year.

(d) Regulatory changes to MDOs and policyholder safeguards

MDOs, like UMP, do not carry on an 'insurance business' within the meaning of the *Insurance Act 1973* (Cth) and are not subject to APRA regulatory requirements, even though they may provide discretionary assistance to members for claims not covered by an insurance policy.

The Federal Government intends to bring MDOs within the APRA regulatory framework. APRA's regulations and prudential requirements will apply to MDOs for business written from 1 July 2003. Accordingly, pre-1 July 2003 liabilities will be exempt from the capital requirements, reducing the immediate capital demands on the industry. Further transitional arrangements will be put into place so that MDOs will have a period of three to five years within which to meet APRA's capital prudential requirements.

Also, the urgent issues group of the Australian Accounting Standards Board has resolved to require MDOs to account for IBNR liabilities in their financial statements.

The Federal Government will also introduce product standards applicable to medical indemnity insurance policies. MDOs will no longer be able to provide medical indemnity cover in the form of discretionary assistance (as UMP has done), but will be required to offer a contract of insurance. Minimum product standards will also be introduced and insurers will be required to offer affordable run-off or 'tail' cover. In the past, this has been a significant obstacle to a practitioner changing insurers and the new regime is intended to remove that obstacle and ensure that practitioners who do change insurers will not be left with gaps in cover.

(e) Risk management

Combined with its regulatory reform measures, the Federal Government intends to introduce measures to improve clinical risk management. The Prime Minister has expressed a desire to see improved incident handling and, to that end, doctors who receive a premium subsidy from the Commonwealth will be asked to participate in safety and quality of service activities.

A process of consultation with States and Territories through the Australian Council for Quality and Safety in Health Care, and with MDOs and allied health professional groups is intended to identify suitable existing programs in which doctors can participate. The Prime Minister has called upon State and Territory governments to consider how the State Health Complaints Commissioner arrangements might assist with measures to improve incident handling.

(f) NSW premium caps

In New South Wales, the *Health Care Liability Act 2001* prohibits a person from practising as a medical practitioner unless they have approved professional indemnity insurance to cover their services. The characteristics that approved insurance policies are required to have are published by the Minister as Orders in the Government Gazette. The current Order, made on 14 December 2001, imposes caps in some respects on the premiums that may apply to approved medical indemnity policies. For example, a general practitioner who provides obstetric services may not be charged a premium that exceeds four times the premium for general practitioners who do not provide those services.

The Prime Minister has called on the New South Wales Government to remove the caps on premiums on medical indemnity policies in order to allow medical indemnity insurers to set premiums according to risk and so operate on a commercially sustainable basis.

(g) Premium monitoring

The Federal Government expects medical indemnity insurers to review their premium structures based on what it claims is the reduced risk exposure resulting from the range of initiatives that have been, or are proposed to be, introduced at Commonwealth and State levels. The Prime Minister has called on the ACCC to monitor premiums to determine whether they are justified from commercial and actuarial standpoints.

(g) Tort reform

Finally, the Prime Minister stated in his media release that it is vital that State and Territory governments continue their efforts in tort reform laws in their jurisdictions in order to provide greater certainty to insurers. New South Wales received special mention for its efforts but the Prime Minister called for national consistency.

Financial Services Reform

In the *AAR Annual Review of Insurance Law 2001*, we set out an overview of the then proposed Financial Services Reform (**FSR**) legislation⁷. The legislation was passed and commenced on 11 March 2002. We now consider its effect on the insurance industry in greater detail.

FSR applies to any person who provides a 'financial service'.

A person provides a financial service if they do a range of things, including:

- providing 'financial product advice'; or
- dealing in a 'financial product'

or such other things as are prescribed by FSR. Most life and general insurance products are specifically designated as 'financial products' under FSR. Reinsurance, health insurance and Commonwealth, State and Northern Territory insurance, however, are specifically excluded.

From 11 March 2002, a person carrying on a 'financial services business' in Australia must hold an Australian financial services licence, although entities that were lawfully carrying on business prior to that date will generally have the benefit of a two-year transition period to move to the new regime. There are, however, some FSR provisions for which no transition period is available and these are briefly described below.

How does FSR affect insurance products?

Who needs to be licensed?

A business that provides a 'financial service' must be licensed. This includes businesses that:

- **provide financial product advice.** This category includes insurers or intermediaries who make recommendations or statements of opinion that are intended to influence a prospective insured's decision in relation to a particular insurance product. It also includes recommendations or statements that could reasonably be regarded as having such an influence.
- **deal in a financial product.** This category includes insurers and agents who issue insurance and also intermediaries who arrange for a person to acquire insurance.

Intermediaries, in particular, need to review their information and advertising material directed at prospective clients. Statements in brochures to the effect of:

⁷ See page 116

'We recommend that you take out [this particular] insurance' or

'[This particular] insurance is appropriate in your circumstances'

constitute financial product advice and may only be made by financial services licensees.

There are a number of exemptions that apply to the licence requirement. For example:

- an insurer licensed by APRA will not need an Australian financial services licence to provide a service that is regulated by APRA and that is provided only to wholesale clients;
- insurance agents who provide insurance services only to their related bodies corporate are also excluded from the licence requirements; and
- loss adjusters successfully lobbied to obtain a regulation exempting the handling and settlement of insurance claims (including negotiating and developing claims strategies), as these are not taken to be financial services under FSR.

What licence must be obtained?

FSR requires all persons who carry on a financial services business to hold an Australian financial services licence in respect of each type of business. Therefore, if a person carries on different businesses, each requiring a licence, then the person must obtain a licence to cover all of those businesses.

So an intermediary that issues insurance products on behalf of an insurer and also provides advice to its clients about those products must apply for, and obtain, an Australian financial services licence to cover both activities.

What are the requirements of the licence?

Financial services licences are issued by ASIC and may be issued subject to conditions imposed by ASIC on the licensee. The licensee must comply with any conditions attached to the licence, in addition to statutory obligations, the principal requirements being:

- (a) The licensee must ensure its financial services are provided efficiently, honestly and fairly.
- (b) The licensee must ensure its **representatives** also comply with the legislation and are adequately trained to provide the services.
- (c) ASIC has released Policy Statement 46 in relation to the training of a financial product adviser's representatives.
- (d) The licensee must have **risk management** and **dispute resolution** systems in place. Licensees not regulated by APRA need to implement adequate risk management systems to comply with FSR, although ASIC has not released any policy statement in relation to this requirement.

Licensees also need to have an internal dispute resolution system that meets standards prescribed by ASIC and, for retail clients, need to implement a system for compensating those clients for breaches of the *Corporations Act*

- requirements by the licensee. ASIC has released Policy Statement 165 in relation to internal and external dispute resolution systems.
- (d) The licensee must deal with **clients' money** as required by the Corporations Act. A licensee must also establish a separate account for moneys to be held in trust for insurance premiums paid in advance.
- (e) The licensee must comply with **ASIC requirements**. A licensee must notify ASIC as soon as practicable of breaches of its licence and also of the appointment of representatives.
- (f) The licensee must comply with the **product disclosure requirements**.

What are the product disclosure requirements?

The product disclosure requirements apply **in addition** to the disclosure requirements under the *Insurance Contracts Act 1984* (Cth).

For the insurance industry, the Product Disclosure Statement (**PDS**) represents a significant change from pre-FSR practice. The PDS must set out the cost and benefits of the insurance, any risks associated with it, its significant characteristics such as exclusions, and any cooling-off period. ASIC has released policy statements by way of guidance for compliance with the PDS requirements introduced by FSR.

The legislation requires the provision of a PDS when a licensee first offers or recommends insurance products to retail clients.

Retail vs wholesale clients

FSR provides that an insurance product is deemed to be acquired by a **wholesale client** if it is not acquired by a person as a **retail client**. Where the principal product being acquired is a general insurance product, in order to be deemed a retail client:

1. the acquirer of the product must be either an individual or a small business (fewer than 20 employees or 100 for manufacturing businesses); and
2. the insurance product must be within one of the following classes of insurance prescribed by the legislation and as defined in the regulations:
 - motor vehicle insurance;
 - home building insurance;
 - home contents insurance;
 - sickness and accident insurance;
 - consumer credit insurance;
 - travel insurance;
 - personal and domestic property insurance; or
 - a kind of general insurance product prescribed in the regulations.

Any dealing in, or provision of, a financial service that relates to a general insurance product that is not in any of the above categories does not constitute the provision of a product or service to a retail client. Note that the above categories relate only to general insurance. They do not include life insurance products.

Insurance agents and transition

Generally, representatives of financial services providers are subject to the same transition period as their principals.

However, s1436A of the *Corporations Act* contains special transitional provisions relating specifically to insurance agents. The transition period for an insurance agent ends at the earliest of the following:

- (a) when the agent submits an opt-in notice with ASIC stating that he or she no longer wishes to be covered by the *Insurance (Agents & Brokers) Act 1984* (Cth) (**IABA**);
- (b) when the agreement between the agent and insurer (s10 of the IABA) is no longer in force;
- (c) when the agent is granted an Australian financial services licence for its activities previously covered by its agreement with the principal; or
- (d) on 11 March 2004.

Consequently, where an insurer obtains a licence shortly after 11 March 2002, its authorised agents will continue to be regulated by the pre-FSR legislation, the IABA, until the earliest of the above events occurs. For that transition period, the insurer will continue to be bound by the terms of the IABA in respect of the agent's activities. For example, the insurer will remain liable for the conduct of its agents under s11 of the IABA and the payment of money to the agent by an insured will discharge the insured's liability to the insurer under s14.

Agents who are subject to more than one authorising agreement with insurers may lodge an opt-in notice with ASIC covering one or more of those agreements. If the agent elects to opt-in with respect to more than one of its agreements, the agent may specify different dates from which it no longer wishes to be covered by the IABA.

What disclosure/systems changes do insurers, agents and brokers need to have made from 11 March 2002?

In addition to complying with any licensing and product disclosure requirements that may arise because the transitional relief arrangements do not apply, the following matters need to be addressed because there is no transitional relief at all for these requirements that apply on and after 11 March 2002.

(a) Prohibition on hawking – s992A

From 11 March 2002, it is a breach of the *Corporations Act* to offer, for issue or sale, insurance in the course of, or because of, an unsolicited meeting. It is also prohibited to do so in the course of, or because of, unsolicited personal contact (such as by telephone), unless certain procedural and disclosure requirements are met.

Although originally intended to apply to both retail and wholesale clients, the subsequent passing of the *Financial Services Reform Consequential Provisions Act 2002* limits the prohibition to retail clients and to face-to-face meetings and telephone calls. Nevertheless, it is important to note that the prohibition applies to both **new** customers and any pre-FSR customers who continue to be customers after 11 March.

The prohibition in s992A has the potential to have a significant impact on the way in which insurers, agents and brokers promote, distribute and arrange insurance for their customers and clients. In particular, those involved in the direct marketing and cross-selling of insurance products need to carefully review their distribution methods for compliance with the requirements that apply from 11 March. The prohibition also applies to third parties involved in the direct marketing of insurance products, such as telemarketing organisations, since the prohibition applies to the person who offers, for issue or sale, not merely issues, the product.

(b) Confirming transactions – s1017F

From 11 March 2002, confirmation of transactions must be provided to insureds who are **retail clients** when the insurance is acquired, disposed of, or when any other transaction occurs (other than the acceptance of a claim). Insurers and agents must either provide a standing facility to confirm these transactions or must provide a confirmation note in writing or electronically that contains the information prescribed by the legislation (such as the amount of premium paid and cooling-off rights).

(c) Cooling-off periods – s1019B

From 11 March 2002, **retail clients** have the benefit of a 14-day cooling-off period within which they may cancel their insurance in exchange for a refund of the premium. The insurer may pro-rate the cancellation only where the insurance is issued for a defined period. However, the refund may be reduced for reasonable administrative costs and other amounts permitted to be deducted by law (such as non-refundable tax liabilities).

The cooling-off period does not begin until the licensee satisfies its obligation to provide confirmation of the transaction (as to which, see above), or else the end of the fifth day after the transaction (whichever is earlier). Of course, if the client makes a claim on the policy, there is no right to a refund of the premium.

(d) Trust provisions – s1017E

From 11 March 2002, an insurer or agent must establish a separate trust account for premium moneys received but for which the insurance has not yet been issued. This applies to products issued to both **retail and wholesale clients**. The money can only be withdrawn to refund to the client or when the insurance is issued. The client may agree that the money it pays is not held in trust on its behalf, but this consent must be provided in writing.

FSR licensing issues – ASIC guidance papers

On 25 November 2002, the Australian Securities and Investments Commission (**ASIC**) released industry-specific guidance papers designed to assist industry participants to complete their applications for an Australian Financial Services (**AFS**) licence. Guidance papers were released for:

- life & general insurance brokers; and
- insurance multi-agents.

The guidance papers cover essential terms under the new FSR regime, provide information about issues facing applicants and set out a detailed table with suggested answers to the questions in Part A of the application. The suggested answers are not designed to cover every specific situation; rather, they are designed to assist industry participants to identify any issues they may need to resolve prior to making an application.

Life & general insurance brokers' guide

This guide is aimed at those insurance brokers who are currently registered as insurance brokers under the *Insurance (Agents and Brokers) Act 1984* (Cth) (ie insurance brokers who hold pre-FSR registration), and applicants who do not hold a current licence or registration.

This guide defines an insurance broker as a person who generally acts on behalf of insureds by providing advice about insurance products, arranging insurance policies and dealing with claims.

This guide recognises that the way an insurance broker conducts its business will determine the range of financial services and products for which the broker will need to be licensed. This requires an insurance broker to carefully analyse its business activities and to separately identify each type of financial service and financial product that forms part of its financial services.

It is essential that an insurance broker who operates under specific business arrangements obtains express authorisation under its new FSR licence to be able to continue providing the same types of services (eg a life insurance broker selling general insurance products via an agency agreement; a general insurance broker selling life insurance products via an agency agreement; or a life insurance broker providing financial services on securities products under a proper authority of a pre-FSR licensee).

This guide also provides general answers to questions in Part A of the application, which will assist applicants to identify issues that may need to be addressed prior to lodging their application, including the identification of the appropriate assessment process and the selection of all financial services and product authorisations essential for the insurance broker to continue providing all its services.

Insurance multi-agents' guide

This guide is designed to provide simple step-by-step instructions to obtaining the type of authorisations required to operate as an insurance multi-agent under an AFS licence.

ASIC issued this guide because it was concerned that many applicants do not understand what a 'qualified AFS licence' is and, as a result, they may not be selecting all the financial services and product authorisations required to operate uninterrupted under the new regime.

This guide defines a 'qualified AFS licence' as a special AFS licence for insurance multi-agents (insurance agents that represent more than one insurer) that wish

to hold an AFS licence, but cannot meet the competency requirements under s912A(e) and (f) of the *Corporations Act 2001* (Cth) in respect of their competency and training and competency of representatives.

Under a qualified AFS licence, a multi-insurance agent can be authorised only to provide financial product advice and deal with:

- general insurance products;
- life risk insurance products; and
- investment life insurance products.

If an insurance multi-agent wishes to provide any additional financial services, or provide financial services in relation to additional financial products, it must apply for a standard AFS licence, which would require compliance with all competency requirements. To be eligible to apply for a qualified ASF licence, the applicant must have been an insurance multi-agent immediately prior to 11 March 2002.

Why apply for a qualified AFS licence?

This guide recognises that an insurance multi-agent may not have been required to hold any formal qualifications in the past, and may have had insurance industry experience that facilitated the conduct of its business. However, the guide notes that if a multi-agent's agency agreements with insurers cease, the multi-agent would need to become a representative of an AFS licensee or obtain an AFS licence.

If a multi-agent wants to act as a principal or is not able to become a representative of a licensee, a qualified AFS licence will allow them to obtain the authorisation to advise and deal in relation to insurance products, despite not having the competencies that would otherwise be required under s912A(e) and (f). Of course, a multi-agent who can meet the competency requirements should apply for a standard AFS licence.

It is important to note that a qualified AFS licence will cease at the end of the two-year transitional period – ie 11 March 2004 – or if it is cancelled, or if a standard licence is obtained. If a qualified licensee intends to carry on business as a principal after the conclusion of the two-year transitional period, it must successfully apply for a new standard AFS licence by the end of the transitional period and, consequently, must comply with all the competency requirements.

This guide also provides general answers an insurance multi-agent would give to questions in Part A of the application.

Post-FSR issues – guidance from ASIC

Class orders and transitional provisions

Since commencement of FSR, ASIC has released class orders by which it provides relief from, or clarifies, the operation of the FSR provisions of the *Corporations Act*. Since 11 March 2002, there have been three class orders that expressly affect insurance industry stakeholders.

Class order (CO) 02/435, issued on 11 April 2002, clarifies the operation of the transitional provisions of FSR with respect to insurance brokers. It provides that insurance brokers who obtain the benefit of the transitional provisions do so not only for their activities, which are expressly subject to the *Insurance (Agents and Brokers) Act 1984*, but also to any of their activities in providing financial product advice in relation to, and dealing in, risk insurance products.

Issued on 28 June 2002, CO 02/734 also relates to those insurance brokers who have the benefit of a transition period under FSR. Unless a regulated principal decides to opt-in to the FSR regime early, the FSR provisions do not apply to the regulated activities of that person until the earlier of 11 March 2004, or the date on which the person ceases to have the status that made them a regulated principal. ASIC will provide relief to insurance brokers pursuant to CO 02/734 by extending by eight weeks the transition period for brokers who failed to renew their registration under the *Insurance (Agents and Brokers) Act*.

On 9 October 2002, ASIC issued CO 02/1071 to clarify the operation of the product disclosure transitional provisions by identifying what is a 'class of financial products'. The FSR regulations provide that a general insurance product is in the same class as another financial product only if the other financial product is a general insurance product, and both products either provide the same kind of cover or provide cover in relation to the same kind of asset. The class order modifies the operation of this regulation and provides an additional requirement that both products must be issued by the same person.

Licensing applications to date

At the IBNA Conference in Darwin on 12 September 2002, Ian Johnston, the FSR Executive Director of ASIC, made some informative statements that will be of interest to potential AFS licence applicants in the general insurance industry. According to Mr Johnston, the majority of applicants to date have been new applicants, requiring full assessment. He conceded that there has been delay in the processing of these applications, due both to errors by applicants and ASIC's own assessment procedures. ASIC claims to have improved its assessment process, and suggests that applicants should better understand transitioning issues before applying.

Mr Johnston offered the following tips for licence applicants:

- understand the difference between streamlined assessment and composite assessment (the latter is required for applicants who were licensed pre-FSR but who wish to provide additional services post-FSR);
- be clear about what authorisations you need (for example, know what 'general advice' means in the context of providing financial product advice);
- study Policy Statement 146 before applying;
- understand the difference between representatives and authorised representatives (the latter are external to the licensee organisation);
- applicants with retail clients will be expected to have a greater focus on consumer protection (which may be reflected in the proofs required by ASIC); and
- only insurance multi-agents can apply for a qualified licence.

Mr Johnston said, 'We cannot emphasise enough the benefits to you of planning and applying early.'

Hawking guide

On 24 October 2002, ASIC released an update of *The hawking prohibitions: an ASIC guide*, which provides industry with guidance on issues that should be considered when complying with the hawking prohibitions contained in the *Corporations Act 2001*, including s992A, which applies to the hawking of insurance products.

The guide was originally released in July 2002 to provide general guidance on the hawking prohibitions and, in particular, for issues such as when, in ASIC's view, a meeting or telephone call is 'unsolicited', the meaning of 'because of' and consequences of breaches of the prohibitions.

Most revisions to the guide in the October update are minor in nature. For example, the term 'offeror' is now defined by the guide to mean a person who offers financial products for issue or sale. Secondly, the examples contained in the original guide have been relegated to the form of notes and new disclaimers relating to those notes now appear in the guide. The only substantive changes to the guide are:

- ASIC considers a meeting or telephone call to be unsolicited unless it takes place in response to a positive, clear and informed request from a consumer. The former guide required a positive, specific and informed request. ASIC now recognises that some requests will be fairly general and others more specific. Further, the purpose of a meeting or telephone call may change during the meeting or call. Where an offeror is in doubt, the scope of the meeting or telephone call should be confirmed with the consumer.
- In determining the purpose of the meeting or telephone call, ASIC has moved away from a subjective test (what the customer expected to discuss) to an objective test (what was reasonably within the scope of the request).

Policy illustration rates

On 26 September 2002, ASIC announced the final update to Life Circular G12, which prescribes the investment return and the inflation rates for policy illustrations for the period 1 January 2003 to 10 March 2004.

Life Circular G12 supplements Life Circular G11, which sets out the disclosure requirements for promotional material in the life insurance industry. Unless otherwise expressly permitted, it is prohibited to publish policy illustrations using rates other than those prescribed by Life Circular G12.

Life Circulars G11 and G12 continue to apply during the FSR product disclosure transition period but will not apply after the end of the transition period.

This means that for the period 1 January 2003 to 10 March 2004, ASIC will continue to apply the rates in the attachment to policy illustrations for life insurance products that are subject to the transitional disclosure arrangements under s1438 of the *Corporations Act 2001*.

After the end of the transition period, the life insurance policy illustration rates must be based on rates and assumptions that have been developed by the life insurer on reasonable grounds, and in accordance with the new FSR provisions and ASIC Policy Statement 170 *Prospective Financial Information*.

External dispute resolution

Section 912A of the *Corporations Act 2001* sets out the general obligations of financial services licensees, and s912(1)(g) requires that if a financial services licensee intends to provide financial services to persons as **retail clients** then the licensee must have a dispute resolution system. Subsection 912A(2) not only requires the licensee to implement an internal dispute resolution procedure but also to maintain membership of an external dispute resolution scheme that has been approved by ASIC.

To date, ASIC has approved four consumer complaints resolution schemes under Policy Statement 139. The General Insurance Enquiries and Complaints Scheme (**IEC scheme**) is one of those four schemes. The IEC scheme is a national scheme developed by the Insurance Council of Australia (**ICA**) to handle enquiries and complaints and to resolve claims disputes that come within the terms of reference of the scheme.

At the time of publishing, there were 85 general insurers participating in the IEC scheme. The claims review panel, referee and adjudicator operate as the determination arm of IEC. Binding determinations can be made on participating insurers by an adjudicator for amounts not exceeding \$3,000 and by a panel or referee for amounts not exceeding \$120,000. A panel or referee may also make recommendations, for an amount greater than \$120,000 but not exceeding \$290,000.

Important FSR provisions for the insurance industry

We set out below a brief summary of some particular provisions that are specifically relevant to the insurance industry.

Corporations Act

Content and authorisation of Financial Services Guide (FSG)

s942C(2)(f), (g) and (j) These provisions are particularly relevant to authorised representatives who issue an FSG, as they delineate the main requirements for information that should be in an FSG (for example, information on remuneration (including commission), information on associations or relationships and information on binders).

s981A(1) This section is relevant to licensees who have money paid to them by or for clients in relation to financial services or products, as this money then falls within the purview of this subdivision and, accordingly, must be paid into a prescribed account, cannot be the subject of a set-off or charge and is taken to be held on trust.

s985B(1) This section applies to licensees who are not insurers, but who nevertheless arrange or effect contracts of insurance. Once the insured pays the licensee, they have discharged their liability to the insurer in respect of that money.

s1019A(1) This section sets out the classes of financial products (including insurance products) that are subject to cooling-off periods.

s1019B(5) Cooling-off period for return of financial product.

This section sets out when the right to return a financial product cannot be exercised. For example, the right to return cannot be exercised:

- after a claim has been made under a contract of insurance;
- after the period of time that the insurance is taken out to cover has expired.

Corporations Regulations

Reg 7.1.31 Passing on prepared documents

This regulation explains when a person is taken not to provide a financial service for the purposes of s766A(2)(b) of the *Corporations Act* (this is particularly relevant to those disseminating insurance brochures, as that activity is generally excluded from the definition of providing a financial service).

Reg 7.1.33 Handling insurance claims

This regulation explains when a person is taken not to provide a financial service for the purposes of s766A(2)(b) of the *Corporations Act* (this is particularly relevant to those handling or settling insurance claims, as those activities are generally excluded from the definition of providing a financial service).

Reg 7.6.01(1)(p) Need for Australian financial services license: general

The *Corporations Act* requires those carrying on a financial services business to have a licence. However, there are exemptions to the requirement. This regulation exempts financial services relating to insurance entered into, or proposed to be entered into, for the purposes of a law (including a State or Territory law) that relates to workers' compensation where the person is licensed to provide the service under the law of the State or Territory in which the service is provided.

Reg 7.6.04(1)(g)-(j) Conditions on Australian financial services licence

This regulation lists various conditions on Australian financial services licences. These are relevant to licensees, who must:

- provide a copy of an authorisation of any of their authorised representatives upon request;
- take reasonable steps to ensure that each of their authorised representatives supply a copy of their authorisation by the licensee upon request, and
- make available a copy of its license upon request.

Reg 7.7.02(3)(c) Situations in which FSG is not required

This regulation sets out that an FSG is not necessary for insurance products relating to rental vehicles, covering personal injury and death, property damage or both.

Reg 7.7.04(1)-(2) FSG given by licensee: remuneration, commission and benefits

This regulation is particularly relevant to licensees and intermediaries who refer clients to licensees, as it provides that the FSG must disclose all remuneration (including commission) and benefits received or to be received for referrals.

Regs 7.7.07(1) and 7.7.07(2)(a)-(b) FSG given by authorised representative

This regulation applies to authorised representatives of licensees, as it states that the FSG provided by the authorised representative must disclose all remuneration (including commission) and benefits received or to be received for referrals.

Reg 7.8.01(4) Obligation to pay money into an account

This regulation applies to licensees who are paid money by, or on behalf of, insureds (or intending insureds) in connection with a contract of insurance, or who are paid money by, or on behalf of, insurers for, or on, account of insureds (or intending insureds). All such money must be paid into an account that satisfies certain requirements, including being held with an Australian-approved deposit-taking institution.

Reg 7.8.02(6B) Accounts to be maintained for s981B of the Act

This regulation applies to licensees who are paid money by or on behalf of an insurer for or on account of an insured (or intending insured). Regardless of whether the money has been invested by the licensee, the insured (or intending insured) is entitled to the money as soon as the licensee receives it.

Reg 7.8.05 Money held in trust: risk accepted by insurer

If a licensee holds money on behalf of an intending insured and the relevant risk has been accepted by the insurer, this regulation provides that the money is held on trust by the licensee on behalf of the insurer.

Reg 7.8.08 Debts of financial services licensee in relation to premiums etc

This regulation contains provisions that stipulate how moneys received by licensees from intending insureds are to be dealt with once the relevant insurer has accepted the risk. For example, sub-regulations 7.1.08(1)-(4) apply where the premium is known. They require the licensee to pay the premium to the insurer within 90 days of cover commencing or to notify the insurer within seven days thereafter if the licensee has not received the full premium. The regulations also contemplate circumstances in which the premium might not be known, in which case the licensee is requested to forward the amount received or an estimate of the premium likely to be payable.

Reg 7.9.07 Modification of Act: Product Disclosure Statement in relation to insurance options

The disclosure provisions set out in Part 7.9 of the regulations are modified such that a product issuer does not have to provide a Product Disclosure Statement (*PDS*) if a product holder seeks to change their insurance cover under a contract associated with a superannuation product or retirement savings account.

Reg 7.9.14B Product information: '1019C information about certain vehicle insurance'

This regulation is particularly relevant to those that issue insurance for the death or injury of motor vehicle drivers in certain circumstances. With certain exceptions, as soon as possible after issuing the product, the issuer must give the holder of the financial product a statement that contains some of the information required to be provided in a PDS.

Reg 7.9.15 More detailed information in PDS: unauthorised foreign insurer

This regulation is particularly relevant to unauthorised foreign insurers (as defined in the regulation) who issue financial products. In this situation, the PDS must set out detailed information including a statement that the product issuer is an unauthorised foreign insurer and that the person should consider whether to obtain further information about the insurer and its local regulatory regime.

Reg 7.9.16 More detailed information in PDS: consumer credit insurance product

This regulation is particularly relevant to those who issue consumer credit insurance products (as defined in the regulation). In this situation, the issuer must provide more detailed information (which is specified) in the PDS. This includes, for example, a brief explanation of the purposes of consumer credit insurance.

Reg 7.9.39 Benefits determined by life insurance products

This regulation is particularly relevant to superannuation funds where the benefits paid to each member are wholly determined by reference to life insurance products. In some situations, the fund information provided to the holder of a superannuation product in this situation does not need to be as comprehensive as it otherwise would be.

Reg 7.9.64A Notification of exercise of right of return – risk insurance products

This regulation is particularly relevant to retail clients with risk insurance products. The client has the right to return the product by notifying the person who sold or issued it to them in a way permitted by the person who sold or issued it to them.

Reg 7.9.65 Return of financial product

This regulation applies to retail client insurance products that will expire within the usual cooling-off period (a possible example is travel insurance). For those products, the cooling-off right cannot be exercised after the start of the relevant event (such as a holiday) or the end of the usual 14 days, whichever is earlier.

Not-for-profit pool

In December 2002, the Australian Competition and Consumer Commission (**ACCC**) granted an interim authorisation under section 88(1) of the *Trade Practices Act 1974* (Cth) to Allianz Australia Insurance Limited, QBE Insurance (Australia) Limited and NRMA Insurance Limited, allowing them to participate in a joint venture agreement for the supply of public liability insurance to not-for-profit organisations that provide services to the broader community.

Some Australian not-for-profit organisations (**NFPOs**) have been experiencing difficulties in securing insurance, particularly public liability insurance. NFPOs are having to choose either not to participate in certain activities or enterprises; pass on the costs to the community; or to retain the risk themselves.

The joint venture pool arrangement was an initiative of the Insurance Council of Australia (**ICA**) that resulted from a perceived need for public liability insurance cover for certain NFPOs that do not have the financial capacity to purchase insurance at the rates being offered.

The key features of the pool are as follows:

- Cover will only be offered initially where the main exposure is in NSW.
- The NFPOs will need to have the following characteristics to be eligible:
 - provide services to the broader community;
 - have a NFPO tax status or turnover/funding of less than \$2 million per annum;
 - do not distribute profits to members; and
 - comprise mainly of volunteer members.
- The proposed arrangement will not provide coverage for larger organisations that have the financial capability to purchase public liability insurance.
- An internal dispute resolution process will be in place to consider any appeals from decisions as to whether or not a particular organisation qualifies as an NFPO.
- The premium to be charged to NFPOs will be determined by categorising the NFPO according to risk and then applying a multiplier to a base premium.

New business opportunities that meet the pool arrangement eligibility criteria will be referred to the pool. This will ensure the viability of the pool arrangement by the sharing of all risks evenly among the pool members. Pool members will remain free to supply public liability insurance individually to any person who does not meet the eligibility criteria.

Public liability insurance will now be available to certain NFPOs that had previously been unable to obtain cover or had to cancel events because of the cost of cover.

Terrorism Insurance Bill 2002

Background

The Bill, introduced into Parliament on 12 December 2002, is the Australian Government's response to the withdrawal of cover for terrorism risks by insurers following the events of 11 September 2001 in the US.

Framework

The Bill establishes a framework to implement a scheme by which cover for terrorism risks is automatically deemed to be included in certain insurance contracts (the *scheme*). The scheme is subject to a transition period, which starts from 30 June 2003.

The Government sees the benefits of the scheme framework as follows:

- it allows the establishment of a pool of \$300 million (funded from premiums collected from insureds) relatively quickly;
- it avoids problems of undiversified risks;
- it provides certainty for post-event compensation eligibility;
- it has low administrative costs as compared with alternative opt-in models;
- it does not constitute a tax (and therefore allows the government to use the insurance powers in the Constitution); and
- it does not force or encourage commercial insurers/reinsurers to withdraw from the market.

The Bill deems all *eligible insurance contracts* to include terrorism risk cover. Contracts of insurance are eligible insurance contracts to the extent that they provide insurance cover for loss or damage to tangible property located in Australia, either with or without business interruption or public liability cover (this definition may be refined through regulations in 2003).

As such, the Scheme obliges insurers issuing *eligible insurance contracts* to provide terrorism cover to their insureds. The scheme will be mandatory, and, as currently proposed, will extend to apply to insurance contracts issued by overseas insurers into Australia that fall within the definition of *eligible insurance contracts*. The starting point is contracts that provide insurance cover for loss or damage to tangible property located in Australia (the *underlying property*), either with or without insurance cover for business interruption losses arising from loss or damage to the underlying property, or insurance cover for public liability associated with the underlying property. State insurance (for example, compulsory third party motor vehicle liability covers and workers compensation covers) will not be included in the definition. Types of insurance contracts that do not fall within the starting point definition, but are nevertheless to be treated as eligible insurance contracts for the purposes of the Act, will be prescribed by regulations. Certain types of insurance

coverage will be excluded from being eligible insurance contracts through regulations and the Explanatory Memorandum to the Bill identifies that these will include:

- insurance for buildings or infrastructure owned by State or Commonwealth Governments (but not Government Business Enterprises);
- home and contents insurance (domestic policies);
- insurance for private residential property;
- marine insurance;
- aviation insurance;
- motor vehicle insurance;
- life insurance;
- health insurance;
- private mortgage insurance;
- medical indemnity insurance;
- professional indemnity insurance; and
- reinsurance.

Section 6 of the Bill provides a mechanism for a declaration to be made that a terrorist act within the meaning of the Bill has happened in Australia. There is a detailed definition of the term terrorist act in the Bill. Following consultation with the Attorney-General, the relevant Minister must, by notice in the Government Gazette, declare that a terrorist act has occurred for the purposes of the Bill, if he or she is satisfied that one or more related terrorist acts have happened in Australia.

For a terrorist act to be a declared a terrorist incident for the purposes of the Act, it must have happened in Australia after the start-up time (30 June 2003). A threat of terrorist action (as opposed to an actual act) is only to be taken to have happened in Australia if the threatened action would happen in Australia, and if the Minister is satisfied that the threat actually resulted in economic loss to a person. An act of war cannot constitute a terrorist act.

The making of a s6 declaration then triggers the insurers' obligations to indemnify insureds under terrorism cover that is deemed to be included in *eligible insurance contracts* under s7 of the Bill.

Reinsurance is to be made available to insurers of *eligible insurance contracts* by a new statutory authority set up under the Bill, the Australian Reinsurance Pool Corporation (the **ARPC**), which will also manage the scheme. Insurers are not obliged to reinsure with ARPC, but, if they do so, they will be required to retain part of the risk of liability arising from a declared terrorist incident (**DTI**). The Treasurer will set the retention level by issuing directions to the ARPC. It is anticipated that the retention will initially be set at \$1 million per insurer per annum, and \$10 million across the industry per event. The Treasurer can direct the ARPC to set particular premiums for reinsurance contracts. The reinsurance premiums will drive the premiums payable for the terrorism component of the primary cover. Premiums will depend on the risk of insured properties and facilities, and are expected to cost from around 2% of underlying base premium with surcharges of 10% and 12% applying to properties located in capital cities, CBDs and other urban areas respectively (to be designated by postcodes).

Premiums that insurance companies pay for ARPC reinsurance will be used to build up the first layer of funds (an expected pool of \$300 million) available to cover claims from DTIs and to meet the administrative costs of the ARPC. The pool will be supplemented by a Commonwealth Government guarantee of \$10 billion, giving aggregate cover of up to \$10.3 billion when the pool is fully funded. Charges for the deemed coverage will not be levied until the date of policy renewal. During the transition period, reinsurance will be provided by the ARPC free of charge to insurers.

The government's objective is to operate the scheme only while terrorism insurance cover is unavailable commercially on reasonable terms. To this end, various components of the scheme (including pricing and the classes of insurance for which insurers will be required to provide terrorism risk cover) are not enshrined in the Bill, but are to be addressed in delegated legislation. Assessments of the scheme will be undertaken every two or three years to assess the state of the market and the possible wind-up strategy of the scheme.

Anti-terrorism funding legislation

As a result of the terrorist attacks in the US on 11 September 2001, Australia has enacted legislation directed at preventing the financing of terrorism.

The legislation:

The *Charter of the United Nations (Anti-terrorism Measures) Regulations 2001*, which came into force on 15 October 2001:

- prohibits any person or entity who holds an asset (or any assets generated from that asset) owned or controlled by a proscribed person or entity, to use or deal with that asset, or allow that asset to be used or dealt with; and
- prohibits any person or entity to directly, or indirectly, make assets available to a proscribed person or entity.

The list of proscribed persons and entities currently includes more than 100 organisations suspected of being associated with, or involved in, terrorist activities.

The Regulations require all individuals and companies in Australia (as well as Australian citizens overseas) to freeze funds or other assets of proscribed persons or entities. Failure to do so is a criminal offence and may result in fines. In the Regulations, 'asset' generally means anything of value, including intangible assets.

Other legislation

The *Financial Transaction Reports Act 1998* (Cth) (the **FTR**) currently requires insurers and brokers to report in writing to the Australian Transaction Report and Analysis Centre (**AUSTRAC**) if the insurer or broker is a party to a transaction, and has reasonable grounds to suspect that information concerning the transaction, or attempted transaction, may be relevant to the investigation of a breach of Australian law. This is irrespective of whether the transaction in question is a recent transaction – the obligation under the FTR arises as soon as practicable after forming a suspicion. Failure to comply with the FTR Act is a criminal offence and may result in imprisonment and/or fines.

Relief from proceedings

Both the Regulations and the FTR protect insurers and brokers against penalties or other consequences because of their actions in complying with the Regulations or the FTR. Under the Regulations, insurers and brokers will not be liable to suit for anything done in good faith and without negligence, in purported compliance with the Regulations. Under the FTR, protection will be given, even if a report is provided to AUSTRAC in the mistaken belief that such a report was required under the FTR. In addition, there are provisions in the *Privacy Act 1988* (Cth) that allow an organisation to disclose personal information, if the organisation:

- reasonably believes that the disclosure is necessary to prevent or lessen a threat to an individual's life or safety or public health or safety;
- suspects unlawful activity and discloses personal information in reporting the matter to relevant persons or authorities; or
- believes that the disclosure is reasonably necessary for the prevention, detection or investigation of breaches of the criminal law.

Summary

Insurers and brokers should regularly:

- check the list of proscribed persons and entities on the Department of Foreign Affairs and Trade website (www.dfat.gov.au), and ensure that they are not dealing with any of the proscribed persons or entities (for example, by providing insurance cover or paying insurance claims to such persons or entities); and
- report to AUSTRAC any transactions in which they have taken part and that involve any of the proscribed persons or entities.