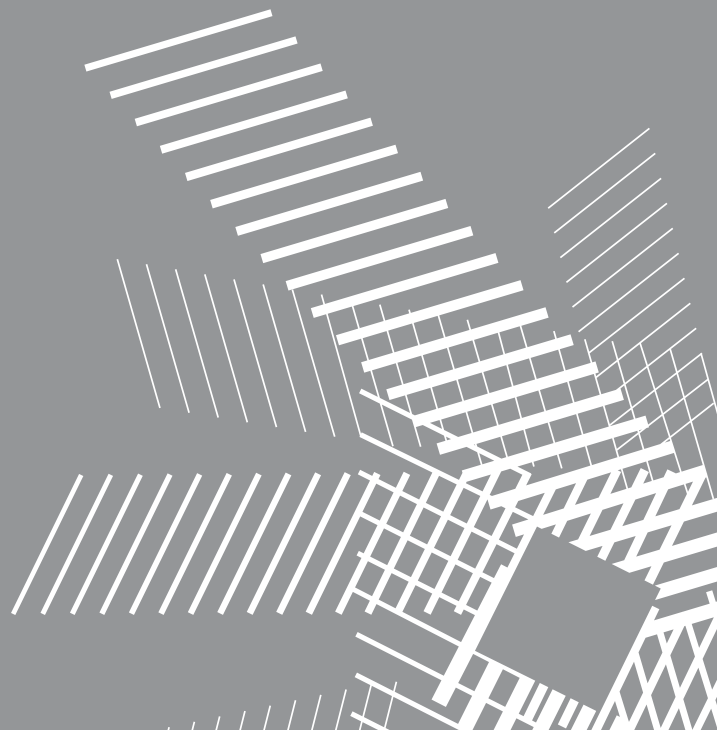


Annual Review of Insurance & Reinsurance Law **2008**



For further information about Insurance & Reinsurance Law, please contact:

SYDNEY

John Morgan, Editor

T +61 2 9230 4953

John.Morgan@aar.com.au

Oscar Shub, National Practice Leader

T +61 2 9230 4305

Oscar.Shub@aar.com.au

Andrea Martignoni

T +61 2 9230 4485

Andrea.Martignoni@aar.com.au

Michael Quinlan

T +61 2 9230 4411

Michael.Quinlan@aar.com.au

Dean Carrigan

T +61 2 9230 4869

Dean.Carrigan@aar.com.au

Matthew Skinner

T +61 2 9230 4038

Matthew.Skinner@aar.com.au

John Edmond

T +61 2 9230 4287

John.Edmond@aar.com.au

Michael Ball

T +61 2 9230 4973

Michael.Ball@aar.com.au

Malcolm Stephens

T +61 2 9230 4828

Malcolm.Stephens@aar.com.au

BRISBANE

John Baartz

T +61 7 3334 3254

John.Baartz@aar.com.au

MELBOURNE

Louise Jenkins

T +61 3 9613 8785

Louise.Jenkins@aar.com.au

Annette Hughes

T +61 3 9613 8430

Annette.Hughes@aar.com.au

PERTH

Jenny Thornton

T +61 8 9488 3805

Jenny.Thornton@aar.com.au

HONG KONG

Simon McConnell

T +852 2840 1202

Simon.McConnell@aar.com.au

HANOI

Bill Magennis

T +84 4 3936 0990

Bill.Magennis@aar.com.au

HO CHI MINH CITY

Nigel Russell

T +84 8 3822 1717

Nigel.Russell@aar.com.au

This publication is available online at <http://www.aar.com.au/pubs/ari/index.htm>

For more information about Allens Arthur Robinson's Insurance & Reinsurance practice, including publications, recent experience and current team details, please go to: www.aar.com.au/services/insur

We would very much like your feedback on this Review.

If you would like further information about our regular Forums on Insurance & Reinsurance Law, please contact Business Development Manager Jessie Plaia on +61 2 9230 4539.

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Also available online at:

<http://www.aar.com.au/pubs/ari/index.htm>

Allens Arthur Robinson 

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Written and published by Allens Arthur Robinson

Deutsche Bank Place, Corner of Hunter and Phillip Streets, Sydney NSW 2000

www.aar.com.au

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 and Reinsurance Law* enters its second decade. It does so in circumstances where the global financial crisis has overtaken us, but the cases and the regulatory changes reported in this edition reflect a much more benign litigation and insurance market. However, this is not to say that the cases are not important, indeed some of them have much greater importance in a period of financial stress.

In particular, there are a number of decisions relating to the notification of facts and circumstances that require careful consideration, having regard to the fact that insureds may be entering a market in 2009 where terms and prices harden, with the consequence that the locking in of a claim to current covers may well be advantageous. From an insurer's point of view, the difference between a relatively vague disclosure or notification of facts and circumstances and what constitutes an actual notification may well become of critical concern. These cases give some guidance on what are sometimes difficult issues.

Apart from cases dealing with this subject, there is a wide range of decisions reviewed this year.

On the regulatory front, we now have the DOFI reforms in place and we are entering the new year with finalisation of the APRA reforms for the prudential supervision of corporate groups. In October, there were some significant changes to the *Insurance Act 1973* (Cth) with the introduction of a policyholder compensation facility and a new regime for judicial management of insurers instead of the insolvency regimes under the *Corporations Act 2001* (Cth). There has also been a strengthening of the powers of APRA, particularly its information-gathering powers.

Although there may be no expectation for strengthening of regulatory arrangements directly relating to the insurance industry in the forthcoming year, there are many outstanding and prospective issues that are likely to have an impact on insurers. For example, there are several outstanding judgments in relation to the liabilities of directors, and the transfer of the uniform consumer credit laws to a federal regime and regulation through ASIC will obviously affect various forms of credit insurance as well as the risks and liabilities associated with those who are providing and intermediating credit products. The ambitions of ASIC to prescribe the form of professional indemnity insurance for holders of Australian financial services licences will be further tested when those licences are required to be held by various credit providers and their intermediaries.

A large number of people have contributed to the review and it is difficult to adequately acknowledge and thank them all but I would, in particular, like to acknowledge and thank Jenni Priestley, Caitlin Sinclair and Arlene Cullen for their assistance. Jenni and her team, together with our publications group, have done another fine job in producing this review.



John Morgan

Editor



John Morgan
Editor

Partner, Sydney
T +61 2 9230 4953
John.Morgan@aar.com.au

Contributors

Abigail Gill
Alicia Salvo
Allen Clayton-Greene
Amanda Taylor
Andrea Martignoni
Andrew Byrne
Andrew Maher
Angela Morris
Anna Brown
Brett Cook
Bryn Dodson
Caitlin Sinclair
Carl Xu
Catie Shavin
Claire Harris
Claire Machin
Damian Walsh

Dean Carrigan
Duncan Travis
Eibhlin McBride
Hannah Biggins
Harry Evans
Hugh Foley
Jackson Allen
James Sidwell
Jason Ng
Jenni Priestley
Joe Power
Joelle Vincent
John Morgan
John Rainbird
Jonathon Dooley
Justin Simpkins
Kieran Humphrey

Lisa Mortimer
Mark Farquhar
Mark Hare
Mark Lindfield
Matthew McCarthy
Megan Sandler
Monique Carroll
Peter Haig
Philip Hopley
Rebecca O'Brien
Rebecca Semple
Rima Hor
Sarah Bryden
Simone Collier
Simon McConnell
Susie Stone

Allens Arthur Robinson Insurance & Reinsurance

The global economic crisis is no longer something about which people speculate. It is a reality that has significant ramifications in all areas of economic life, but most significantly for the insurance industry.

In times of crisis, people who have suffered loss or damage become more inclined to enforce, through the courts, their legal rights against alleged wrongdoers. These claims inevitably affect the insurers who insure directors and officers of corporations for claims against them in that capacity, professional services companies for the provision of professional advice and services, and those organisations that become involved in disputes, the outcome of which may be insured. This critical situation, coupled with the growth of class actions and availability of litigation funding, must inevitably see a rise in insurance-related and insurance-funded litigation.

Allens Arthur Robinson (**Allens**) has been servicing clients in Australia for more than 180 years and the Asia Pacific region for the past three decades. Allens is one of the largest and most highly regarded law firms in the Asia Pacific region, with 189 partners and more than 600 other legal staff.

We provide a full range of commercial legal services to many of the region's leading corporations and government organisations, including more than 70 of Australia's, and more than 25 of the world's, top 100 companies (among them a large number of national and international insurance and broking companies and Lloyd's syndicates).

Our leading insurance and reinsurance practice offers clients a team of specialists who can quickly identify the critical issues and regulatory risks and offer practical and commercial solutions.

We are known internationally for our expertise in all aspects of insurance law, including corporate, regulatory and contentious matters. We have more than 20 years' experience representing London-based insurance syndicates in claims in Australia. We also have a well-established practice in Asia, with a dedicated insurance and reinsurance team based in Hong Kong.

It was very pleasing to be ranked as a leading insurance firm by Chambers Global and Asia Pacific Legal 500 in 2008 and for our Insurance and Reinsurance Group to be recognised as comprising a 'strong team of front and back-end people with immense technical expertise' (*Chambers Global 2008*). We have also previously received the ANZIIF award for 'Insurance and Reinsurance Law Firm of the Year'.

We offer the full range of insurance and reinsurance services, including advice on government policy, and regulatory and legislative matters and the conduct of large, high-value and complex litigation.



Oscar Shub
National Practice Leader

Partner, Sydney
T +61 2 9230 4305
Oscar.Shub@aar.com.au



Oscar Shub

National Practice Leader

Partner, Sydney
T +61 2 9230 4305
Oscar.Shub@aar.com.au



John Baartz

Partner, Brisbane
T +61 7 3334 3254
John.Baartz@aar.com.au



Michael Ball

Partner, Sydney
T +61 2 9230 4973
Michael.Ball@aar.com.au



Dean Carrigan

Partner, Sydney
T +61 2 9230 4869
Dean.Carrigan@aar.com.au



John Edmond

Partner, Sydney
T +61 2 9230 4287
John.Edmond@aar.com.au



Annette Hughes

Partner, Melbourne
T +61 3 9613 8430
Annette.Hughes@aar.com.au



Louise Jenkins

Partner, Melbourne
T +61 3 9613 8785
Louise.Jenkins@aar.com.au



Bill Magennis

Partner, Hanoi
T +84 4 3936 0990
Bill.Magennis@aar.com.au



Andrea Martignoni

Partner, Sydney
T +61 2 9230 4485
Andrea.Martignoni@aar.com.au



Simon McConnell

Partner, Hong Kong
T +852 2840 1202
Simon.McConnell@aar.com.au



John Morgan

Partner, Sydney
T +61 2 9230 4953
John.Morgan@aar.com.au



Michael Quinlan

Partner, Sydney
T +61 2 9230 4411
Michael.Quinlan@aar.com.au



Nigel Russell

Partner, Ho Chi Minh
T +84 8 3822 1717
Nigel.Russell@aar.com.au



Malcolm Stephens

Partner, Sydney
T +61 2 9230 4828
Malcolm.Stephens@aar.com.au



Matthew Skinner

Partner, Sydney
T +61 2 9230 4038
Matthew.Skinner@aar.com.au



Jenny Thornton

Partner, Perth
T +61 8 9488 3805
Jenny.Thornton@aar.com.au

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Rectification of Insurance Contracts

Case Name:

Metlife Insurance Ltd v Visy Board Pty Ltd & 25 Ors

Citation:

[2007] NSWSC 1481, Supreme Court of New South Wales per Brereton J

Date of Judgment:

13 November 2007

Issues:

- The required degree of certainty as to the form of the contractual element intended to be rectified
- The value of pre-contractual, as opposed to post-contractual, evidence

This case examines the circumstances in which a court may rectify a contract. The judgment discusses, in particular, the certainty as to the form of that which the intended contractual element was to take, the weight to be given to various pieces of evidence in relation to contractual negotiations both before and after the unrectified contract's formation, and the court's discretion to deny rectification if a party had relied on the unrectified contract to its detriment.

The plaintiff, Metlife Insurance Ltd (*Metlife*), was the insurer in a salary continuance insurance plan issued to the first and second defendants, Visy Board Pty Ltd and Visy Paper Pty Ltd (*Visy Board*). Under the policy, where employees of Visy Board became disabled, the insurer would pay specified amounts to the policy owner, which would hold them in trust for the employee and pay in instalments. Under the policy, the payments were to continue until the employee's death or expiry of the benefit period (stated to be '67 years').

Metlife sought rectification of the policy, to change the benefit period to '65 years or the onset of permanent and total disability' (in which case a lump sum would be paid out to the employee). While Visy agreed to the relief, 22 defendants who were in receipt of regular payments under the salary continuance insurance opposed it.

Justice Brereton found that, generally, rectification can be awarded where it is established that:

- there is a common intention as to certain terms between the parties in negotiations leading up to the time of the agreement;
- there is proof that the written contract does not embody the parties' final intention; and
- the omitted element is to be compatible with the proof in clear terms, so that the court does not have to make the contract on the parties' behalf.

Justice Brereton stated that the proof must establish the form that the contract should have taken, and be clearly and specifically stated.

His Honour found that the evidence as to negotiations leading up to the contract's formation made it clear that the parties shared a mutual intention to create an agreement that would include a benefit period expressed as 'until age 65, ceasing on total and permanent disablement'.

Discussions held after the formation of the contract had, however, indicated a contrary intention. Justice Brereton found that while this evidence was admissible, it should be treated with caution, as it did not provide insight into the parties' intention prior to and at the time of execution, only into their later intention.

Justice Brereton then considered the court's discretion to decline to make an order for rectification where the parties had relied to their detriment on the contract in its unrectified form. His Honour considered that, as there was no evidence of such reliance, the discretion would not be exercised and the case for rectification was made out.

This case outlines the requirements for contractual rectification and emphasises the need for pre-contractual evidence to be in a clear and specific form.

Requirement to provide summary of scheme to affected policyholders

Case Name:

Calliden Group Limited in the matter of Calliden Group Limited

Citation:

[2007] FCA 2019, Federal Court of Australia per Lindgren J

Date of Judgment:

19 December 2007

Issues:

- Whether the requirement under s17F of the *Insurance Act 1973* (Cth) to provide approved summary of scheme to every affected policyholder could be dispensed with
- Distinction between contracts of insurance and contracts of guarantee

The Federal Court considered whether a company could dispense with the legislative requirement to provide a summary of the proposed scheme to every affected policyholder so as to obtain court endorsement of a scheme, the effect of which would be the transfer of insurance business to a related entity.

Calliden Group Limited (the **Group**) and Calliden Limited (**Calliden**) applied to the Federal Court, seeking confirmation of a scheme, in accordance with section 17F of the *Insurance Act 1973* (Cth) (the **Act**). The scheme's purpose was to transfer the whole of the Group's insurance business to Calliden.

Section 17C(2)(c) of the Act provides that a party may not apply for confirmation of a scheme unless 'an approved summary of the scheme' has been given to every affected policyholder. However, s17C(5) provides that the court may dispense with this requirement if the court is satisfied that, because of the nature of the scheme or the circumstances attending its preparation, compliance is not necessary. The applicants sought to rely on the s17C(5) exemption.

In considering whether to dispense with this requirement, it was necessary for the court to consider a deed poll that the Group executed in 1997 in favour of persons entitled to insurance cover under contracts of insurance or reinsurance insured by Monde Re (a subsidiary of the Group). Approved summaries of the proposed scheme had not been provided to Monde Re policyholders.

The Federal Court ultimately held that the deed poll did not amount to a contract of insurance but, rather, was in the nature of the guarantee. In reaching this conclusion, Justice Lindgren noted that:

- the language of the deed poll and, indeed, its very title referred to 'guarantee';
- unlike a contract of insurance, the deed poll did not have any of the insureds as a party; and
- none of the persons benefited by the deed poll were required to pay any premium or other amount to the Group.

The Federal Court found that the deed poll had not been entered into as a part of the Group's insurance business. As a result, the applicants were not required to provide the approved scheme summary to the policyholders of Monde Re.

This case confirms that the courts will, in circumstances where it is appropriate to do so, exercise their discretion to alleviate applicants from potentially onerous notification requirements under the Act in respect of proposed schemes.

Dispensing with the requirement to provide affected policyholders with an approved transfer scheme summary

Case Name:

*In the matter of MDU
Australian Insurance Company
Pty Limited*

Citation:

[2008] FCA 342, Federal Court
of Australia per Emmett J

Date of Judgment:

14 February 2008

Issues:

- Under what circumstances will a scheme to transfer an insurance business 'affect' a policyholder?
- Orders allowing general insurers to dispense with the requirement under the *Insurance Act 1973* (Cth) to provide affected policyholders with an approved transfer scheme summary

The *Insurance Act 1973* (Cth) prohibits general insurers from transferring their insurance business unless it is via a court-approved scheme. Before an insurer applies for court approval, each affected policyholder must be provided with an APRA-approved scheme summary. In this case, MDU Australia Insurance Company Pty Limited and Avant Insurance Limited successfully sought orders to dispense with this requirement.

Courts, when asked to make this type of order, will consider the applicants' particular circumstances. General insurers may wish to note the matters relevant in persuading Justice Emmett to accede to the request made by MDU Australia Insurance Company Pty Limited (*MDU*) and Avant Insurance Limited (*Avant*) (together, the *applicants*):

- **Applicants' relationship and the general purpose of the scheme**
The applicants were both wholly owned subsidiaries of the same parent company and the scheme's purpose was to simplify the group's structure and operations.
- **Situation of transferee's business**
MDU was effectively in run-off with relatively few policies, all of which were issued around 10 years earlier. The last claims were also made around this time.
At the time of hearing, MDU had just 10 open files in respect of which a claim had been notified. Of these, only one claim had the potential to be significant and only one file (the judgment does not reveal which) had recorded any activity since the time of notification.
- **The necessity of providing policyholders affected by the scheme (the affected policyholders) with an approved scheme summary**
In relation to Avant's affected policyholders, his Honour looked to the predicted financial effect of the transfer, with reference to the impact on the business's prudential security ratio.
Financial analysis indicated that Avant policyholders would 'in effect be better off as a result of the amalgamation' because Avant's prudential security ratio (measured by reference to the ratio of the business's capital base to minimum capital requirement, and already well above APRA's minimum) would improve. His Honour found this to mean that any prejudicial effect of the transfer scheme was outweighed by the disadvantage to the applicants caused by the cost of compliance. On this basis, the applicants should not have to provide Avant-affected policyholders with an approved scheme summary.

His Honour considered that although there were approximately 14,000 potentially affected policyholders, the significant period of time that had elapsed since the last claim meant it was highly unlikely that any significant number would be affected.

The court ordered that the applicants obtain from APRA the necessary approval for the scheme summary, but that it only needed to be provided to the 10 policyholders with an outstanding claim.

General insurers involved in the transfer of an insurance business may take comfort that this decision shows that courts are conscious of, and will take into account, relevant practical considerations (eg the cost of notification or whether policyholders will be affected in such a way that they should receive notification of an approved scheme) when deciding to make exceptions for compliance with procedural matters under relevant sections of the Insurance Act.

Investors seek declaration that insurer is liable to insolvent company

Case Name:

Employers Reinsurance Corporation v Ashmere Cove Pty Ltd

Citation:

[2008] FCAFC 28, Federal Court of Australia, Full Court per Heerey, Sackville and Siopis JJ

Date of Judgment:

7 March 2008

Issues:

- The court's power to declare an insurer liable to indemnify an insolvent company
- The court's power to join a party to an action

The court upheld the trial judge's decision to join an insolvent company's insurers to an action against the company. The court allowed investors to seek a declaration that the insurers were liable to the insolvent company under a policy of insurance, even though the company's liquidator did not wish to dispute the insurer's liability. The investors were then able to proceed directly against the insurers.

Knightbridge Managed Funds Ltd (**KMF**) ran managed investment schemes. In these schemes, investors pooled their funds, and KMF then found borrowers and arranged for the lenders to take mortgages on the borrowers' property as security.

KMF obtained a professional indemnity policy (the **policy**) from the appellants (the **insurers**). The policy excepted 'any Claim...directly or indirectly arising out of...the non-repayment of any loan which was originated or managed by KMF'.

On 16 December 2000, KMF notified the insurers that certain borrowers had defaulted and that it anticipated investors bringing claims against KMF. The first respondents (the **investors**) claimed that they had suffered loss in managed investment schemes run by KMF. They sued KMF in the Federal Court, alleging negligence and breaches of the Corporations Law.

The insurers declined to grant indemnity, alleging the proceedings fell within the exception in the policy for claims arising from non-repayment of loans.

By the time of the proceedings, KMF was in liquidation and had no funds to meet claims for compensation. KMF's liquidator chose not to claim against the insurers under the policy.

The investors sought to join the insurers in their claim against KMF, seeking a declaration that the insurers were liable to indemnify KMF under the policy. Due to the insolvency of KMF, the investors wanted to be able to recover money under the policy.

The insurers opposed the joinder. Justice French ordered joinder at first instance, and the insurers appealed, unsuccessfully, to the Full Federal Court, which had two issues to determine.

The first was whether the court had judicial power to join the insurers in the investors' action, even though there was no contract between the insurers and the investors.

The Full Federal Court rejected the argument that there was no real dispute between the insurers and investors, and the insurers' claim that any dispute with the investors about the policy's meaning was hypothetical. The court held that the investors had a 'real interest' in demonstrating that the insurers were liable to pay KMF under the policy, because that money would then be available to the investors if they succeeded in their action against KMF.

The second issue was whether, if the court had power to join the insurers in the action, it was appropriate for it to do so. The Full Federal Court considered it was appropriate to join the insurers as there was no substantial injustice, since, at most, they were only required to defend their decision not to indemnify KMF. Therefore, joining the insurers would, for all practical purposes, resolve the dispute between the parties.

The insurers applied to the High Court for special leave, which was refused.

This case will have far-reaching consequences for insurance companies. People with claims against an insured will now be able to bring proceedings directly against the insurers, even if the insurer denies liability and the insured had made no claim on the policy. Therefore, insurers are more likely to be involved in litigation where they have denied indemnity.

Plaintiffs apply to join defendant's insurer in an action for contravention of the Corporations Act

Case Name:

Zhang v Minox Securities Pty Ltd

Citation:

[2008] NSWSC 689, Supreme Court of New South Wales per Barrett J

Date of Judgment:

9 July 2008

Issues:

- Joinder of an insurer as a defendant, under s6(4) of the *Law Reform (Miscellaneous Provisions) Act 1946* (Cth)

This case examines the circumstances in which a plaintiff may join a defendant's insurer as a defendant.

Zhang and Liu (the *plaintiffs*) had applied to join QBE Insurance (Australia) Ltd (*QBE*) as a defendant in the proceedings they had brought against Minox Securities Pty Ltd (the *defendant*)

The plaintiffs were suing in their own capacity and as representatives of persons who invested in promissory notes issued by Mount Street Mezzanine Pty Ltd and Bayshore Mezzanine Pty Ltd (both of which were in liquidation).

The plaintiffs contended that by the operation of section 6(1) of the *Law Reform (Miscellaneous Provisions) Act 1946* (Cth) a charge attaches to insurance monies that are, or may be, payable in respect of any liability that the defendant may be found to have to the plaintiffs. The charge was said to arise in the present circumstances because the defendant was allegedly indemnified by QBE against the liability to the plaintiffs. On that basis, subject to the court's leave, s6(4) of the Law Reform Act would enable the plaintiffs to maintain an action against QBE to enforce the charge. QBE resisted the application, on the ground that the relevant policies did not respond to the defendants' liability for damages.

Justice Barrett confirmed that for the plaintiffs to obtain leave under s6(4) of the Law Reform Act, they needed to show that:

- there is an arguable case:
 - as to the liability of the defendant; and
 - that the relevant policy of insurance responds; and
- that there is a real possibility that the defendant will not be able to meet the order if obtained.

Accordingly, Justice Barrett examined each of the claims against the defendant, all of which involved contraventions of the financial services provisions of the *Corporations Act 2001* (Cth) by Mr Chen.

QBE had issued two policies to the defendant: a professional indemnity policy and a financial institutions policy.

The professional indemnity policy provided indemnity for civil liability for compensation as a result of a breach of professional duty in the conduct of financial planning and insurance broking. However, indemnity did not extend to any act, error or omission in respect of a financial or investment product that was not on the defendant's approved product list. The court determined that this policy did

not apply to the plaintiffs' claim, as the relevant promissory notes were not included in the list of the defendant's approved products.

The financial institutions policy applied in respect of funds management, finance broking and securities dealing by the defendant, but excluded liability in relation to the provision by, or on behalf of, the defendant, of financial advice usually provided by a financial planner. The court accepted QBE's argument that all of the claims against Mr Chen were concerned with, or related to, 'advice' given by him and that the advice was of a kind usually provided by a financial planner.

As there was found to be no arguable basis for contending that either the professional indemnity policy or the financial institutions policy responded to the plaintiffs' claims, the court refused to grant the plaintiffs leave, pursuant to s6(4) of the Law Reform Act, to join QBE as a defendant.

This case provides guidance as to the court's approach to applications for leave under s6(4) of the *Law Reform (Miscellaneous Provisions) Act 1946* (Cth).

No case to answer submissions in defending allegations of arson and fraud

Case Name:

Oakley & Anor v Insurance Manufacturers of Australia Pty Ltd

Citation:

[2008] VSC 68, Supreme Court of Victoria per Kaye J

Date of Judgment:

17 March 2008

Issues:

- Principles when considering a 'no case to answer' submission
- Insurer bringing defence of arson
- Fraudulent exaggeration of quantum of claim

An insurance claim was denied on the basis of allegations of arson and fraudulent exaggeration. After the insurer presented evidence, the plaintiffs submitted there was 'no case to answer'. The judge found he 'could' (as opposed to 'would') find in favour of the insurer, and so held that the plaintiff had a case to answer.

The plaintiffs' house was destroyed by fire. They lodged a claim under a policy with their insurer, the defendant. The defendant refused the claim, alleging that the plaintiffs had deliberately burnt down their house and fraudulently exaggerated the quantum of their claim.

As the defendant has the burden of proving arson and fraudulent exaggeration as defences, it was agreed that the defendant should present its case first. After the defendant's evidence, the plaintiffs submitted that there was 'no case to answer'.

Justice Kaye set out six principles for considering a submission of 'no case to answer'. Most of the discussion centred on whether a judge sitting alone should consider a 'no case to answer' submission differently from a final judgment. His Honour found that the correct approach is to determine whether, on the balance of probabilities, he 'could' find in favour of the defendant (as opposed to whether he 'would', in final judgment).

Justice Kaye then discussed the strength of the defendant's evidence. Notably, he decided that the evidence of the defendant's witnesses, despite credibility issues, should not be rejected at the 'no case to answer' stage, as later evidence might have strengthened or weakened the defendant's credibility.

Ultimately, while the defendant's case was circumstantial, his Honour found there was sufficient evidence that a judge 'could' reasonably uphold the defences of arson and fraud.

Ordinarily, the party that puts forward a 'no case' submission will not be allowed to call any evidence if the submission does not succeed. However, this is ultimately a matter for the judge's discretion. Justice Kaye found that the allegations of arson and fraud were serious enough that the plaintiffs should have every opportunity to respond to them, and so, the plaintiffs were permitted to call evidence.

This case clarifies the test that a judge should use when a 'no case to answer' submission is made, and how evidence will be considered in that context. Insurers should note that where arson and fraud are alleged, the insured may well have two chances to challenge an allegation of fraud: once on a 'no case' submission, and then, by leading evidence.

Insurance of builders and the ability to raise fraud in an insurance dispute

Case Name:

Allianz Australia Insurance Ltd v Douralis & Ors

Citation:

[2008] VSCA 72, Supreme Court of Victoria, Court of Appeal, per Nettle, Dodds-Streeton JJA and Coghlan AJA

Date of Judgment:

8 May 2008

Issues:

- Whether a domestic buildings insurance policy nominating a company as a builder indemnified building owners in relation to a building contract with the company's controller
- Whether an insurer can refuse to pay a claim where fraudulent statements have been made in an affidavit filed by the claimant in the course of a proceeding

The Victorian Court of Appeal considered whether property owners who are party to a building contract with a builder are indemnified under a contract of insurance to which the builder's company, rather than the builder personally, is a party. The court also considered whether an insurer may refuse payment because a claimant relied on a false affidavit in a proceeding.

Mr Simpson was the controller of a company that had executed an insurance policy with Allianz that provided cover for domestic building work, as required by the *Building Act 1993 (Vic)*. Mr Simpson, as distinct from the company, entered into a building contract with the claimants and, at some point after commencing work, gave them a certificate of insurance issued by Allianz. Definitions of the 'insured' varied between the certificate of currency, the policy and its schedules.

The first issue on appeal was whether the claimants could recover from Allianz, despite their building contract being with Mr Simpson personally. The claimants relied on a certificate of currency which stated that the 'Insured Builder' was the company but included all principals, partners, directors and employees who were registered domestic building practitioners. The court held that Mr Simpson and the company were treated throughout by all relevant parties as essentially interchangeable, such that, in contracting with Mr Simpson, the claimants were covered under the policy.

The second issue on appeal was whether Allianz was able to refuse to pay the claim, due to false statements made in an affidavit filed by the claimants in a proceeding brought against Allianz following the rejection of their claim. Section 56 of the *Insurance Contracts Act 1984 (Cth)* provides that where a claim under a contract of insurance against an insurer is made fraudulently, the insurer may refuse payment of the claim. The court held that to come within this provision, the fraud must be directed to obtaining payment, or some other benefit, under the policy. The operation of s56 is, therefore, limited to an initial insurance claim and does not apply to further claims made during a proceeding.

This case illustrates the importance of accurately specifying who is covered by a particular policy covering building work and ensuring that this is consistent throughout all documentation. It also illustrates one of the limits that the court will place on the insurer's ability to rely on fraud in order to refuse to pay an insurance claim.

Claim by franchisor for damages for lost revenue resulting from fire at franchisee's premises

Case Name:

RAA-GIO Insurance Limited v O'Halloran & Ors; Australian Kitchen Industries P/L v O'Halloran

Citation:

[2007] SASC 245, Supreme Court of South Australia per Duggan, Nyland and Kelly JJ

Date of Judgment:

4 July 2007

Issues:

- Meaning of 'in connection with' and 'arising out of' in an exclusion clause
- Claim for loss arising out of interference with a proprietary interest or right; alternatively, a claim for pure economic loss

In this case, the meaning of the commonly used terms 'in connection with' and 'arising out of' were considered in the context of an exclusion clause, together with a claim by a third-party franchisor for lost revenue and profits resulting from a fire at the franchisee's premises.

An employee, H, attended his office building after hours for purposes unconnected with his employment, and started a fire accidentally by failing to dispose properly of a cigarette butt. At the time of the fire, Australian Kitchen Industries Pty Ltd (**AKI**) leased part of the office building, pursuant to a franchisee agreement with DIY Productions Pty Ltd (**DIY**), and AKI carried out the franchised business from the leased premises. AKI alleged it had suffered damage as a result of H's negligence: namely, lost franchise fees and profit, or the lost value of its leasehold interest in the premises.

H claimed that he was entitled to claim for any loss or damage under an insurance policy issued by RAA-GIO Insurance Limited (**RAA**), which indemnified him for legal liability incurred in respect of any accident resulting in bodily injury or damage to property. In denying indemnity, RAA relied on an exclusion clause that provided that the insurer was not liable for claims:

- arising out of ownership, possession or use by the insured of any land or building other than those buildings described in the situation shown in the certificate (**Exclusion Clause A**); or
- arising out of, or in connection with, any business, profession or occupation of the insured or of any other person indemnified by the policy other than that of the landlord (**Exclusion Clause B**).

Exclusion Clause A

The first issue was whether the fire and subsequent damage 'arose out of' H's 'use' of the office building.

The court considered that the phrase 'arising out of' had a wider application than the phrase 'caused by', but that some element of causal or consequential relationship between the claims by AKI and the use by H of the office building was required.

For the purposes of Exclusion Clause A, the court found that the relevant 'use' by H of the building imported an element of control over the actual premises, or status in connection with the premises, such as that of a landlord. Adopting a narrower meaning derived from a legal dictionary, the court held that here, 'use' meant the 'application or employment of something, especially a long continued possession or

employment of a thing...as opposed to a position or employment that is merely temporary or occasional'.

The court concluded that it was not appropriate to give the word 'use' a broader meaning here, as to do so would unreasonably limit the scope of the indemnity cover, so that Exclusion Clause A would apply where there was only a tenuous connection between the accident and the property. The court observed, by way of example to show that the broader meaning of 'use' was not appropriate, that a third party's shopping visit to retail premises could provide the necessary element of use.

H's presence at the office on this occasion was not associated with his work and was, therefore, not a relevant use of the building for the purposes of the policy, and Exclusion Clause A did not apply.

Exclusion Clause B

The question of whether H's claim 'arose out of' or was 'in connection with' his business, profession or occupation turned largely on the meaning of the words 'in connection with'. The court held that, while the term has a large scope, its meaning must be derived from the context in which it was used. In the instant case, a nexus between the subject matter of AKI's claim and the insured's business, profession or occupation was required. H was not performing any of the duties associated with his occupation at the time that the negligent act had caused the fire. His presence in the building where his office was located, for a purpose completely unrelated to his occupation, could not provide the necessary link between the claim and the occupation. As such, Exclusion Clause B did not apply.

Characterisation of AKI's claim for loss

AKI claimed that, under its lease with DIY, it had proprietary or possessory rights that had been affected by the fire. The court found that, for a claim of this nature to succeed, there must be a sufficient nexus between the proprietary or possessory interest and the claim in negligence. This nexus will not exist where the claim is for the loss of the benefit of a contract with a third party.

Properly characterised, AKI's claim was for the injury to its rights under the franchise agreement (though this finding was largely influenced by the manner in which AKI pleaded its case). AKI's damage arose because H's negligent act reduced DIY's ability to carry out its role as franchisor, thereby reducing AKI's profits under the franchise agreement. It was not a loss arising from an interference with any proprietary right that AKI might have had with respect to the leased premises.

Alternatively, AKI argued that its claim for pure economic loss could succeed, based on the notion of vulnerability in *Perre v Apand Pty Ltd*.¹ In rejecting the claim, the court characterised AKI's 'vulnerability' as no higher than 'the ordinary risk of exposure to damage from negligent acts', which did not place AKI in the 'very exceptional and vulnerable position' established in *Perre*.

The meaning of, and potential scope for, phrases such as 'in connection with' should be considered carefully when drafting exclusion clauses. While 'caused by' is narrower than 'arising out of' and 'in connection with', the true meaning of these phrases will depend upon the context in which they are used. This case also highlights the court's reluctance to allow claims for loss of profits or pure economic loss.

Waiver of a breach of a condition precedent by insurers

Case Name:

Kosmar Villa Holidays Plc v Trustees of Syndicate 1243

Citation:

[2008] EWCA Civ 147, England and Wales Court of Appeal per Forbes J and Rix and Jacob LLJ

Date of Judgment:

29 February 2008

Issues:

- Whether an insurer's early communications that it is dealing with a claim amounts to a waiver of the right to deny liability
- What constitutes an 'unequivocal communication'

The England and Wales Court of Appeal considered whether early indications from an insurer to an insured that they are dealing with a claim amount to an 'unequivocal communication' that waives their right to later rely on a condition precedent to deny liability.

This decision arose from a claim by Mr Evans, who suffered a serious spinal injury from diving into the shallow end of a swimming pool at a holiday resort run by the insured (*Kosmar*). In breach of a condition precedent of its insurance contract, *Kosmar* failed to give immediate notice of the incident to its insurers (*Euclidian*). *Kosmar* subsequently gave notice, after receiving a claim letter from Mr Evans' solicitors. *Euclidian* rejected *Kosmar*'s insurance claim for breach of the condition precedent, on the basis of *Kosmar*'s failure to notify.

Kosmar successfully defended Mr Evans' claim and sought an indemnity from *Euclidian* for its costs in the proceeding. *Kosmar* argued that either the doctrine of election or the doctrine of estoppel applied to prevent *Euclidian* from relying on the condition precedent of immediate notification to deny liability. Both doctrines required an unequivocal communication from *Euclidian* that it was waiving its rights under the insurance contract.

At first instance, Justice Gross of the High Court held that several communications by *Euclidian*, including:

- a letter to *Kosmar*, saying that *Euclidian* had taken the view 'not to deny liability yet';
- a letter to Mr Evans' solicitors, noting their interest as insurers and requesting that any correspondence should be forwarded to them; and
- a further letter permitting the owners of the pool to inspect it

evidenced an unequivocal communication to *Kosmar* that *Euclidian* accepted liability for the insurance claim.

On appeal, the England and Wales Court of Appeal held that *Euclidian*'s communications were not unequivocal. Lord Justice Rix, on behalf of the court, relied on the following factors to support the decision:

- *Euclidian* did not state in express terms either that it was waiving the need for immediate notification or that it was accepting liability under the policy for indemnifying *Kosmar*.
- Conduct that suggested *Euclidian* was dealing with the claim should be considered in the context of *Euclidian*'s active pursuit of further information about *Kosmar*'s failure to comply with the notification clause.

- Despite previously paying out claims notwithstanding non-compliance with the notification clause, there was no evidence that Euclidian had waived the need for timely notification in a claim as potentially serious as that relating to Mr Evans.
- Euclidian should be given a reasonable amount of time to consider all of the relevant issues in order to make a properly informed choice about Kosmar's claim.

The judge also commented that in such equivocal circumstances there is no need for a reservation of rights, even where such a reservation may be prudent. He stated that it would not be good practice for legal doctrine to encourage insurers to repudiate claims for late notification or even to destabilise their relationship with their insured by immediately reserving their position, especially at a time where they were asking pertinent questions about a claim.

This case is relevant to insurers, as it held that an express acceptance of liability is required to waive their rights under an insurance contract. It is authority for the proposition that it is not necessary that insurers immediately reserve their rights, or repudiate claims, despite the fact that in some circumstances it may be prudent to do so.

The primacy of arbitration clauses over service of suit clauses

Case Name:

ACE Limited v CMF Energy Corporation

Citation:

[2008] EWHC 1843 (Comm), Queen's Bench Division, Commercial Court, per Clarke J

Date of Judgment:

30 July 2008

Issues:

- The priority between a service of suit clause and a clause compelling the parties to an insurance contract to arbitrate disputes

The Queen's Bench Division of the Commercial Court of England and Wales held that a 'service of suit' clause by which an underwriter submitted to the jurisdiction of a competent United States court did not detract from the parties' contractual obligation to arbitrate all disputes arising out of the insurance policy.

The assured, CMS Energy Corporation (**CMS**), entered into a contract of insurance with certain Lloyd's underwriters (the **underwriters**) which provided, relevantly, that:

- All disputes arising out of this policy shall be submitted to arbitration. The decision of the arbitrator shall be final and binding and may be enforced by any court having jurisdiction (the **arbitration clause**).
- The parties agree that the speedy resolution of any disputes between them is a mutual and material inducement to enter into this policy and this in no way infringes on any rights accorded in the service of suit clause, the effect of which is to provide without waiver of any defence, the ultimate assurance of the amenability of underwriters to certain courts.
- In the event of a failure of the underwriters to pay an amount claimed to be due, the underwriters at the request of the Insured, will submit to the jurisdiction of a court of competent jurisdiction within the United States (the **service of suit clause**).

CMS began proceedings in a United States court to recover monies claimed under the policy. The underwriters then applied to the London Commercial Court for an anti-suit injunction to restrain CMS from continuing the US proceeding. The underwriters argued that CMS was bound by the arbitration clause to submit all disputes to arbitration.

The court found in favour of the underwriters, for the following reasons:

- An arbitration clause specifying that all disputes are to be referred to arbitration is to be interpreted in a broad and expansive manner, in favour of arbitration. In the absence of an express provision excluding a particular type of dispute from arbitration, the court will not assume an intention that particular disputes may be resolved in another forum.
- The purpose of the service of suit clause was to provide an ultimate assurance that the underwriters would submit to the jurisdiction of a particular court, should CMS seek to enforce an arbitral award against the underwriters. The parties' intention in this regard was reinforced by the wording in paragraph (b) above.

- A liberal interpretation of the service of suit clause would have, at the option of CMS, removed from the scope of the arbitration clause the sort of dispute most likely to arise under the policy, creating uncertainty about the appropriate forum in which to hear the dispute.
- Where, as here, the service of suit clause required that all matters be determined in accordance with the law and practice of a particular court, this evidenced an express agreement that the relevant court determine any dispute upon its merits. It did not displace the primacy of the arbitration clause.

Service of suit clauses are a tool used commonly in the US to ensure that a competent US court has jurisdiction over the underwriter in a contract of insurance. In this case, the court considered in some detail the US authorities on the interaction between clauses in the form of (a) and (c), and was ultimately influenced by these authorities.

The court's decision highlights the United Kingdom's strong policy in favour of arbitration. Parties who wish to retain the option of pursuing traditional legal process in the face of an arbitration clause will require clear and unambiguous language to this effect.

Does silence constitute an inferred admission that a claim made by another party to a dispute is valid?

Case Name:

Cassatone Nominees Pty Ltd v Queenslandwide House & Building Reports Pty Ltd & Ors

Citation:

[2008] QCA 102, Queensland Court of Appeal per McMurdo P, Fraser JA and Fryberg J

Date of Judgment:

2 May 2008

Issues:

- Section 601AG of the *Corporations Act 2001* (Cth)
- Rule 293 of the *Uniform Civil Procedure Rules 1999* (Qld)
- Whether silence is an admission of liability

In reversing a summary judgment of the Supreme Court, the Queensland Court of Appeal ruled that silence does not necessarily constitute an admission of the validity of a claim, particularly where the claim does not have sufficient information accompanying it for any reasonable inference to be drawn.

Cassatone Nominees Pty Ltd (the *appellant*) claimed for losses caused by deficiencies in a pre-purchase building inspection report prepared by Queenslandwide House & Building Reports Pty Ltd (*QHBR*). QHBR had been deregistered in June 2006, after the appellant had instituted proceedings. The appellant, in reliance on section 601AG of the *Corporations Act 2001* (Cth) (the *Act*), joined Vero Insurance Ltd and CGU Insurance Ltd (the *insurers*) as second and third defendants, claiming that QHBR's liability to the appellant was covered by an insurance policy issued by the insurers. Section 601AG of the Act provides:

A person may recover from the insurer of a company that is deregistered an amount that was payable to the company under the insurance contract if:

- (a) the company had a liability to the person; and
- (b) the insurance contract covered that liability immediately before deregistration.

After filing its claim, the appellant consented in writing to an extension of time, to 4 December 2006, for the insurers to file their defences. In correspondence between the appellant and the insurers, the insurers admitted the existence of a policy of insurance covering QHBR, but alleged that they were not liable to indemnify QHBR, due to material non-disclosure or, alternatively, on the basis that they had avoided the policy.

The appellant sought full details of the material non-disclosure on which the insurers relied. On 29 November 2006, the insurers replied by forwarding an earlier letter, in which they denied liability to QHBR. The insurers invited the appellant to inform the insurers of its proposed course of action in respect of its claim.

On 5 December 2006, the appellant obtained default judgment against the insurers. The insurers appealed the default judgment, and sought summary judgment, pursuant to rule 293 of the *Uniform Civil Procedure Rules 1999* (Qld). Summary judgment is available to a defendant under rule 293, if the court is satisfied that all or part of the plaintiff's claim has '*no real prospect of succeeding*'.

The insurers' principal contention at the summary judgment hearing was that QHBR's silence in the face of the insurers' denial of liability constituted an admission that the insurers' claims concerning QHBR's failure to comply with the duty of disclosure were valid. In support of that contention, the insurers pointed to a letter to QHBR dated 27 March 2003, in which the insurers referred to evidence suggesting a widespread practice of QHBR preparing sub-standard building inspection reports and put QHBR on notice that they intended to deny liability to QHBR in relation to claims made under the relevant insurance policy. The letter invited a response from QHBR within 14 days of the date of the letter. No response was received.

The insurers contended, without adducing any evidence of the truth of the claims against QHBR, that QHBR's conduct in not responding to their letter of 27 March 2003 constituted an inferred admission in respect of those matters. On that basis, the insurers submitted that there was no contract of insurance covering the appellant's claim immediately prior to the deregistration of QHBR.

The Supreme Court of Queensland set aside the default judgment, and granted summary judgment to the insurers.

The appellant appealed the summary judgment to the Queensland Court of Appeal. The appellant contended that the primary judge had erred in '*eliding the distinction between wrongful repudiation and avoidance*' of the insurers' policy with QHBR.

In considering the appellant's contentions, the Court of Appeal looked to the effect of s28 of the *Insurance Contracts Act 1984* (Cth), which concerns (relevantly) the effect of a failure of an insured to comply with the duty of disclosure. The court pointed to the insurers' failure to plead, pursuant to s28(2), fraudulent non-disclosure by QHBR or any other legal basis for their denial of liability. The court observed that the insurers had not established that there was any legal basis for their purported avoidance of the policy with QHBR. For this reason, it held that the insurers' denial of liability may amount to a wrongful repudiation of the contract of insurance that was not accepted by QHBR and hence did not have the effect of terminating the contract of insurance.

The insurers argued it should be inferred that, by its silence, QHBR had admitted the insurers' denial of liability and avoidance of the insurance contract. In response to that submission, the Court of Appeal adopted the rule in *Wiedemann v Walpole*² [at 539] that '*[s]ilence is not evidence of an admission, unless there are circumstances which render it more reasonably probable that a man would answer the charge made against him than that he would not*', and found that there was insufficient evidence available to sustain a finding that QHBR's alleged silence constituted an admission, particularly given that the 27 March 2003 letter was an internal letter between the insurers and their broker, and did not provide sufficient particulars of the complained-of conduct of QHBR.

In any event, the court found that s601AG of the Act did not create the appellant as successor in title to insurance claims held by QHBR but, rather, created a new statutory cause of action in the appellant, distinct from any rights QHBR previously held.

For this reason, the court held that summary judgment was not appropriate and made orders setting aside the summary judgment, with costs.

The decision reinforces the body of authority declaring that s601AG of the *Corporations Act 2001* (Cth) creates an independent statutory cause of action separate from the rights previously held by the deregistered company under a contract of insurance. It further demonstrates that an insurer must provide sufficient particulars of its decision to deny indemnity to an insured, if the insurer wishes to rely on that person's silence as an admission that the insurer was entitled to avoid the policy.

Insured should act to seek stamp duty refunds

Case Name:

Qantas Airways Ltd v Chief Commissioner of State Revenue

Citation:

[2008] NSWSC 1049, Supreme Court of New South Wales per Handley JA

Date of Judgment:

8 October 2008

Issues:

- Insureds may be entitled to stamp duty refunds

The NSW Supreme Court recently held that the *Duties Act 1997* (NSW) did not, prior to 20 June 2006, impose duty on general insurance effected with persons who were not registered or authorised as 'general insurers' under the *Insurance Act 1973* (Cth). In 2005, the Duties Act was altered so that it referred to 'authorised' general insurers rather than to 'registered' general insurers, no doubt so as to more accurately follow the terminology of the Insurance Act. In accordance with that finding, the court ordered the Chief Commissioner of State Revenue for NSW to refund more than \$5.1 million (plus interest) to the taxpayer (in this case, Qantas) paid as stamp duty on general insurance effected with persons who were not registered or authorised as general insurers under the Insurance Act.

Prior to 1 July 1998, duty was imposed under the *Stamps Act 1920* (NSW) on persons who effected general insurance, including general insurance effected with persons who were not registered or authorised as general insurers under the Insurance Act.

On 1 July 1998, the Stamps Act was superseded by the Duties Act.

Section 236(2) of the Duties Act provided for an insured who effected general insurance with a person who was not a registered insurer under the Duties Act to lodge a return and pay duty to the Commissioner 'within 21 days after the end of the month in which the premium relating to the insurance is paid to an [unregistered] insurer'. If no 'premium' was payable to an 'insurer', no duty was payable.

'Insurer' was defined in s247 of the Duties Act to include a 'general insurer'. That section provided that a person was a 'general insurer' if they satisfied three criteria, including that the person was 'registered as a general insurer under the Commonwealth Insurance Act 1973'. Relevantly, persons who were not registered or authorised as general insurers under the Insurance Act did not fall within the definition of 'insurer' in s247 of the Duties Act.

If a person who was not registered or authorised as a general insurer under the Insurance Act was not an 'insurer' for the purposes of s236(2) of the Duties Act (see above), then no 'premium' was payable to an 'insurer' and, consequently, no duty was payable.

On 20 June 2006, the Duties Act was amended to clarify that, from that date, duty was payable on policies of general insurance effected with persons who were not registered or authorised as general insurers under the Insurance Act.

In the period from 1 August 2001 to 31 March 2006, Qantas paid premiums on general insurance policies placed with persons who were not registered or authorised as general insurers under the Insurance Act (the *policies*). The Commissioner issued Qantas with assessments for duty payable totalling more than \$5.1 million (plus interest) on the policies. Qantas objected to the assessments, on the basis that no duty was payable. The Commissioner disallowed the objections and Qantas appealed to the NSW Supreme Court.

The Commissioner submitted that:

- The definition of 'insurer' in s247 of the Duties Act did not apply to s236 of the Duties Act;
- The term 'insurer' in s236 should be read as including persons who were not registered or authorised as general insurers under the Insurance Act; and
- Consequently, Qantas was liable to pay duty on the policies.

Acting Justice Handley rejected the Commissioner's argument. His Honour held that the Duties Act did not impose duty on general insurance effected with persons who were not registered or authorised as general insurers under the Insurance Act in the period prior to 20 June 2006, and ordered that the duty paid on the policies be refunded, together with interest.

The Commissioner has filed an appeal with the NSW Court of Appeal. The appeal is likely to be heard in early 2009, with a decision expected later in the year.

The decision means that insureds may be entitled to a refund of stamp duty levied in NSW on policies of general insurance effected with persons who were not registered or authorised as general insurers under the *Insurance Act 1973* (Cth) in the period up to 20 June 2006. Refunds may also be available for duty paid in similar circumstances in other jurisdictions in which similar provisions were enacted. In NSW, insureds have a right to require the Commissioner to assess or reassess the amount of duty paid in the five-year period immediately prior to the date on which the request is made. If the Commissioner ultimately declines to refund any alleged overpayment, the decision can be appealed to the Administrative Decisions Tribunal or Supreme Court. There are similar provisions in other jurisdictions. The ability of an insured to recover duty paid before the start of the five-year period is not dealt with in the decision. If the relevant revenue authority is not willing to exercise its discretion and voluntarily refund the overpayment falling outside the five-year period, insureds should consider seeking advice in relation to what steps they might be able to take in the relevant jurisdiction.

Beaconsfield Mine collapse: interpretation of insurance contracts

Case Name:

Allstate Explorations NL v QBE Insurance (Australia) Ltd

Citation:

[2008] VSCA 148, Supreme Court of Victoria, Court of Appeal, per Buchanan, Dodds-Streeton JJA and Pagone AJA

Date of Judgment:

21 August 2008

Issues:

- Interpretation of provisions in an insurance contract having regard to the overall structure and intent of the policy

The Victorian Court of Appeal considered the possibility of an insurance policy providing indemnity for loss that is not causally connected to the physical loss, where the structure and terms of the policy suggest that physical loss is a threshold requirement for engagement of the indemnity agreement.

This case relates to the Beaconsfield Mine incident of 2006, where a rock-fall resulted in the death of one miner and the entrapment of two others. As a consequence of the rock-fall, an inspector ordered that all mining activities stop until further notice (under the *Workplace Health & Safety Act 1995 (Tas)*).

The owners and operators of the Beaconsfield Mine (the *plaintiffs*) sought to recover some of the losses caused by the mine closure from its insurer, QBE Insurance (Australia) Ltd (the *defendant*), under its 'Industrial Special Risks Insurance Policy' (the *policy*). The plaintiffs contended that the mine closure was an insured event which was '*due to the operation of a peril insured against*' within the meaning of clause 23 of the policy.

Clause 23 provided:

Notwithstanding anything contained herein to the contrary, the Property Insured under this Policy is also covered against the risk of loss, destruction or damages arising from the actions of any civil authority during the conflagration or other catastrophe and for the purposes of preventing, minimising or retarding same and shall also include the closure of any premises/operations by any civil authority due to the operation of a peril insured against.

The plaintiffs argued that this provision acted as a separate and independent head of indemnity, providing cover against loss, regardless of whether such loss was causally related to any physical loss or damage to the insured property. The defendant submitted that the clause should be construed as forming part of the scheme of insurance provided for in the main indemnity sections and did not provide any additional cover. It argued that as the order for the mine closure was not the result of any loss or damage to the insured property, the policy did not respond to the business interruption losses claimed by the plaintiffs.

Acting Justice Pagone, with whom Justices Buchanan and Dodds-Streeton agreed, held that clause 23 of the policy must be read in the context of the rest of the policy. The structure of the policy clearly indicated that the cover only related to losses consequent on physical loss and that the clause was not intended to enlarge the risk insured against. Acting Justice Pagone held that if the additional independent cover was intended to be provided by the clause in dispute as the

plaintiffs submitted, then it would have been clearly worded to state that. Instead, the provision operated to clarify the cover provided by the main indemnity provisions and did not create an independent head of indemnity.

The court held that indemnity was provided for losses arising out of physical loss, destruction of, or damage to any property insured and did not extend to the closure of the mine in the absence of such loss, destruction or damage.

This case is useful in indicating the way in which insurance contracts will be interpreted, taking into account the overall structure of the policy and the intention of the parties, which may be implied from it.

Can a business be insured if it doesn't exist? Testing the metaphysical limits of consequential loss cover

Case Name:

Coromin Ltd v AXA Re & Ors

Citation:

[2007] EWHC 2818 (Comm),
High Court of England & Wales,
Commercial Division, per
Cooke J

Date of Judgment:

30 November 2007

Issues:

- Scope of business interruption or consequential loss insurance

This English decision considers questions of construction in a claim for business interruption loss. While the case is fact-specific, and the coverage secured by the global policy undoubtedly broad, the judgment provides guidance on policy construction and demonstrates the willingness of courts to accommodate the commercial realities of business when interpreting policy terms.

It should be noted that the available forms of cover for business interruption losses vary between countries. In Australia, business interruption insurance is often incorporated into policies known as industrial special-risks insurance policies and described as 'consequential loss insurance'. The principles in this decision are, nevertheless, instructive in an Australian context.

The claimant, Coromin Ltd (**Coromin**) was a captive insurer for Anglo-American Plc, one of the world's largest diversified mining and natural resources groups. Coromin sought indemnification from its reinsurers for physical damage and business interruption loss as a result of a defective mill motor at a copper mining and processing facility in Chile. The 'all-risks' cover was placed in June 2004 for 12 months and the incident giving rise to the claim occurred in March 2005, triggering a 24-month indemnity period for business interruption losses. A new plant, the 'molybdenum plant', was constructed outside the policy period but within the business interruption indemnity period – and was affected by the defective mill motor. The question that arose was whether Anglo could recover from Coromin, and Coromin from reinsurers, a loss caused by interrupting 'a business' that had not been in existence either when the incident happened or during the policy period.

The business interruption provisions insured against 'loss resulting from the interruption of or interference with the business'. The business was defined to include all operations and activities of the insured with no qualification or limitation in terms of scope or time. The reinsurers argued that they were not liable for a risk of which they had no knowledge and which they were subsequently unable to rate.

The court decided in favour of Coromin. 'Business' was to be given its ordinary meaning and was defined to include 'all operations and activities of the Insured' without qualification or temporal distinction. The only requirement was that the interruption was caused by the insured event and fell within the indemnity period. The issue was solely one of causation. Mr Justice Cooke refused to imply any term that sought to restrict the word 'business' to business being carried on during the initial policy period or as at the date of damage, on the basis that these terms were

not reasonable, let alone necessary (particularly where the policy in question was a global policy). His Lordship also rejected arguments raised by the reinsurer that they had not been able to rate the cover. The cover had been rated on historic values. The court's view was that the reinsurers should bear the consequences of using this 'blunt tool' for rating purposes.

While this decision does not represent a departure from, or significant development in, the common law, the finding that insurers are bound by the post-placement expansion of a business is likely to contribute to the behaviour of players in the industry. We can expect insurers to be more exacting at the placement stage over the question of the future expansion and business plans of insureds and be mindful to explicitly word policies to limit the scope of business interruption cover to losses flowing from business carried on by the insured at the time of the damage.

A relaxing of approach by the English Courts: what constitutes an effective notification of circumstances

Case Name:

HLB Kidsons v Lloyd's Underwriters & Ors

Citation:

[2008] EWCA Civ 1206, England and Wales Court of Appeal per Rix and Toulson LJJ and Sir Richard Buxton

Date of Judgment:

5 November 2008

Issues:

- Notification of circumstances under a claims-made policy
- Notification provision in claims-made policy operates as a condition precedent in the absence of express wording

The English Court of Appeal considered the effectiveness of a number of notifications of circumstances that were made by an insured prior to the expiry of insurance cover. It confirmed that the standard nature of the notification provision, which is used in many professional indemnity policies, did not present a significant hurdle for the insured to overcome in order to demonstrate that an effective notification of circumstances had been made.

HLB Kidsons (*Kidsons*) operated a company that marketed tax-avoidance schemes, called Solutions at Fiscal Innovation Limited (*S@FI*), and was insured under a 'claims made and notified' professional indemnity policy for the period 1 May 2001 to 30 April 2002. This policy contained a standard notification clause that required the insured to provide the underwriters, as soon as practicable, with written notice of any circumstances that it became aware of during the policy period that could give rise to a claim.

Kidsons received a number of claims in respect of S@FI's activities after the expiry of the policy cover, alleging negligence and misrepresentation in relation to the possibility of its tax avoidance schemes being challenged and rejected by the UK's tax authority.

Kidsons duly sought indemnity, relying on four presentations made to underwriters during and after the policy period as evidence of it having notified them of the circumstances that had given rise to the claims. Underwriters argued that the four notifications were either so vague as to the possibility of a claim being made as to be ineffective or else they were communicated to them after the policy had expired.

At first instance, the High Court made a very limited declaration of indemnity on the basis that:

- the first two notifications in September and October 2001 were invalid because they were not expressly stated to be a notification of circumstances and did not contain sufficiently clear and unambiguous information that would cause a reasonable underwriter to conclude that a notification was being made;
- the third notification in April 2002 was effective because it provided more detailed information as to the possibility of claims being made, including the advice of senior counsel. However, this notification was deemed to be valid only in relation to certain limited categories of claims and only in respect of those underwriters that had received the information (which did not include the following market); and

- the fourth notification in July 2002 to the following market underwriters was invalid because, being made three months after the third notification and two months after expiry of the policy, it could not be said that this was made 'as soon as practicable', as required as a condition precedent under the policy.

On appeal, Kidsons sought to overturn the High Court's findings on the second, third and fourth notifications. In particular, it argued that the second notification of circumstances was broad enough to encompass all of the claims for indemnity, and that the prompt notification of circumstances to the following market underwriters was not a condition precedent for cover.

In dismissing the appeal, the Court of Appeal:

- overturned the High Court's finding in relation to the second notification, and held that this was effective when considered objectively and given the lack of specificity required by the policy's notification provision. Its 'fairly loose and undemanding' standard wording was satisfied here, and it was relevant that the notification had been presented by the claims side of the brokers to the underwriters' claims handlers and had contained a claims bordereau;
- overturned the finding of the limited scope of the third notification, holding that it encompassed some more, but not all, of the claims now brought against S@FI. This stemmed from the Court of Appeal's finding that the second notification – which was drafted in slightly wider terms – had been effectively made; and
- upheld the High Court's finding that the fourth notification was not made as soon as practicable. It also agreed that compliance with the policy's notification requirement, although not expressed to be a condition precedent to cover, should be regarded as having this effect. It pointed out that the price an insured pays for having a deeming provision in a claims-made policy, which allows claims to be made after its expiry, is that it should be a condition precedent that a proper and timely notification of circumstances be given.

This judgment has reduced the severity of the High Court's finding that was regarded by the London market as permitting insurers to take a strict approach to the adequacy of notifications made to them. The approach taken by courts in Australia to similar policy provisions is demonstrated by the recent decision of the Full Federal Court in *CGU Insurance v Corrections Corporation of Australia Staff Superannuation*³. Any argument in an Australian court concerning the late notification of circumstances would not succeed in the absence of any demonstrable prejudice as a result of section 54 of the *Insurance Contracts Act 1984*.

The operation of 'known circumstance' exclusions in professional indemnity policies

Case Name:

CGU Insurance Limited v Anthony Porthouse

Citation:

[2008] HCA 30, High Court of Australia per Gummow, Kirby, Heydon, Crennan and Kiefel JJ

Date of Judgment:

30 July 2008

Issues:

- Denial of indemnity because of prior 'known circumstance'
- Scope of objective standard in 'known circumstance' exclusions

The High Court considered whether and when a 'known circumstance' exclusion in a professional indemnity policy will permit an insurer to deny indemnity without the insured having known before the policy began that the relevant circumstance might later result in a claim.

In June 2001, Anthony Porthouse, a barrister, wrongly advised his client, James Bahmad, that the *Workers' Compensation Act 1987* (NSW) (the **Act**) did not apply to Mr Bahmad's proposed damages claim against the New South Wales Department of Corrective Services (the **State**) for an injury he sustained while performing community service. Later that year, the Act was amended to preclude damages awards for injuries that did not satisfy a permanent impairment threshold of 15 per cent (the **amendment**). The amendment did not apply to proceedings commenced before 27 November 2001. Mr Bahmad's injury did not satisfy the 15 per cent threshold and his proceeding was not filed until 11 December 2001. At trial, the New South Wales District Court decided that the amendment did not apply to Mr Bahmad's claim and awarded him damages. The State appealed.

Before the appeal was heard, Mr Porthouse obtained a professional indemnity insurance policy from CGU Insurance Limited (**CGU**) for the period 30 June 2004 to 30 June 2005 (the **policy**). The policy contained a 'known circumstance' exclusion (the exclusion), which excluded cover for claims arising from a 'known circumstance', being:

'Any fact, situation or circumstance which:

- (a) an Insured knew before this Policy began; or
- (b) a reasonable person in the Insured's professional position would have thought, before this Policy began,

might result in someone making an allegation against an Insured in respect of a liability, that might be covered by this Policy.

In August 2004, the State's appeal was successful and Mr Bahmad's damages award was reversed. Mr Bahmad later successfully sued Mr Porthouse for negligence.

Mr Porthouse claimed indemnity under the policy for his liability to Mr Bahmad. CGU, relying on the exclusion, declined Mr Porthouse's claim. Mr Porthouse then commenced a proceeding against CGU. Mr Porthouse succeeded at trial and on appeal to the NSW Court of Appeal. CGU then appealed to the High Court.

The earlier finding that Mr Porthouse, before the policy commenced, had not known that Mr Bahmad might make an allegation of negligence against him, was not challenged. Instead, the High Court considered the proper construction of the second limb of the exclusion and, in particular, the phrases 'a reasonable person in the Insured's professional position' and 'would have thought ... might result in'.

On the meaning of the phrase, 'a reasonable person in the Insured's professional position', the High Court found that it 'posits an objective standard, with a modification relating to professional, not personal, matters'. The court also observed that the phrase 'describes a hypothetical reasonable person with the experience and knowledge of the insured coupled with the capacity of such a reasonable person to draw a conclusion (whether it is plain and obvious or not) as to the possibility of someone making an allegation against the insured'. Neither the language nor the context of the policy permitted imputing to the reasonable person the insured's 'personal idiosyncrasies or ... state of mind', which may, in fact, be unreasonable.

On the meaning of the phrase 'would have thought ... might result in', the court decided that the hypothetical reasonable person must conclude that there was a 'real (not fanciful or remote) possibility (not a certainty) of an allegation being made'.

Ultimately, the High Court held that 'there can be no real doubt [on the undisputed facts of the case] that a reasonable barrister ..., who knew of the potential for the effect on his client's case of [the amendment], and who knew of the appeal and of his role in creating his client's problem, would have thought that there was a real possibility that an allegation might be made in respect of a liability which might be covered by the policy'. Consequently, the High Court allowed the appeal and entered judgment for CGU.

For insurers, the decision reinforces the broad protection that 'known circumstance' exclusions in claims-based policies afford you against indemnity claims arising from the prior conduct of insureds. For insureds, it is important that you regularly and carefully reflect on your conduct to identify potential claims and then notify those circumstances to your insurers in a timely way. Cautious circumstances notification practices can assist you to avoid being denied cover for claims that subsequently arise from those circumstances.

Scope of notification clauses in 'claims-made' policies

Case Name:

*Kajima UK Engineering Limited
v The Underwriter Insurance
Company Limited*

Citation:

[2008] EWHC 83, England
and Wales High Court, Queen's
Bench Division, per Akenhead J

Date of Judgment:

25 January 2008

Issues:

- Scope of notification clauses in 'claims made' policies
- Defects and damages that emerge after the expiry of a professional indemnity policy considered part of the subject matter of an earlier notification within the policy period

The England and Wales High Court considered the extent to which notification clauses in 'claims made' policies encompass subsequent claims.

Kajima UK Engineering Limited (**Kajima**) was employed as a contractor to design and build a block of flats comprising certain 'accommodation pods'. In February 2001, Kajima notified its professional indemnity insurer, The Underwriter Insurance Company Limited (**TUIC**), that the 'accommodation pods' were 'settling and moving excessively causing adjoining roofing and balcony and walkways to distort under differential settlement' (the **notification**). In the notification, Kajima also indicated that there was a risk of other possible damage and that an investigation was under way to identify and confirm the cause and potential consequences of the problem.

Significantly, the policy with TUIC was on a 'claims made' policy and included cover for future claims arising from circumstances 'which might reasonably be expected to produce a claim', provided that the circumstances were notified during the relevant period of insurance which, in this case, was from 20 May 2000 to 19 May 2002.

The initial notification made in February 2001 was made well within the policy period: however, after the expiry of the policy, various other defects emerged, including:

- problems associated with the use of incorrect panels and inadequate components for floors and walls;
- poor fire integrity of timber components of the building; and
- (leading to the evacuation of all tenants), a risk that the flats may collapse due to inadequate wind loadings.

After conducting its own investigation, TUIC denied indemnity for a large part of the defects claimed by Kajima because TUIC did not consider those defects to be covered by the notification. These subsequent defects were deemed not to have arisen outside the policy period.

The issue before the court was whether the defects that emerged after the expiration of the policy were within the scope of the notification.

The court held that the notification was only effective in relation to the specific circumstances that were notified. In other words, the notification covered only:

- the defects which caused;
- the symptoms of; or
- the consequences of,

the circumstances that were notified in February 2001.

The court held that the notification did not cover defects or deficiencies that did not, or may not, have anything to do with the notified circumstances but were revealed coincidentally in the course of investigations. In this case, that included the defects discovered after the policy had expired.

This decision of the UK High Court emphasises that each notification must be considered on its own terms. The case is a useful reminder to insureds and insurers alike of the need to make a full and comprehensive notification to properly trigger policy coverage.

General rules of construction of contracts

Case Name:

Vero Insurance Ltd v Tran

Citation:

[2008] NSWSC 363, Supreme Court of New South Wales per Hamilton J

Date of Judgment:

22 April 2008

Issues:

- Interpretation of contracts for commercial and business transactions

In this decision by the NSW Supreme Court, notes of oral agreements drawn up by a mediator at the conclusion of a mediation between several parties were held not to constitute a binding contract. Contrary to the intention of the parties, no written agreement was executed.

The plaintiff, Vero Insurance Ltd (**Vero**), claimed a declaration that there was a binding contract between it and the six defendants (together **Tran**) for the settlement of the District Court proceedings. Vero also claimed, by way of specific performance, an order that Tran would execute its obligations under that contract.

The first and second defendants raised the following defences:

- there was no intention to create legal relations, because the parties did not intend to be bound unless and until a formal contract was drawn up and signed;
- the fourth and fifth defendants were not parties to the mediation agreement or the mediation; and
- the solicitor who represented the first and second defendants at mediation lacked the authority to do so.

At the conclusion of the mediation between the parties, the mediator read out his written notes of what the parties had agreed. During the course of the evening after the mediation had finished, the first defendant telephoned and faxed the mediator, announcing that the first and second defendants could 'not accept the term and conditions put to us by the cross defendants [sic]'.

The issue considered by the court was whether the mediator's notes constituted a binding contract. The question of how commercial contracts should be construed was considered against the following principles:

- communications between the parties must be interpreted by reference to the subject matter and the surrounding circumstances, including the relationship between the parties; and
- it is not the subjective thing known as the meeting of the minds, but the objective thing, manifestation of mutual assent, which is essential to the making of a contract; and
- that commercial contracts must be construed in a commercial way, taking a commonsense approach.

Justice Hamilton found that the direct evidence showed an express intention of the parties to settle terms according to a written, executed agreement. As no such written agreement was executed, there was no binding settlement among the parties.

This case demonstrates that when construing informal contracts, the court will take into account various factors including the relationship between the parties, previous communications between them, and any other surrounding circumstances. Generally, this shows that commercial contracts must be construed in a commercial way, taking a commonsense approach.

Onus of proving a limitation of liability on an insurance policy

Case Name:

Stewart v QBE Insurance (Australia) Limited & Anor

Citation:

[2008] NSWDDT 6, New South Wales Dust and Diseases Tribunal per Justice Kearns

Date of Judgment:

1 February 2008

Issues:

- Onus of proving a limitation of liability on an insurance policy
- Evidence to demonstrate a limitation of liability on an insurance policy

Justice Kearns considered the preliminary issue of whether liability under an insurance policy was unlimited. No evidence was available from either side as to the wording of the policy, so the question had to be determined by deciding who bore the onus of proof.

The plaintiff in this case is the estate of Mr Stewart. Mr Stewart held an insurance policy with QBE Insurance (Australia) (the *insurer*). This judgment is a determination of a preliminary issue in the case, that is, whether the relevant insurance policy had unlimited liability.

The plaintiff argued that the policy was unlimited. The insurer argued that the policy was limited to the statutory minimum level of cover under the *Worker's Compensation Act 1987* (NSW), which, at the relevant time, was \$40,000.

The policy itself had disappeared. The insurer put forward evidence that there was a policy and at the time it was made, a statutory minimum cover existed. Justice Kearns said that little, if anything, could be drawn from these facts. The plaintiff offered no evidence of the unlimited liability.

With no evidence available, the decision of whether liability under the policy was limited became a question of who bore the onus of proof. Justice Kearns found that the evidentiary burden should fall with the party that asserts. As the insurer is asserting that there is a limit on the policy, the insurer must bear the onus of proving the limit.

Justice Kearns stated that an insurer must put forward some evidence of the limit on the policy. Recognising that this will be difficult if the policy has disappeared, Justice Kearns stated that evidence from members of the insurance industry as to the practices in the circumstances may be a possible line of evidence to prove a limitation.

In this case, the insurer did not present any evidence of these matters and it was held that the policy was unlimited.

This case serves as a warning to insurers. If an insurer claims that a policy has a limitation, then the insurer must be able to prove it; otherwise it will be presumed that the policy was unlimited.

A costly error: an ambiguously worded excess provision

Case Name:

Standard Life Assurance Ltd v Oak Dedicated Ltd & Ors

Citation:

[2008] EWHC 222 (Comm)
England and Wales High Court,
Commercial Division, per
Tomlinson J

Date of Judgment:

13 February 2008

Issues:

- Professional indemnity policy – construction of excess provision
- Broker's duty of care – failure to place cover that meets an insured's needs

The English High Court was called on to decide whether a professional indemnity policy incorporated a 'per claimant' excess in addition to the more usual 'per claim' excess, which had the effect of leaving the insured without cover. In deciding that it did, it found the insured's broker had been negligent in preparing and agreeing an unclear policy wording.

Standard Life Assurance Limited (*Standard Life*) sought the determination of a number of preliminary issues relating to a claim for indemnity arising out of the mis-selling of mortgage endowment policies. Standard Life also sued its professional indemnity underwriters, who had declined indemnity, as well as the broker who had arranged the cover on its behalf.

The key issue for the court to determine was whether or not Standard Life's professional indemnity policy permitted the aggregation of 97,000 individual claims that had a collective value of more than £100 million. Underwriters denied that it did and, in addition, argued that a separate excess of £25 million applied to each claimant.

The excess provision of the policy wording was stated as being:

In respect of each and every Claim and/or Loss the amount as specified in item 4(ii) of the schedule...

Item 4(ii) of the schedule provided as follows:

...£25 million each and every claim and/or claimant including costs and expenses.
(emphasis added)

The phrase 'and/or claimant' was an unusual and ambiguous choice of words. None of the lay or expert witnesses could recall ever seeing a financial institutions policy that adopted this wording in order to impose a per claimant excess; the words 'each and every claimant' would normally be used. However, none could give a plausible meaning to these words other than to impose a per claimant excess and it was clear from the evidence that these words had featured prominently on the placement slip scratched by the underwriters. On this basis, the court concluded that the policy did not permit the aggregation of related claims made by separate claimants.

Standard Life was left in a position where the court's construction of the policy gave it a meaning that completely undermined its commercial objective to provide protection from a catastrophic event that generated large numbers of related claims for compensation. No individual claimant's claim came anywhere near to the extremely high excess, and Standard Life was not able to lead any evidence that

would have allowed it to rectify the policy wording because of a mistake or to suggest that the underwriters had conducted themselves on the basis that there was no per claimant excess.

In light of this finding, it is not surprising that Standard Life's broker, who was joined to the litigation, was found to have been negligent in placing the cover. A contributory negligence defence based on the fact that Standard Life had reviewed the draft policy beforehand was described as 'limp'. The broker was aware that it was critically important for Standard Life's professional indemnity cover to be able to aggregate claims from different claimants arising from a common cause. Indeed, the broker had represented to Standard Life that the cover met this need. Despite this, the policy wording prepared by the broker was ambiguous, permitting underwriters to successfully argue that it contained a per claimant excess.

Apart from the obvious lesson of the importance of drafting clear policy wordings (particularly where aggregation provisions are concerned) this case is a reminder that the courts in England and Australia, when interpreting the meaning of a policy, will strive to give meaning to the words used, even though this may lead to a highly uncommercial result for one party. It also underscores the scope of a broker's duty to arrange and maintain cover that clearly meets its client's needs. Coverage will only be clear in so far as it leaves no room for significant debate and does not expose an insured to an unnecessary risk of litigation.

Storm damage: construction of exclusion clause and assessing proximate cause

Case Name:

Caine v Lumley General Insurance Limited

Citation:

[2008] NSWCA 4, Supreme Court of New South Wales, Court of Appeal, per Mason P, McColl JA and McClellan CJ

Date of Judgment:

6 February 2008

Issues:

- Construction of exclusion clause and objectives of policy
- Proximate cause of loss or damage
- Extra costs of reinstatement

The NSW Court of Appeal considered the construction of an exclusion clause and the proximate cause of loss resulting from a heavy storm.

This case was an appeal from a decision of Justice Einstein rejecting the appellants' claim for monies said to be due under a commercial business policy (the *policy*).⁴

The appellants owned a caravan park business in northern NSW. The business included 34 permanent caravan sites with vans. Each caravan had an annex and solid tropical roof, both of which were attached to the caravan.

The caravan park was struck by a severe storm, including hail and torrential rain, causing damage to a number of the caravans, tropical roofs and annexes. The appellants claimed that, under the policy, they were entitled to be paid the reinstatement value of the property damaged. The insurer paid \$100,000 in respect of the damage to the caravans (which it asserted included the annexes and tropical roofs), on the basis that this was the limit of its liability under the policy. The insurer relied on exclusion clause 15, which provided that the policy did not cover damage to:

Caravans and all aluminium foam sandwich construction where caused by hail, unless the hail penetrates the entire thickness of the material damaged, causing water to enter. Limit of Liability \$100,000 any one year.

The key questions for the court were whether the reference in the policy to 'caravans' included the annexes and tropical roofs, and if so, whether the damage to the caravans was caused by hail, thus attracting exclusion clause 15.

At first instance, Justice Einstein held that:

- The word 'caravan[s]' was used to describe the permanent or semi-permanent structures at the caravan park, including the annexes and tropical roofs.
- The proximate cause of the loss and damage was hail.

Before the Court of Appeal, the appellants submitted, among other things, that Justice Einstein erred in finding that the word 'caravan' encompassed the annexes and tropical roofs, and that the proximate cause of the damage was the concurrence of wind, rain and hail, not hail alone.

The Court of Appeal affirmed the decision of Justice Einstein and held that:

- The 'overwhelming conclusion to be drawn from the policy is that it was intended to cover the 'structures' which the appellants offered as accommodation'. Those structures included the caravans, annexes and tropical roofs. The object of the policy was to insure the structures, not their individual components.
- Justice Einstein's conclusion that the reference to 'hail' in exclusion clause 15 meant damaged by hail in the sense that hail was the proximate cause of the damage was correct. The Court of Appeal noted that '[d]amage which was caused by hail, without, at least, elements of a storm coinciding, would be a meteorological anomaly.' In this case, the evidence showed that the penetration of hail into the caravans was the proximate cause of damage.
- Even if the appellants were correct in their submission that the proximate cause of damage was the concurrence of wind, rain and hail, they may still be excluded from recovery, because where there is more than one cause of loss or damage, one covered and one or more excluded, the insurer is not liable (known as the *Wayne Tank*⁵ principle).

Finally, the Court of Appeal considered clause D5 of the policy, which provided that the insurer would pay the extra cost of reinstatement to comply with regulatory requirements or the requirements of any municipal or statutory authority. The Court of Appeal found that additional reinstatement costs incurred by the appellants as a result of local council requirements were not limited by the cap of \$100,000 in exclusion clause 15.

This case demonstrates that the court will look to the policy as a whole and the commercial objects that it is intended to achieve when interpreting an exclusion clause. Further, it provides a useful example of how the court applies commonsense standards in determining proximate cause.

Obligation of contractor to obtain insurance covering liability of a sub-contractor

Case Name:

A Goninan & Co Ltd v Direct Engineering Services Pty Ltd
[No 2]

Citation:

[2008] WASCA 112, Western Australian Supreme Court, Court of Appeal, per Martin CJ, McLure & Buss JJA.

Date of Judgment:

15 May 2008

Issues:

- Contractual construction – use of deleted clauses to aid in interpretation
- Terms governing the extent of coverage to third parties
- Obligation to obtain insurance between a contractor and a sub-contractor

The WA Court of Appeal found that the terms of a contract between a principal and contractor obliged the contractor to obtain insurance for the liability of sub-contractors for property damage and, further, that an insurance policy taken out under the head contract covered the sub-contractor for its negligent acts.

Hamersley Iron Pty Ltd (**HI**) and Direct Engineering Services Pty Ltd (the **Contractor**) contracted to upgrade a railway workshop owned by HI (the **head contract**). The Contractor sub-contracted part of the head contract to A Goninan & Co Ltd (the **Sub-contractor**), for the Sub-contractor to install a stairway and fit handrails at the property. In the course of carrying out these works, employees of the Sub-contractor caused a fire that substantially damaged the property.

Pursuant to an insurance policy held by the Contractor, its insurer, AXA Colonia Versicherung AG (**AXA**), indemnified the Contractor and reimbursed HI for its losses. AXA, purportedly in exercise of its right of subrogation, then sought indemnity against the Sub-contractor. The Sub-contractor claimed that it was insured under the AXA policy held by the Contractor and, for that reason, it would be circuitous for AXA to seek indemnity against it.

At first instance, Justice Murray found that if the Sub-contractor was not an insured person under the Contractor's AXA policy, AXA was entitled to subrogate the action and sue the Sub-contractor. On appeal, that decision was reversed. The Sub-contractor argued its appeal on three grounds:

- the Contractor was obliged to obtain insurance under the head contract against the liability of sub-contractors for property damage; and
- the Sub-contractor was insured under the AXA insurance policy of the Contractor; and
- even if the Sub-contractor was not insured under the AXA policy, the court at first instance should have set off against the Contractor's claim the amount that the Contractor ought to have insured the Sub-contractor for in compliance with its obligations under the head contract.

Central to the court's decision was the construction of the insurance-related general conditions of the head contract, the special conditions of the head contract, and the wording of parts of the AXA policy. The head contract contained provisions that were unambiguous as to whether the Contractor was obliged to maintain insurance cover for its sub-contractors. Specifically, the relevant clauses did not specify who was to be the insured under any policies of insurance taken by the Contractor under the head contract.

Further, some general condition clauses concerning the obligation of the Contractor to maintain insurances had been deleted from the head contract. In its reasoning, the Court of Appeal found that the rules of contractual construction permitted *'deleted words or clauses to be referred to as an aid to construing ambiguous words or an ambiguous clause in the concluded agreement'* at para [40].

The Court of Appeal found that the preferred construction of the head contract was that the Contractor was obliged to obtain insurance against the liability of sub-contractors for property damage because:

- the Contractor had a 'significant interest' in any sub-contractors being insured:

'If a Sub-contractor's negligent act or omission were to damage HI's property, HI may (as it did in the present case) recover its loss from the respondent. No doubt, in such circumstances, the respondent would have a right of reimbursement against the Sub-contractor under the subcontract or in tort, but that right may be of limited or no value if the Sub-contractor is uninsured';
- referring to the clauses which had been deleted from the general conditions in the head contract:

'The apparent purpose of the deletion of cl 11(a), (b) and (c) and the insertion of cl 11(d)(v) was to impose on the [Contractor], rather than HI, the obligation and expense of obtaining the insurance described in cl 11(d)(v). Nothing in cl 11(d) (as amended) and (e) precludes the respondent from negotiating with any Sub-contractor a contribution towards the expense incurred or to be incurred by the respondent in effecting and maintaining the requisite insurance.'

In considering the second ground of appeal, the Court of Appeal approached the AXA policy with a 'businesslike interpretation'. Relevantly, section V of the policy extended insurance to cover *'any person, organization or entity to whom the Insured is in writing obliged to provide insurance'*. The Court of Appeal also noted that the policy included insurance against liability for damage to the property of a third party. In finding that the Sub-contractor was covered under the AXA policy held by the Contractor, the Court of Appeal held that the obligation in writing referred to by the policy did not necessarily need to be between the insured and the 'person, organization or entity' to which the insured claimed the insurance extended (ie, the Contractor and the Sub-contractor), but could be satisfied 'if the [Contractor] has assumed an obligation in writing to a third party to provide another person, organisation or entity with insurance such as is afforded by the policy, etc.' In this case, the relevant writing was embodied in the head contract.

In late 2008, the Sub-contractor applied for special leave to appeal to the High Court. This was refused.

This decision considers issues of contractual construction, including whether the use of deleted clauses from a contract can be taken into account in determining the interpretation of other clauses. Of interest to insurers is the Court of Appeal's finding that a policy of insurance that extends to 'any person or entity to whom the insured is obliged, in writing, to obtain insurance', does not require that the obligation in writing be between the person or entity and the insured (or insurer).

'Material change' in original risk and non-disclosure

Case Name:

Scottish Coal Co Limited & Ors v Royal & Sun Alliance Insurance PLC & Ors

Citation:

[2008] EWHC 880 (Comm),
England & Wales High Court,
Commercial Division, per
Justice David Steel

Date of Judgment:

28 April 2008

Issues:

- 'Material change' in original risk
- The effect of affirming an insurance policy after becoming aware of a right to avoid the policy
- 'Reasonable steps' in safeguarding property, preventing accidents and minimising loss or damage

The owners of a coal mine made a claim under their insurance policy in respect of a roof collapse at the mine. The underwriters tried, unsuccessfully, to resist paying the claim, arguing that the coal mine owners used mining methods that had materially changed the original risk, and that they had failed to disclose this information.

The underwriters argued that the risks insured were those associated with 'conventional' long-wall mining. The roof collapse had, in fact, occurred during a 'cross-cut' mining operation and was therefore argued not to be a risk covered by the policy.

The insured submitted that the relevant risk, as defined in the policy, was that of 'impact caused by roof fall', and therefore covered all mining operations, whether or not routine or conventional.

Justice Steel accepted the insureds' submission, noting that although the decision to mine through the cross-cut may have increased the risk of 'impact caused by roof fall', this risk was nonetheless included in the impact risk cover.

The underwriters also argued that they were entitled to avoid the policy on the basis that, leading up to the renewal of the policy, the insured failed to disclose the proposal to mine through a 'cross cut'. Expert evidence was adduced to show that, although mining through a cross-cut involved some risk, it was not necessarily a high risk.

The insureds submitted that any non-disclosure of cross-cut mining was immaterial because the underwriters were only concerned about factors impacting on their maximum exposure or which gave rise to long-term risks. They were not interested, it was submitted, in 'individual transient mining operations'.

Justice Steel found that there had been a non-disclosure, but could not reach a conclusion on whether that non-disclosure had been material. Ultimately, it did not matter because, even after discovering the non-disclosure, the underwriters agreed to extend the policy, thereby affirming the contract.

Finally, Justice Steel rejected the underwriter's argument that, because the mine owners made a number of mistakes in their cross-cut mining operation, the policy could be avoided. In this case, the insured did not fail to 'take all reasonable steps to safeguard insured property', and was not reckless. Therefore, the underwriters were liable to pay the insureds' claim.

This case illustrates that, after an insurer becomes aware of a right to avoid a policy of insurance, it must be careful not to engage in conduct that could be seen as affirming the policy, as this risks waiving the right of avoidance. It also shows that the operation of 'material change in risk' clauses is limited to risks that lie outside the policy. Such clauses will not apply where the insured engages in particularly risky conduct that is nonetheless included in the risk covered.

Construction of a joint names insurance clause

Case Name:

Tyco Fire & Integrated Solutions Ltd v Rolls-Royce Motor Cars Ltd

Citation:

[2008] EWCA Civ 286, England and Wales Court of Appeal per Master of the Rolls, per Rix and Keene LLJ

Date of Judgments:

2 April 2008

Issues:

- Joint names insurance
- True construction approach

In an English case concerning joint names insurance, the Court of Appeal considered whether a joint names insurance clause relieved a contractor from liability to its employer.

Rolls-Royce Motor Cars Ltd (***Rolls-Royce***) contracted Tyco Fire & Integrated Solutions (UK) Ltd (***Tyco***) to construct fire protection systems, including a sprinkler system (the ***works***), at a Rolls-Royce manufacturing plant. Flooding occurred during construction, causing damage to the works and the existing manufacturing plant structures (the ***existing structures***). For the purposes of the case, it was assumed that this damage was due to Tyco's negligence.

Clause 2.3 of the contract expressly provided that Tyco indemnify Rolls-Royce against any damage arising from Tyco's negligence. On this basis, Tyco accepted liability for the water damage to the works.

However, Tyco argued that it was not liable to indemnify Rolls-Royce for damage to the existing structures, as clause 13.5 of the contract relieved Tyco of its liability. Clause 13.5 provided that:

'The Employer [Rolls-Royce] shall maintain, in the joint names of the Employer, the Construction Manager and others including, but not limited to, contractors, insurance of existing structures...against the risks covered by the Employer's insurance policy referred to in Schedule 2 (ie the Specified Perils)'

Schedule 2 defined 'Specified Perils' to include bursting or overflowing of water tanks and pipes.

Initially, Rolls-Royce referred its claim for damages to adjudication. The adjudicator directed Tyco to pay for the damage caused to the existing structures.

Tyco then issued a claim to recover the money that it had paid to Rolls Royce following the adjudication.

Tyco asserted that:

- clause 13.5 of the contract provided for joint names insurance and relieved Tyco of liability for its negligence; and
- on the basis of the 'rule of law' laid down in *Cooperative Retail Services Ltd v Taylor Young Partnership Ltd*⁶, one joint insured (Rolls-Royce) cannot sue another joint insured (Tyco) in respect of a risk covered by their co-insurance. In addition, Tyco argued that the insurer could not recover by way of subrogation.

The judge at first instance declared in favour of Tyco, finding that the indemnity given by Tyco in clause 2.3 should be read as subject to a 'special regime' of insurance laid down in clause 13.5 in respect of the specified perils. Therefore, clause 13.5 effectively relieved Tyco of liability to Rolls-Royce for the damage caused to the existing structures.

Rolls-Royce appealed the decision. The Court of Appeal allowed the appeal, finding that the construction of clause 13.5 did not provide for a special regime of insurance concerning the existing structures and did not limit the scope of Tyco's indemnity obligations under clause 2.3.

When considering the construction of clause 13.5, the court held that the wording of clause 13.5 that dealt with existing structures did not include Tyco, as 'others including, but not limited to, contractors' did not specifically cover the 'Contractor', (in this case, Tyco). This construction of the contract was sufficient to resolve the appeal in favour of Rolls-Royce.

However, the Court of Appeal cautiously went on to consider whether there was an overriding 'rule of law' providing that joint co-insureds cannot sue one another in respect of damage within the scope of a joint names policy.

In obiter statements, Justice Rix noted that in his view there is no such 'rule' that prevented a co-insured from suing another co-insured and that the position depends on the true construction of the underlying contract. Where the contract demonstrates the clear intention of the parties to limit liability, that limitation should prevail. When the intention is not clear, as was the case here, there is no general rule of law that limits one co-insured from suing another co-insured. The courts will need to look to the contract to determine the true position between the parties. This will also extend to an insurer suing in the name of one co-insured, by way of subrogation, subject to express waiver of subrogation rights.

As demonstrated by this case, it is important when drafting contractual clauses concerning liabilities and indemnities (particularly regarding negligence) that they are expressed clearly and are in line with joint names insurance provisions. It will also be prudent to consider dealing with waiver of subrogation.

Crash landing: no indemnity for construction faults for Sydney Airport's third runway

Case Name:

Baulderstone Hornibrook Engineering Pty Ltd v Gordian Runoff Ltd

Citation:

[2008] NSWCA 243, Supreme Court of New South Wales, Court of Appeal, per Allsop P, Beazley and Campbell JJA

Date of Judgment:

9 October 2008

Issues:

- Whether design caused construction problems with Sydney Airport's third runway
- Whether professional indemnity policy intended to cover design risks also extended to construction faults

The third runway at Sydney Airport was built (literally) on shifting sands. The NSW Court of Appeal considered who was responsible for the difficulties with the construction, and whether various policies of insurance responded to the claim.

The Federal Airports Corporation (**FAC**) (which later became the Sydney Airports Corporation Ltd (**SACL**) when Sydney Airport was privatised) engaged Baulderstone Hornibrook Engineering Pty Ltd (**BHE**) as the head contractor for the design and construction of a third runway at Sydney Airport. BHE engaged subcontractors, including Reinforced Earth Pty Ltd (**RE P/L**), for the design of reinforced earth walls on the project, and Connell Wagner NSW Pty Ltd (**CW**), to provide engineering services, including the reinforced earth walls.

At the outset of the project, FAC put in place a programme of insurance for the benefit of the contractors, broadly covering professional indemnity risks and not construction risks. The program had various layers of insurance provided by different insurers.

A dispute arose between FAC (and later SACL) and BHE about the adequacy of the construction of reinforced earth walls forming the perimeter of the third runway, and on an adjacent area, relating to subsidence of backfill. SACL sued BHE for damages. Those proceedings were settled and, as part of that settlement, BHE undertook to rectify defects at a cost of around \$60 million.

BHE claimed indemnity from its insurers in respect of its settlement with SACL. The insurers denied indemnity. Shortly before BHE finalised the settlement with SACL, it commenced proceedings against the insurers. BHE settled with each of the insurers except for Gordian Runoff Ltd (**Gordian**), CGU Insurance Ltd (**CGU**), and HIH Casualty and General Insurance Ltd (In Liquidation) (**HIH**), which provided the second, fourth, and bottom layer of insurance respectively.

The trial judge found that neither the Gordian nor the CGU policy responded, because the liability of BHE for SACL's claim against it under the design and construction contract could relevantly be described, for the purposes of the policies, as arising out of construction risks (which were uninsured) and not arising out of professional indemnity risks (which were insured).

BHE appealed to the Court of Appeal in respect of the Gordian and CGU policies, arguing that the defaults by BHE, RE P/L and CW were mandated by the contract and design documents, and therefore were of an engineering or design character, and not of a construction character. President Allsop, with whom Justices Beazley and Campbell agreed, dismissed the appeal, finding that:

- although BHE could be considered a designer of the third runway, the claim by SACL against BHE was in relation to the construction of the third runway, rather than the design;
- the policy was not enlivened even though RE P/L and CW each failed to carry out their design or engineering duties;
- the design documents did not mandate the faulty construction procedure and technique employed; and
- the failure of BHE to test and employ proper compaction and construction techniques in the hand compaction area fell within the exclusion clause relating to claims arising out of construction work.

This was a long and expensive piece of litigation that serves as a reminder – if one were needed – that policies for large construction projects can give rise to protracted and expensive court proceedings about the extent of their coverage and the construction of their terms, often leading to appeals.

Application of construction industry security of payments legislation to insurance policies

Case Name:

Zurich Specialties London Ltd v Thies Pty Ltd

Citation:

[2008] NSWSC 1010, Supreme Court of New South Wales per Bergin J

Date of Judgment:

25 September 2008

Issues:

- 'Reasonable precautions' provisions in construction risks policies in NSW

The NSW Supreme Court considered whether 'reasonable precautions to safeguard' provisions in a construction risks policy amount to a 'construction contract' for the purposes of the *Building and Construction Industry Security of Payment Act 1999 (NSW)*.

The defendant, Thies Pty Ltd, held a construction risks policy with the plaintiff, Zurich Specialties London Ltd, under which Thies was indemnified for its planning, development and construction work on Sydney's Lane Cove Tunnel. A term in the policy required the defendant to 'take and cause to be taken all reasonable precautions to safeguard' the insured subject matter under the policy and to prevent loss or damage.

Part of the tunnel collapsed during construction and, consequently, the defendant made a claim under the policy. Following unsuccessful negotiations between the parties in respect of payment of the claim, the defendant purported to serve a 'Payment Claim' notice under the *Building and Construction Industry Security of Payment Act 1999 (NSW)* (the **Act**) requiring the parties to submit their dispute to adjudication in accordance with the Act. The defendant did so on the basis that the 'reasonable precautions' term in the policy fell within the definition of a 'construction contract' in the Act, which definition includes contracts 'under which one party undertakes to carry out construction work, or to supply related goods or services, for another party'.

The court considered the 'reasonable precautions' term having regard to the commercial purpose of the policy and concluded that the term did not amount to a 'construction contract' under the Act. In particular, the court held that the term was in fact a condition in the policy pertaining to the manner in which construction work was to be carried out that had to be satisfied prior to indemnity being available to an insured; it was not an agreement by the defendant to carry out construction work for the plaintiff. Accordingly, the court found that the Act did not apply.

This decision highlights that 'reasonable precautions' provisions in construction risks policies will not amount to 'construction contracts' for the purposes of the Act because they are not agreements by the insured to carry out construction work for the insurer. Accordingly, a party to such a policy will not be able to avail itself of the adjudication mechanism in the Act in respect of disputed claims under such policies.

Employers' liability policy: the 'Trigger Litigation'

Case Name:

Durham v BAI (Run Off Limited (In Scheme of Arrangement), Fleming & Eddleston v Independent Insurance Company Limited (In Provisional Liquidation), Edwards v Excess Insurance Company Limited, Thomas Bates & Son Limited v BAI (Run Off) Limited (In Scheme of Arrangement), Akzo Nobel UK Limited & Amec PLC v Excess Insurance Company Limited, Municipal Mutual Insurance Limited v Zurich Insurance Company and Others

Citation:

[2008] EWHC 2692 (QB), England and Wales High Court, Queen's Bench Division per Burton J

Date of Judgment:

21 November 2008

Issues:

- Construction of employers' liability policies in the UK
- Meaning of 'injuries sustained' or 'diseases contracted' under UK law

In this collective hearing of six actions, together referred to as the 'Trigger Litigation', the England and Wales High Court considered how employers' liability policies should respond to the claims of victims of mesothelioma. At issue was whether cover is triggered by the date of exposure to asbestos or the date a tumour develops.

In this case, former employees who had been exposed to asbestos and their employers (the **claimants**) sought to recover from the insurers (the **defendants**) under employers' liability (**EL**) policies in respect of former employees who had developed mesothelioma as a result of being negligently exposed to asbestos during their employment.

The central question the court was asked to determine was which EL policy should respond to employee claims for damages related to exposure to asbestos causing mesothelioma: the insurer on risk when the exposure took place, or the insurer on risk when the tumour developed, up to 40 years later? To reach a decision, the court considered the policy wording, which was expressed as providing cover in respect of 'injuries sustained' or 'diseases contracted' during the policy period.

The claimants argued that the relevant negligent act was the harmful exposure of employees to asbestos, which in turn was the cause of mesothelioma and that, accordingly, the insurers on risk at the time of exposure should indemnify employers.

The defendants contended that the injury did not occur until the disease manifested itself when the mesothelioma tumour came into existence. They relied heavily on the England and Wales Court of Appeal decision in *Bolton Metropolitan Borough Council v Municipal Mutual Insurance Ltd and Commercial Union Assurance Company Limited*⁷, where the meaning of the term 'injury' was considered in a public liability insurance policy. The Court of Appeal in that case held that 'injury' for the purposes of triggering the cover under an insurance policy did not arise until such point in time as the tumour developed.

In this case, the court found in favour of the claimants, and held that the EL policies covering the period of exposure should respond to the claims. For the purposes of these policies, the court held that the words 'sustained' and 'contracted' should be construed in the same manner as a causation test; that is, they should be read as if they said 'caused'. The court acknowledged that it would

make no sense that the policies be interpreted in a manner that meant that the employees lost their right to be indemnified if they developed tumours later, when no longer employees.

The construction adopted by the court is consistent with the commercial purpose of EL policies, namely to ensure that cover is available in respect of injuries or diseases caused as a result of activities undertaken during the course of employment, or suffered as a result of the employers' negligence. The result was also consistent with public policy underpinning both *The Compensation Act 2006 (Contribution for Mesothelioma Claims) Regulations 2006 No.3259* and the *Employers' Liability (Compulsory Insurance) Act 1969 c.57* (UK), namely, that employees should be able to look to insured employers, and that an employee injured as a result of tortious exposure is covered, irrespective of what may happen afterwards.

The *Bolton* decision (which we reported on in our *2006 Annual Review*) was distinguished on the basis that EL policies are not to be interpreted in the same way as public liability policies, which are written on a 'disease occurring' basis. The court determined that it was not bound by *Bolton*, which did not consider EL wordings nor the factual matrix of EL insurance.

It is relevant to note that the court accepted the defendant's contention that in mesothelioma cases there is no 'injury' or 'disease' at the date of inhalation. While the inhalation of fibres heightens the risk of subsequent injury, the mere presence of fibres in the lungs does not constitute an injury. However, this point was ultimately irrelevant in the context of the court's construction of the EL wordings.

Leave to appeal has been granted.

This case confirms that EL policies in England specifying an 'injury sustained' or 'disease contracted' trigger for cover will respond on an 'exposure' basis to cover mesothelioma claims. The decision clearly reflects a strong desire to give claimants some avenue of recourse and avoids what has been described as a 'black hole' for the victims of mesothelioma because there is no effective EL policy in place at the date of the injury.

The mysterious case of the missing diamonds

Case Name:

McConnell Dowell Middle East LLC v Royal & Sun Alliance Insurance PLC

Citation:

[2008] VSC 501, Supreme Court of Victoria per Hansen J

Date of Judgment:

25 November 2008

Issues:

- Meaning of 'theft' in an exclusion clause
- Preservation of life extension of cover

If there are circumstances that suggest dishonest misappropriation of insured property, is that enough to be considered 'theft' under a policy exclusion? And if there is a clause that covers loss incurred in order 'to protect life', does protecting life need to be the sole cause of the loss? Justice Hansen of the Victorian Supreme Court examined these issues.

McDonnell Dowell Middle East LLC (*MacDow*) was an engineering, construction and maintenance company that entered into a joint venture with Societe Miniere Aoudou Pacco (*SMAP*) to operate a diamond mine in the Central African Republic (the *CAR*). By leasing agreements dated June 1999 and January 2000, MacDow purchased the plant and equipment and hired them to SMAP for the operation.

MacDow was insured under two construction-risks material-damage policies (the *policies*) with Royal & Sun Alliance Insurance PLC (the *Insurer*). The policies insured McDonnell's plant and equipment (among other things) in the event of an 'Occurrence', which is defined as:

an event or continuous or repeated exposure to conditions, which, during the Period of Insurance, causes or contributes to physical loss or damage...

The policies also extend to cover 'loss, damage or liability caused by or arising out of the deliberate or intentional acts by the Insured which the Insured considers reasonably necessary to protect life' (the *'preservation of life' extension*). However, the policies exclude 'loss due to disappearance or revealed by inventory shortage alone, unless such loss can be attributed to burglary and/or theft and/or any attempt thereat' (the *disappearance exclusion*). Theft is not defined in the policies.

In March 2000, diamonds went missing from the CAR mine and all of MacDow's employees in CAR were placed under house arrest pending investigation. The plant's supervisor left CAR but returned later in the year and concluded that some plant and equipment were missing from the site. None of the investigations conducted produced any meaningful results (the *first loss*).

In December 2000, MacDow decided to cease the operations and withdraw its personnel from the CAR. To this end, it requested return of, or payment for, the plant and equipment. In October 2001, plans to retrieve the plant and equipment from the operation were abandoned due to the precarious civil and political situation in the CAR (the *second loss*).

MacDow made claims under the policies for the first loss and the second loss. The Insurer denied indemnity, arguing that:

- the plant and equipment were not stolen;
- there was no 'Occurrence' within the definition above;
- even if there was an 'Occurrence', the disappearance exclusion applied; and
- for the second loss, the preservation of life extension did not apply.

In respect of the first loss, Justice Hansen found that, under the leasing agreements between MacDow and SMAP, MacDow remained the owner of the equipment. SMAP failed to accurately respond to MacDow's queries as to the whereabouts of the lost items, which amounted to 'events causing or contributing to [MacDow's] physical loss of possession of the items' within the meaning of 'Occurrence' under the policies.

On whether this claim was excluded by the disappearance exclusion, his Honour found that it was not because the first loss was due to theft. He found that 'theft' should be given a meaning by 'reference to the intentions of the parties' and that it did not need to be proven to a criminal or even civil standard. In the circumstances, it was reasonable to infer that there had been a dishonest misappropriation.

In respect of the second loss, Justice Hansen found for MacDow on similar grounds. SMAP had every opportunity to return the plant and equipment but did not do so because it or its agent dishonestly misappropriated the items. The preservation of life extension applied in this case because even though there may have been commercial factors that led to MacDow's decision not to retrieve the plant and equipment from the CAR operation, the fact that the mission would have 'carried an unacceptable risk to life' was still a motivating factor.⁸

Accordingly, the Insurer was ordered to indemnify MacDow for the first loss and the second loss.

This case confirms that reference to 'theft' in an exclusion clause does not necessarily refer to the criminal offence or the civil action. It also confirms that clauses that extend cover to loss or damage caused by the insured and necessary to protect life will apply, even if the insured's conduct was also motivated by commercial reasons.

Construction of costs extension clauses

Case Name:

Wesfarmers Federation Insurance Ltd v Stephen Wells trading as Wells Plumbing

Citation:

[2008] NSWCA 186, Supreme Court of NSW, Court of Appeal per Hodgson, Basten JJA, and Handley AJA

Date of Judgment:

11 August 2008

Issues:

- Meaning of expression 'if you are entitled to be indemnified' in costs extension clause
- Inference that insurer agrees to costs being incurred by insured

Can an insured recover legal costs under a costs extension clause in an indemnity policy even if recovery under the clause is expressed as being subject to an entitlement to be indemnified under the policy?

Stephen Wells held a business liability policy with Wesfarmers Federation Insurance (*Wesfarmers*), which insured him against liability to independent contractors but not to his employees. The policy included the following costs extension clause:

If you are entitled to be indemnified under this policy for a claim made against you, we pay the reasonable legal costs incurred with our prior written consent in defending or settling the claim.

[Emphasis added].

Mr Hubbard suffered burns while working for Mr Wells and successfully sued him in the NSW District Court, on the basis that he was injured as an independent contractor engaged by Mr Wells. In the same proceedings, Mr Wells joined the insurer in a cross-claim and the insurer was ordered to pay Wells the judgment amount and his legal costs pursuant to the policy.

On appeal, the NSW Court of Appeal found that Mr Hubbard was an employee of Mr Wells, not an independent contractor. In light of the fact that the policy did not cover Mr Wells' liability to employees, an issue considered by the court was whether the insurer was liable to indemnify Mr Wells for his legal costs under the costs extension clause, given that it was preconditioned upon Mr Wells 'being entitled to be indemnified' under the policy.

Applying the rule in *Fitzpatrick v Job*⁹, the court ruled that 'entitlement to indemnity' in the costs extension clause meant 'entitlement to indemnity with respect to claims made by the claimant against the insured'. Accordingly, on the basis that Mr Hubbard's statement of claim alleged that he was 'engaged as an independent contractor', the insurer was liable to indemnify Mr Wells for his legal costs pursuant to the costs extension clause. However, the court indicated that this finding would have been different if the costs extension clause had been expressed to be conditional upon the establishment of 'legal liability for which the insured is entitled to be indemnified under this policy'.

Another issue considered by the court was whether the insurer had consented to Mr Wells incurring legal costs, as required under the costs extension clause. Relevantly, the insurer appointed lawyers to protect Mr Wells from Mr Hubbard's

claim, and the lawyers wrote to Mr Wells to advise him that Wesfarmers denied indemnity but that he should obtain other legal representation. On the basis of that correspondence between the lawyers and Mr Wells, the court drew an inference that the insurer consented to Mr Wells incurring legal costs in defending the proceedings and found, therefore, that the insurer was liable to pay Mr Wells' legal costs in defending the District Court proceedings.

This case illustrates that insurers need to check carefully the wording of costs extension clauses to make sure that they reflect their intended meaning. If the intention is to reimburse the insured for legal costs only if primary liability is established, the drafting should make this clear. The case also highlights that, when drafting letters denying indemnity, insurers must be careful to avoid inadvertently implying that they consent to covering the insured's legal costs.

Dual insurance contributions by a third-party insurer

Case Name:

GIO General Limited v Insurance Australia Ltd trading as NRMA Insurance

Citation:

[2008] ACTSC 38, Supreme Court of the Australian Capital Territory per Harper J

Date of Judgment:

24 April 2008

Issues:

- Scope of dual insurance

In this case, the Supreme Court of the ACT ordered a third-party insurer to contribute half the amount recovered for a personal injury claim against an employer's insurer. Essential to the concept of dual insurance is that both policies indemnify the assured against the same loss.

Mr Gary Gray, an employee of Andre Herzog Pty Ltd (**Herzog**), was injured while unloading steel beams from a company truck. Asserting failure to provide a safe system of work, Mr Gray was awarded \$192,687 in compensation. Herzog was insured by GIO General Ltd (**GIO**) for liability to pay compensation to employees under the *Workers Compensation Act 1951* (ACT). Accordingly, Herzog was entitled to indemnity by GIO in relation to Mr Gray's claim.

Herzog was also insured by the defendant, Insurance Australia Limited trading as NRMA Insurance (**NRMA**) as the registered owner of the truck involved in Mr Gray's injury. GIO sought contribution towards the judgment obtained against Herzog, asserting that NRMA was liable to pay 50 per cent of Mr Gray's damages because the injury arose out of the use of the truck. This assertion was made on the basis that Herzog had dual insurance in relation to Mr Gray's injury.

According to Justice Harper:

- Dual insurance applies when two or more insurers cover the same interest against the same risk.
- The liability need not arise from the same type of policy.
- It is essential that each policy indemnifies the same assured in respect of the same loss.

In this case, each of the elements were satisfied in relation to Mr Gray's injury, and dual insurance applied.

NRMA submitted that liability of a third-party insurer in respect of Mr Gray's claim could not arise because the claim did not mention negligence in relation to the truck. Justice Harper rejected this submission, on the basis that the manner in which Mr Gray's claim against the employer and vehicle owner was framed was immaterial to the issue of whether or not dual insurance applied. The entitlement of the third-party insurer to contribution could not be defeated by an act over which it had no control, namely the decision of the injured person to sue the driver.

Justice Harper found that GIO was entitled to recover from NRMA one half of the amount recovered by Mr Gray from Herzog, a total of \$96,343.

This case demonstrates the operation of dual insurance where two or more insurers cover the same interest against the same risk. Where these conditions are satisfied, it is likely that each insurer will be required to contribute to the insured loss.

Double insurance: only available when indemnity for same insured for the same risk

Case Name:

Collyear v CGU Insurance Ltd

Citation:

[2008] NSWCA 92, Supreme Court of New South Wales, Court of Appeal per Giles, Hodgson JJA and Handley AJA

Date of Judgment:

15 May 2008

Issue:

- Availability of doctrine of contribution to an insurer where a policy of insurance covers two insureds and only one makes a claim.

The NSW Court of Appeal considered the well-established principles guiding contribution and double insurance, and rejected the proposition that those principles should apply where policies of insurance covered different persons for different risks.

Emibarb Pty Ltd (**Emibarb**) conducted a restaurant business pursuant to a lease (the lease) from the Stuart Park Reserve Trust (the **Trustee**). Wollongong City Council (the **Council**) managed that trust. The restaurant was destroyed by a fire on 9 January 2001.

Emibarb had a policy with Lloyds that covered its interest as lessee, and extended to Emibarb's liability under the lease to reinstate the premises. The Lloyds policy also covered the Trustee's interest as lessor, and required Lloyds to indemnify the Trustee in the event of damage to the premises.

The Council had a policy with CGU, which covered the Council against damage to the premises. The CGU policy did not insure Emibarb's interest as lessee or its obligation of reinstatement.

Emibarb reinstated the destroyed premises, claimed under the Lloyds policy and received \$3.75 million in full settlement. Lloyds claimed contribution from CGU on the principle of double insurance. The claim was dismissed at first instance and Lloyds appealed.

The issue before the Court of Appeal was whether CGU should contribute to the \$3.75 million on the basis of the double insurance principle. Justice Hodgson and Acting Justice Handley (with each of whom Justice Giles agreed) delivered separate judgments, each deciding that the double insurance principle did not apply. It was held that double insurance covers only situations where each insurer must indemnify the same insured in relation to the same risk. Although each policy covered the risk to the Trustee, the Lloyd's policy covered a different risk in relation to Emibarb: namely, the risk that Emibarb would need to reinstate the premises. It was in respect of that different risk that the settlement payment was made to Emibarb. In addition, the Trustee's loss had been eliminated by Emibarb's reinstatement of the premises. The court held that the requirements of the double insurance doctrine had not been made out, and that Lloyds was not entitled to contribution from CGU. The appeal was dismissed.

This case is a reminder of the requirements that must be met before an insurer will be able to look to another insurer for contribution under the double insurance principle. This decision should be of interest to all insurers who might be able to avail themselves of double insurance.

Double insurance: equitable contribution and indemnification payments

Case Name:

Insurance Australia Limited v HIH Casualty & General Insurance Ltd (in liquidation)

Citation:

[2007] VSCA 223, Supreme Court of Victoria, Court of Appeal, per Chernov, Ashley and Redlich JJA

Date of Judgments:

18 October 2007

Issues:

- Nature of a contract of insurance
- Classification of indemnification payments versus benefit payments
- Double insurance and indemnification of the same risk

In a case concerning double insurance, the Victorian Supreme Court of Appeal considered whether payments made under a government scheme set up to assist those disadvantaged by the HIH collapse are indemnification payments, or merely a benefit.

In 1998, Screenco Pty Ltd (**Screenco**) entered into a contract with the Australian Grand Prix Corporation (**AGPC**) to erect scaffolding. Screenco subcontracted this work to another company, RL Dew & Co Pty Ltd (**Dew**), which further subcontracted the work out to Mr Steele.

Mr Steele erected the scaffolding. However, in March 1998, while in use, a section of the scaffolding collapsed, causing a large video screen it had been supporting to fall and be destroyed.

Screenco brought proceedings against Mr Steele in the NSW Supreme Court for breach of contract (in the sum of \$1.5 million plus costs). The court found Mr Steele and Dew liable for 100 per cent of the damage. In contribution proceedings between Dew and Mr Steele, Mr Steele was held liable for 100 per cent of the amount.

Mr Steele was insured under a policy provided by the HIH Group (**HIH**). In addition, the AGPC and its employees, contractors and subcontractors (including Mr Steele), were insured under a policy issued by Insurance Australia Ltd (formerly SGIC General Insurance Ltd) (**SGIC**).

Before HIH went into liquidation in August 2001, it accepted liability for Mr Steele and paid \$80,000 towards his defence costs in the NSW proceedings. Following HIH's liquidation, the Commonwealth Government set up a support scheme (the **scheme**) to assist those disadvantaged by the collapse of HIH, administered by a not-for-profit company called HIH Claims Support Ltd (**HCSL**). Using funds from the scheme, HCSL paid 90 per cent of Mr Steele's judgment sum and legal costs, amounting to \$1.3 million. In return for this payment, Mr Steele assigned his rights under the HIH policy to HCSL.

Mr Steele and HIH then brought proceedings in Victoria against SGIC. HIH claimed equitable contribution from SGIC for the \$80,000 that it paid in defence costs, on the basis that HIH and SGIC had both insured Mr Steele for the same event (double insurance). Mr Steele claimed entitlement to indemnification payments by SGIC, for the NSW judgment sum and costs.

SGIC argued it was not liable:

- for either of the claims because an SGIC policy exclusion clause applied, excluding the event from any SGIC insurance cover; or
- for the judgment sum and costs, as HCSL had already indemnified Mr Steele for those payments.

At first instance, the Supreme Court held that no exclusion clause applied and HIH was entitled to equitable contribution from SGIC for 50 per cent of the \$80,000. In addition, the trial judge held that Mr Steele's contract with HCSL was not a contract of insurance. The trial judge further held that the payments were not indemnification payments; rather, they were benefits provided by the Federal Government to alleviate loss caused by the HIH collapse. Therefore, as the HCSL payments did not constitute indemnity, Mr Steele was entitled to claim his judgment sum and costs under the SGIC policy.

The Court of Appeal upheld the trial judge's finding that no exclusion clause applied. Therefore, SGIC remained liable for \$40,000 in equitable contribution to HIH.

The Court of Appeal also upheld the trial judge's finding that there was no contract of insurance, as the three broad requirements set out in *Prudential Insurance Co v Commissioner of Inland Revenue*¹⁰ were not established. The requirements included:

- an agreement, for consideration, to provide a benefit, upon the happening of an event;
- an uncertainty as to when, if at all, the event will occur; and
- a risk of the insured suffering loss.

The court held that, as the event had already taken place when Mr Steele and HCSL entered into the agreement, and as the payments under the scheme were of a discretionary nature, the event was not *uncertain*. In addition, the assignment of rights by Mr Steele to HCSL did not amount to payment of a premium (the usual form of consideration paid for insurance contracts) for the HCSL payments.

However, the court found that the payments by HCSL were indemnification payments and not merely a 'merciful' benefit. Reasoning behind this finding included:

- the payments effectively indemnified Mr Steele's liability in the NSW proceedings;
- the businesslike quality and contractual nature of the scheme;
- payments under the scheme were provided by reference to the amount awarded against Steele in the NSW judgment; and
- the payments were not a 'provision of social services or public benevolence or "no strings attached" government relief in the face of natural disaster'.

As HCSL's payments were characterised as indemnity payments, Mr Steele could not seek a further indemnification from SGIC, as this would have resulted in double insurance. Therefore, Mr Steele was unsuccessful in his claim against SGIC for payment of his judgment sum and costs. The court went further to note that double insurance also restricted HCSL from exercising a right of subrogation to sue SGIC for the monies paid. Importantly, the court did leave open the possibility of HCSL bringing a claim in its own name against SGIC for contribution to the \$1.3 million HCSL paid to Mr Steele.

As was the case here, where double insurance exists, the insured cannot seek full indemnification from both insurers for the same risk, as an insured can only be indemnified once. However, the judgment suggests that where one insurer pays for the insured's loss, that insurer may seek contribution from the other insurer.

The ability of an insurer to join a third party to action

Case Name:

The Owners Strata Plan 66601 v Majestic Constructions Pty Ltd & Ors

Citation:

[2008] NSWSC 735, Supreme Court of New South Wales per Rein J

Date of Judgment:

18 July 2008

Issues:

- Rights of an insurer when a plaintiff insured resists joining a third party to an action
- Must an insurer grant full indemnity as a precondition for the joining of the third party?

In this case, Justice Rein considered the nature of the rights of subrogation held by the insurer and the circumstances in which an insurer should be entitled to compel an insured to join a third party to an action.

The plaintiff was insured under a building owner's warranty policy (the *policy*) by Allianz. The insured claimed under the policy for the cost of rectification works to correct alleged building defects to the value of \$2 million. Allianz disputed the claim. The plaintiff then commenced proceedings against the builders, Allianz and the developers. After having commenced a cross claim against a firm of engineers, JDT Design Pty Ltd (*JDT*), who were involved in the design of the building, the builders and developers went into liquidation.

Concerned that any claim the plaintiff might have against JDT would become time-barred, Allianz requested that the plaintiff commence proceedings against the engineers. In return, Allianz offered to admit liability under the policy to the value of \$50,000 and to indemnify the plaintiff in respect of any costs orders made against it. The plaintiff refused. Allianz then applied to the court for an order that the plaintiff join JDT.

Justice Rein heard the application and decided that Allianz was not entitled to the order for joinder of JDT. Justice Rein confirmed the general common law position that the right of subrogation cannot be exercised until the insurer has fully indemnified the insured. The judge found that the subrogation clause in question altered this general common law position by requiring that Allianz 'accept liability in respect of a claim' before it was entitled to such rights. However, by paying \$50,000, that is, a portion of the claim, Allianz had not met the requirements of the clause and consequently was not entitled to exercise the subrogation rights.

In his judgment, Justice Rein expressed disapproval of the reasoning of Justice Cole in *Leighton Contractors Pty Ltd v CE Heath Underwriting*¹¹, in which he indicated that an insurer was not required to fully indemnify the insured prior to insisting that the insured join a third party. Justice Rein instead confirmed that an insured is not required to take positive action in respect of the insurer's position prior to full indemnity. This view suggests that Justice Cole's treatment of this issue was out of step with the trend of judicial authority, thereby providing greater certainty for the insurance industry. However, Justice Rein did note that the assessment might differ where, for example, the claim had been lodged shortly before the expiry of the limitation period and the insurer needed time to consider the claim.

¹¹ 27 March 1992, Unreported decision, the Supreme Court of NSW, Cole J

This case demonstrates the tensions caused by the competing interests of the subrogated insurer and the insured, and the difficulties encountered by the courts in determining the appropriate course for litigation when weighing up these interests. Insurers should be aware of these issues when drafting subrogation clauses and taking steps to exercise their rights of subrogation.

Contribution between insurers

Case Name:

Lumley General Insurance Ltd v QBE Insurance (Aust) Ltd

Citation:

[2008] VSC 216, Supreme Court of Victoria per Pagone J

Date of Judgment:

24 June 2008

Issues:

- Contribution between insurers
- Same risk insured by two insurers

In an application for contribution between insurers, the Victorian Supreme Court considered whether the same risk was covered by both insurers. The court held that it was. A right of contribution between insurers exists where two or more insurers are liable in respect of the same loss, such that both insurers would be required to indemnify the assured.

A dispute arose in relation to an accident that occurred during fit-out works of a commercial office by Probuild Constructions (Aust) Pty Ltd (the **contractor**). During the works, an employee of a subcontractor, Commercial Interiors Australia Pty Ltd (the **subcontractor**), dislodged a sprinkler head, causing significant damage to the premises. The subcontractor was insured by QBE Insurance (Australia) Ltd (**QBE**) and the contractor by Lumley General Insurance Ltd (**Lumley**). Lumley paid the claim by the subcontractor and sought contribution from QBE.

QBE denied any obligation to contribute, arguing that the subcontractor who made the claim on the Lumley policy was not the insured, and that any payment made by Lumley was voluntary and not in discharge of any liability of the subcontractor under the Lumley policy. It further submitted that 'true' double insurance required that the subcontractor had authorised or ratified the Lumley policy.

The court observed that contribution between insurers arises where a person is insured against substantially the same risk by two independent insurers. Referring to the judgment of Justice Sackville in *Drayton v Martin*¹², Justice Pagone noted that an insurer under an indemnity policy seeking contribution from a co-insurer must establish that:

- it is liable to indemnify the insured under its own policy;
- it has paid out sums in respect of that liability;
- the co-insurer is also liable under its policy to indemnify the insured; and
- the co-insurer has not paid out monies to meet its liability to the insured.

Each of those four elements was satisfied in the present case. The Lumley policy included the subcontractor as an insured and Lumley had paid the claim, while QBE was also liable under its policy to indemnify the subcontractor, and it had not done so.

Justice Pagone dismissed each of QBE's arguments. Lumley was obliged to indemnify the subcontractor under the Lumley policy; it was not necessary that the

subcontractor make a separate claim under its own policy. The subcontractor was an 'insured' within the meaning of the Lumley policy. In all correspondence between the parties, it was clear that the claim was compensation for damage caused by the subcontractor within the terms of the policy.

The court also made clear that it was not necessary for the subcontractor to have authorised or ratified the Lumley policy, as these requirements are no longer relevant since the enactment of sections 48 and 76 of the *Insurance Contracts Act 1984* (Cth).

This case confirms that an insurer will be entitled to a contribution from another insurer only where the two insurers cover the same risk and payment by one discharges the other's liability. In such circumstances, where one insurer has an obligation under an insurance policy to indemnify the insured, so too does the other.

The scope of an insurance broker's duty of care and skill

Case Name:

Tosich & Anor v Tasman Investment Management Limited & Ors

Citation:

[2008] FCA 377, Federal Court of Australia per Gyles J

Date of Judgment:

20 March 2008

Issues:

- Whether there had been a breach of an insurance broker's duty to use due care and skill in procuring cover
- Whether the relevant cover would have been obtained in the absence of a breach of duty

The court considered the scope of an insurance broker's duty to procure appropriate cover for its client, and whether the relevant cover would have been obtained in the absence of a breach of duty.

On the advice of his financial planner, Tasman Investment Management Limited (*Tasman*), Mr Tosich made an investment that failed. Tosich sued Tasman for his loss. Tasman brought a cross-claim against its insurer and its broker, Aon Risk Services Australia Limited (*Aon*).

The court found in favour of Tosich and proceeded to consider Tasman's cross-claim for indemnity. As Tasman's policy did not cover the advice to Tosich, it became necessary to consider whether Aon breached its retainer by not taking reasonable steps to procure adequate professional indemnity cover for Tasman.

Tasman had professional indemnity cover with Macquarie Underwriting that had expired in March 2002. By that time, due to a reorganisation of the corporate group, Tasman was no longer engaged in financial planning and advisory services. However, the court found that Aon, as a broker, had breached its duty to exercise due care and skill in arranging insurance cover because it failed to raise the need for cover for previous financial planning and advisory activities that Tasman had undertaken (*run-off cover*).

In assessing Tasman's loss, Justice Gyles found it likely that run-off cover would have been available from Macquarie Underwriting. However, Aon argued that if Tasman had complied with its statutory duties of disclosure, it would not have been indemnified by Macquarie Underwriting for claims arising from the failed investment.

Aon did not lead evidence from Macquarie Underwriting as to the relevance and significance of the discloseable matters, and the court held that evidence from other insurers had little, if any, probative value. Justice Gyles determined that Tasman's cross-claim against Aon was successful.

This case is relevant to insurance brokers, as it illustrates the broad scope of a broker's duty to use due care and skill.

A reminder to take care to avoid slip-ups during placement

Case Name:

Dunlop Haywards (DHL) Limited & Anor v Erinaceous Insurance Services Limited & Anor

Citation:

[2008] EWHC 520 (Comm), England and Wales High Court, Commercial Division, per Mr Justice Field

Date of Judgment:

1 April 2008

Issues:

- Broker duty of care
- Construction of policy terms where placement documents are inconsistent
- Rectification of an insurance policy

The English High Court considered several issues of interest to brokers: in particular, the responsibility of brokers and sub-brokers to check contractual documents for inconsistencies during the entire placement process.

Dunlop Haywards (DHL) Limited (*DHL*), a property consultancy business, obtained primary and excess layer professional indemnity cover in 2005. This cover was placed into the London market by a sub-broker engaged by its broker, Erinaceous Insurance Services Limited (*Erinaceous*). The excess layer policy contained a condition limiting the cover to liabilities arising out of DHL's commercial property management activities, but the primary layer policy did not.

DHL subsequently faced exposure to a number of claims for compensation arising out of property valuations it had conducted that had the potential to affect its excess layer. Following notification, the excess layer underwriters denied liability to indemnify, on the ground that a valuation was not a commercial-property management activity. DHL proceeded to sue its brokers, who defended the claim on the basis that it disagreed with the underwriters' interpretation of the excess policy and, in the alternative, argued that the policy should be rectified. The broker also joined the sub-broker as a cross-defendant.

The court was asked to determine two pre-trial applications. The first application was made by the broker to join the excess layer underwriters as defendants, so that they would be bound by the court's ultimate decision on the meaning of the policy and the rectification defence. The second was brought by the sub-broker, who sought to have the cross-claim against them either dismissed or determined summarily in their favour.

The first of the two applications focused on the merits of the broker's defence based on rectification. Under English law (which broadly reflects the position under Australian law), rectification will be granted if there is clear evidence that the parties to an agreement held a common intention in relation to a particular provision, at the time the agreement was entered into, which the written agreement does not accurately represent.

The argument here centred on determining the relevant date by which a common intention had to be shown. Was it: the date when the underwriters endorsed the quotation sheet with a 'FON' (firm order noted'); was it when the underwriters scratched the slip for the excess layer the following month; or was it when the policy document was eventually issued? This was important because the limiting condition of the excess cover was first introduced in the slip.

Following established authority, the court held that the terms of a contract between an insured and insurer in the London market are contained in the slip. Therefore, even though the underwriters were bound to the quotation when it was endorsed by them, the subsequent slip effected a binding variation of its terms.

The court held that the evidence as to rectification was so weak (in that the slip demonstrated there was no common intention not to limit the terms of the excess cover) that the underwriters should not be joined to the proceedings. This weakness, and the fact that DHL's right to indemnity had not yet arisen, outweighed what the court regarded as the real prospect of success that the broker would be likely to have with their separate defence based on construing a valuation as a commercial property management activity.

The second of the two applications was also dismissed. The court agreed with Erinceous that it had a good, arguable case for indemnity or contribution against the sub-broker in the event that it lost the proceedings. This arose mainly from the fact the sub-broker was instructed to place cover on no less favourable terms than the expiring cover and did not identify the discrepancy between the quotation and the terms of the slip prior to its scratching.

The result of these pre-trial applications should remind brokers that the courts in England and Wales (and in Australia) will require them to be vigilant during the placement process to ensure that the terms of a draft slip match the terms of previous quotations and, more generally, meet the insured's overall requirements for cover. As well as exposing themselves to contractual liability to their instructing broker if they do not discharge their duties, sub-brokers should also be mindful of the potential to owe a direct duty of care to an insured, following the 2006 decision of the English High Court in *BP plc v Aon Limited*.¹³

Liability of insured for misrepresentations of its broker

Case Name:

*Limit No 2 Ltd v AXA
Versicherung AG*

Citation:

[2008] EWCA Civ 1231,
England and Wales Court of
Appeal per Longmore, Jackson
& Ward LJJ

Date of Judgment:

12 November 2008

Issues:

- Whether reinsurers are entitled to avoid reinsurance treaties on the basis of representations made by reinsurance brokers without the reinsurers' knowledge
- How long such representations will remain effective

The England and Wales Court of Appeal reinforced the position that an insured/reinsured will be bound by representations made by its broker. The court also held that a representation made in relation to one contract will not apply to the new contract created on renewal.

In 1996, the respondent reinsurers (**AXA**) were approached via fax by reinsurance brokers of the appellant syndicates managed by Limit (the **syndicates**) and offered participation on a first loss facultative/obligation reinsurance treaty protecting the syndicates' energy accounts. The fax cover sheet said that the syndicates, as a matter of principle, maintained high standards and would not normally write construction risks unless the original deductible was at least £500,000 and preferably £1,000,000 (the **representation**). The reinsurers wrote the treaty for a 12-month period, effective 1 July 1996, and later agreed to an extension by an endorsement for another seven months before renewing the treaty for a further 12-month period (together, **the treaties**). In 2005, the reinsurers undertook an investigation of the treaties, which had been loss-making, and discovered that the syndicates had been ceding risks with deductibles typically in the range of £100,000–£200,000.

The reinsurers sought to avoid the treaties, on the grounds of misrepresentation and non-disclosure of material facts. The syndicates argued that no representation had been made and that the fax cover sheet was merely 'broker waffle'. The syndicates argued in the alternative that any representation in relation to the 1996 treaty did not extend to the seven-month endorsement or to the renewal.

At first instance, the court held that the reinsurers were entitled to take the broker's statement at face value and not as mere bluster. The representation was a statement of the syndicates' policy regarding deductibles and was incorrect. It was held to have been a misrepresentation that was material and that had induced the 1996 treaty. The court held that the misrepresentation was continuing at the time of the endorsement and renewal. The reinsurers were, therefore, entitled to avoid the treaties.

The Court of Appeal unanimously held that the reinsurers were entitled to avoid the 1996 treaty and the endorsement extending that treaty, holding that the representation remained effective when the original treaty was extended because the endorsement merely amended the original contract. However, Lord Justice Longmore, delivering the lead judgment, held that the representation was not impliedly repeated on renewal and, as a consequence, the 1998 treaty was not voidable. In reaching this conclusion, Lord Justice Longmore emphasised how powerful the remedy of avoidance is in the hands of an insurer or reinsurer stating:

'The entirety of a contract can be avoided for a wholly innocent misrepresentation provided it is material to the risk in the eyes of a prudent underwriter'.

This case illustrates the need for insurers and reinsurers to be diligent in monitoring representations made by their brokers and to ensure that these are accurate. It also highlights that representations made upon entering a contract will not necessarily continue upon renewal.

Relationship between 'back to back' insurance and reinsurance contracts

Case Name:

Wasa International Insurance Company Ltd & Anor v Lexington Insurance Company

Citation:

[2008] EWCA Civ 150 (Comm), England and Wales Court of Appeal, Commercial Division, per Pill, Sedley and Longmore LJ

Date of Judgment:

29 February 2008

Issues:

- Are insurers and reinsurers only liable to make payments in respect of property damage that occurs during the term of the insurance policy?
- When will a reinsurance contract be considered 'back to back' with an insurance contract?
- Will English courts depart from a foreign jurisdiction's interpretation of an insurance contract when interpreting a 'back to back' reinsurance contract?

In this case, the English Court of Appeal considered the liability of English reinsurers to a claim made by an American reinsured. The main issue was whether the court should apply to the reinsurance contract the same interpretation that an American court had applied to the insurance contract. After concluding that the contracts were back to back, Justice Steel applied the American interpretation, notwithstanding its difference to English law.

In the 1990s, the US Environmental Protection Agency required the Aluminium Company of America (*Alcoa*) to clean up pollution at numerous manufacturing sites. Some sites had a history of pollution going back to the end of World War II.

Alcoa undertook the clean-up and sought to recover its costs from its insurers. The insurers declined indemnity and Alcoa instituted proceedings for its costs against Lexington Insurance Company (*Lexington*). Lexington had insured Alcoa for property damage between 1 July 1977 and 1 July 1980. The Supreme Court of Washington, applying the laws of Pennsylvania, held that Lexington was liable to Alcoa for all of the damage, notwithstanding that some had occurred before and after the relevant three-year insurance policy period.

Lexington settled Alcoa's claim, and subsequently made a claim for the clean-up costs to their English reinsurers, Wasa International Insurance Company Ltd and AGF Insurance Ltd (the *Reinsurers*).

The Reinsurers resisted the claim, arguing that as a matter of English law, they were only liable for an amount remedying the damage that occurred between 1 July 1977 and 1 July 1980.

Lexington argued that, although the original insurance contract was regulated by US law, and the reinsurance contract by English law, the contracts were intended to be 'back to back'. Therefore the presumed intention of the parties to the reinsurance must have been for the reinsurance contracts to have the same meaning as the insurance contract.

Lord Justice Longmore concluded that because of the similar use of wording in the reinsurance and insurance contracts, the parties intended for them to have the same meaning. Therefore, the meaning of the reinsurance contract period necessarily followed the meaning that had been given to the insurance contract period in the United States and Lexington's appeal was allowed.

This case illustrates that English courts will give effect to 'back to back' contracts, even where differences exist in the wording between the insurance and reinsurance contract. Where contracts are 'back to back', it is unlikely that an English court will depart from a foreign jurisdiction's interpretation of an insurance contract when interpreting the reinsurance contract. Therefore, reinsurers will no longer be able to escape reinsurance claims by relying on interpretation differences between foreign and English courts.

Judicial cooperation in cross-border insolvencies

Case Name:

McGrath & Anor v Riddell & Ors

Citation:

[2008] UKHL 21, United Kingdom House of Lords per Lord Hoffman, Lord Phillips of Worth Matravers, Lord Scott of Foscote, Lord Walker of Gestingthorpe & Lord Neuberger of Abbotsbury.

Date of Judgment:

9 April 2008

Issues:

- Judicial cooperation in cross-border insolvencies
- Letters of request

In the winding up of the HIH group of companies, the Supreme Court of NSW sent a letter to the English court requesting the court's assistance to the Australian liquidators in their requests for the English provisional liquidators of HIH to remit English assets to Australia for distribution in accordance with Australian rules. Overturning the first instance and Court of Appeal decisions, the House of Lords has acceded to that letter of request.

In winding up, Australian law (unlike English law at the time) gives priority to insurance creditors in respect of reinsurance recoveries made by the insurance company. The assets in England were largely the proceeds of reinsurance claims on policies taken out in London. Those English assets will now be distributed in accordance with the Australian statutory scheme, which is to the benefit of insurance creditors of the HIH group as a whole.

Provisional liquidators were appointed to HIH and three associated companies on 27 August 2001 by the Supreme Court of NSW. The court requested the High Court in England to appoint provisional liquidators to the same companies and this was agreed.

At first instance, the English High Court held that it did not have power to remit the English assets to Australia in circumstances where the Australian scheme for distribution was different to that which applied in England (the difference being the priority afforded to insurance creditors). That decision was appealed to the Court of Appeal, which held that it did have the power to remit the assets to Australia but it declined to exercise its discretion to do so, as that would have prejudiced the interests of non-insurance creditors. The provisional liquidators appealed to the House of Lords.

In considering whether it had the power to remit the assets to Australia, the House of Lords considered two possible bases for that authority:

1. Comity and general principles of private international law

The court noted a general principle that there should be a single insolvency administration in the court of the insolvent company's domicile that is recognised worldwide and applied to all the bankrupt's assets. Two members of the House of Lords held that the court did have jurisdiction at common law to direct remittal of English assets, notwithstanding that they might be distributed otherwise than in accordance with the English statutory scheme. Two members held that the inherent jurisdiction of the court was not sufficient to enable the court to remit English assets abroad where the distribution of those assets would not be in accordance with the English insolvency regime. The fifth judge declined to resolve the question.

2. Letters of request

Section 426 of the English *Insolvency Act 1986* gives a court with jurisdiction in relation to insolvency law the power to assist other courts with a corresponding jurisdiction in any relevant country (Australia having been designated as a relevant country). A request for assistance having been made, the House of Lords held unanimously that s426 did give the court the power to remit assets to Australia, notwithstanding the differences in the schemes for distribution in the two countries.

That left the question of whether the House of Lords should exercise its discretion to order the remittal of those assets. The Australian scheme for the distribution of assets of an insolvent insurance company is different to that which applied in England at the relevant time in the following respects:

- s562A *Corporations Act 2001* (Cth) (the **Corporations Act**) gives priority to insurance creditors in respect of reinsurance recoveries made by an insurance company; and
- s116(3) *Insurance Act 1973* (Cth) (the **Insurance Act**) provides that assets in Australia at the time of the winding up should be applied to liabilities in Australia in priority to liabilities that are not in Australia.

As the English assets were not 'assets in Australia' at the time of winding up, they were not caught by s116(3) of the Insurance Act. The relevant difference in the statutory schemes for distribution was the priority afforded to insurance creditors by s562A of the Corporations Act. In the event that assets were remitted to Australia, insurance and reinsurance creditors as a whole would benefit at the expense of other creditors.

The House of Lords held unanimously that the court should exercise its authority to remit the English assets to Australia. It noted a number of factors relevant to the exercise of that discretion:

- there is nothing unacceptably discriminatory or otherwise contrary to public policy in the Australian statutory provisions;
- the English insolvency regime now includes very similar preferential provisions for insurance companies to those that apply in Australia, so it could not be said that the Australian law offends English principles of justice;
- different countries inevitably have slightly different categories of preferential creditors, but that is not a bar to an order for remittal; and
- given that creditors had been dealing with an Australian insurance company, the application of Australian law to the distribution of assets was more likely to give effect to the expectations of creditors as a whole than the distribution of some assets according to English law.

The House of Lords noted the desirability of a universal, rather than territorial, approach to cross-border insolvency, with all of the assets of an insolvent company being distributed in accordance with rules of its home jurisdiction. This is consistent with the principles behind the Model Law on Cross-Border Insolvency developed by the United Nations Commission on International Trade Law. Legislation seeking to implement the Model Law has been passed by both houses of parliament in Australia and is awaiting Royal Assent.

The case also illustrates the importance of a letter of request in a cross-border insolvency. The House of Lords was divided as to whether it has the power at common law to order the remittal of assets in the absence of such a request from a country that was not a prescribed country.

In Australia, s581(2)(a) of the Corporations Act contains similar provisions to s426(4) of the Insolvency Act in the UK. Accordingly, the decision is likely to be influential in the event that:

- the court receives a letter of request from a prescribed country and is considering whether to comply with that request; or
- receives an application from foreign liquidators seeking assistance without a letter of request.

However, s581(2)(b) of the Corporations Act provides that the Australian court may act in aid of a court in a non-prescribed country, so the issue of whether any common law power to direct the remittal of assets abroad if a request is received from a non-prescribed country would not arise.

The earlier first instance and Court of Appeal decisions had been very important in forming the thinking of the Australian Prudential & Regulatory Authority (**APRA**) in relation to its proposals for strengthening the capital requirements applicable to offshore reinsurance arrangements. Although APRA has shifted its position in relation to its requirements for holding capital in respect of reinsurance recoverables (APRA announced the change on 2 April 2008), it appears to retain the view that reinsurance arrangements should be subject to Australian law, that there should be a submission to Australian jurisdiction, and that the contract should expressly provide for payment in Australia.

The decision removes some of the concerns raised by APRA, particularly in relation to reinsurance placed in the London market where the fact that the recoverable was payable in the UK had led to the proposition that, under private international law, the debt resided in the UK. However, it does not mean that a similar issue will not arise with a different result in another jurisdiction, and it indicates some of the problems in global markets for the alignment of domestic prudential regulation protecting local policyholders when overseas jurisdictions have their own insolvency laws. It also highlights, perhaps, the need for the private international law rules relating to the location of a debt to be further considered by our courts, and by the courts in those other jurisdictions where reinsurances are likely to be placed. In the meantime, the APRA contractual requirements would appear to aid local insurers in relation to any future, like dispute. This decision represents the adoption of a universalist approach to cross-border issues in common law countries that have similar 'letter of request' legislation.

Effect of a denial of liability on claims cooperation clauses

Case Name:

Lexington Insurance Company & Others v Multinacional de Seguros SA

Citation:

[2008] EWHC 1170 (Comm), High Court of England & Wales, Commercial Division, per Clarke J

Date of Judgment:

23 May 2008

Issues:

- Whether repudiation of liability based on breach of a clause waives any right to later rely on that clause
- Construction of cooperation clauses

The English Commercial Court considered whether a breach of a condition precedent, which required cooperation between a reinsurer and the reinsured when dealing with a claim, could be waived by a denial of liability, based on the breach either as a waiver by election or as a matter of construction.

The insured, a Venezuelan company, made a claim against its insurer, Multinacional de Seguros S.A. (*Multinacional*) under a property and business interruption policy. That policy was reinsured by Lexington Insurance Company (*Lexington*), such that Multinacional was required to cooperate with Lexington in the adjustment and settlement of the claim.

Lexington alleged two breaches of the cooperation policy by Multinacional: first, by failing to produce technical evidence to support its view that the loss adjusters incorrectly concluded that the insured had failed to mitigate its loss (*first breach*); and second, by expressly excluding the defence that the claim was time-barred, despite Lexington's intention to use the defence (*second breach*).

Following the first breach, Lexington sent Multinacional a letter stating that Lexington was discharged from liability because Multinacional had breached the cooperation clause. At the same time, Lexington expressed its desire to continue cooperating to resolve the claim in a 'sensible and commercial' manner. The two parties continued to cooperate between the first breach and the second breach. Multinacional argued before the court that Lexington's denial of liability meant there was no room for the cooperation clause to continue.

Justice Clarke held that Lexington's repudiation of liability did not waive its right to later rely on the cooperation clause because the doctrine of waiver by election would only be enlivened where the reinsurer was presented with a choice between two mutually inconsistent rights. Here, Lexington may change its mind about the defence it asserts (as insurers often do) and abandon it; or rely on a different one or none at all. Thus, raising a defence, although it may involve a choice, is not a contractual election.

Further, the court held that, as a matter of construction, the cooperation clause was still applicable. Whether or not there could be ongoing cooperation in the face of a denial of liability was dependent on the nature of the denial and the stance actually taken by Lexington. A reinsurer that denies liability and refuses to have anything to do with the claim precludes cooperation. A reinsurer which, like Lexington, denies liability yet actively cooperates in the adjustment and settlement of the claim can do so without prejudice to the contention that it is not liable (which may itself be wrong).

His Honour observed that this conclusion was in the interests of both parties as, although the law required defences to be asserted at an early stage, ongoing cooperation and consideration of the validity of the claim could lead to it being settled in whole or in part.

Finally, the court noted that by repeating the 'without prejudice' mantra on all of its correspondence, Lexington should not be regarded as indicating that any ongoing cooperation was extra-contractual.

This decision is authority for the proposition that an early assertion of a defence to deny liability does not preclude ongoing cooperation between the parties to try to resolve the claim in a sensible and commercial manner.

Distributing the proceeds of a terminated reinsurance contract in the event of a winding up

Case Name:

McGrath and Anor re HIH Insurance Ltd

Citation:

[2008] NSWSC 9, Supreme Court of New South Wales per Barrett J

Date of Judgment:

30 January 2008

Issues:

- Application of s562A of the *Corporations Act 2001* (Cth)
- Division of funds between parties entitled to the benefit of the agreement

In the context of a winding up, the Supreme Court of NSW considered whether section 562A of the *Corporations Act 2001* (Cth) applied to the proceeds of a terminated reinsurance contract and to whom the proceeds should be paid.

HIH Insurance Ltd (*HIH*) entered into a reinsurance contract with Swiss Reinsurance Co (*Swiss*). The premiums for the reinsurance were paid by two subsidiaries of HIH, being FAI General Insurance Company Limited and HIH Casualty & General Insurance Company Limited (the *subsidiaries*). Following commencement of the winding up of HIH, HIH and Swiss entered into an agreement to cancel the reinsurance contract. The proceeds of the terminated reinsurance contract (the *proceeds*) were paid by Swiss to HIH, under that agreement.

The applicants, the liquidators of HIH, sought directions to the effect that:

- s562A of the *Corporations Act* did not apply to the proceeds; and
- they would be justified in distributing the proceeds to the subsidiaries in amounts proportionate to the contributions that they had made to the reinsurance premiums.

The court held that s562A was inapplicable to the proceeds because they would not be properly regarded as 'an amount in respect of' a 'liability' of the subsidiaries 'to pay amounts in respect of' a contract of insurance entered into by the subsidiaries 'as insurer'. The court found this on the basis that:

- there was no evidence that the subsidiaries ever became subject to a liability under a contract of insurance that caused the payment by Swiss;
- no claim had been made on Swiss by reference to an insurance liability of the subsidiaries; and
- no amount had been received under the reinsurance contract because the funds were paid according to the agreement cancelling that reinsurance contract.

Justice Barrett directed that the funds be distributed to the subsidiaries as proposed by the applicants. His Honour found that the reinsurance contract had been made by HIH as the agent of the subsidiaries, and that the subsidiaries were therefore entitled to the proceeds of the cancellation agreement in the proportions to which they had each contributed to the reinsurance premium.

This case provides useful guidance as to the application of s562A of the Corporations Act and serves as a reminder that not all payments made by reinsurers to insurers in the context of a liquidation will be subject to the regime established by s562A.

Future claims in respect of reinsurance contracts are 'debts'

Case Name:

New Cap Reinsurance Corporation Ltd (in liquidation) v A E Grant & Ors

Citation:

[2008] NSWSC 1015, Supreme Court of New South Wales per White J

Date of Judgment:

30 September 2008

Issues:

- Whether insurance liabilities are debts for the purposes of s95A of the *Corporations Act 2001* (Cth)

The court considered whether a company's reinsurance liabilities were 'debts' for the purposes of the cash flow insolvency test under section 95A of the *Corporations Act 2001* (Cth).

The liquidator of New Cap Reinsurance (**NCR**) brought unfair preference proceedings against various parties and was required to prove that NCR was insolvent at the date of the impugned payments.

NCR's solvency was to be determined according to s95A of the *Corporations Act 2001* (Cth) (the **Act**). Essentially, that section provides that a person is insolvent if they cannot pay all of their debts as and when they become due and payable. Accordingly, the court considered whether NCR's insurance liabilities should be classified as 'debts'.

Claims on insurance and reinsurance policies have generally been characterised as claims for unliquidated damages for breach of contract and, therefore, not 'debts' for the purposes of the insolvency test under s95A of the Act.

However, Justice White found in this case that NCR's reinsurance liabilities were not claims for unliquidated damages. Rather, they were 'a primary obligation'. The reinsurance liabilities arose under reinsurance contracts and were to be discharged by performance of those contracts, as distinct from liabilities that arose upon breach of those contracts. The reinsurance liabilities were not 'damages' because they did not arise from a refusal or failure to provide indemnity under the reinsurance contracts. Therefore, NCR's reinsurance liabilities were 'contingent debts', which could be taken into account when assessing solvency under s95A of the Act.

This is one of very few cases to consider the proper application of the solvency test to an insurer or reinsurer. This decision expands what is considered to be a 'debt' in the context of the solvency of an insurance or reinsurance company and departs from a long line of authorities to the effect that claims made on insurance and reinsurance policies (other than fixed-sum policies) are claims for unliquidated damages for breach of contract.

'Follow the settlement' provisions in reinsurance contracts where the reinsurance and original contract of insurance are not 'back to back'

Case Name:

Aegis Electrical and Gas International Services Ltd v Continental Casualty Co

Citation:

[2007] EWHC 1762 (Comm), High Court of England and Wales, Commercial Division, per Smith J

Date of Judgment:

25 July 2007

Issues:

- Can 'follow the settlement' provisions bind reinsurers to settlements in circumstances where the underlying policy and reinsurance are not 'back to back'?

The High Court of England and Wales was required to determine whether the reinsured was entitled to reinsurance cover for settled claims arising from damage to machinery at an oil refinery. In doing so, the court considered whether a 'follow the settlement' clause in a reinsurance contract can bind the reinsurer to a settlement when the reinsurance contract contained conditions of narrower scope than the direct contract of insurance.

The reinsured (the **Syndicate**) sought to recover from its reinsurer, Continental Casualty Company (**CCC**), in respect of two settled claims arising from damage to a 'Visbreaker' unit and a reactor at an oil refinery in the Caribbean. The Syndicate settled claims made by the refinery owner and claimed on its reinsurance.

The Syndicate's reinsurance slip provided that the reinsurance was to 'follow the terms, clauses, conditions, exceptions and settlements of the original wording as far as applicable hereto'. At the time that the reinsurance slip was scratched, CCC's underwriter wrote on the slip 'subject to the B & M terms and conditions attached pages 1-3'. The attached conditions were headed 'Boiler & Machinery Coverage Defined' (the **attached conditions**) and contained definitions of 'Accident' and 'Object' that were not contained in the insuring clause or any other significant provisions in the direct contract of insurance. Further, the definition of 'Accident' in the attached conditions excluded damage caused by 'Explosion' (which was not excluded from cover in the original policy).

At the time that CCC scratched the reinsurance slip, it had not seen the terms of the direct contract of insurance.

In relation to the Visbreaker claim, CCC denied cover because the reinsurance's attached conditions restricted cover to damage arising from 'Accidents' and 'Objects' as defined, and damage to the Visbreaker did not fall within those definitions.

The Syndicate argued that the definitions of 'Accident' and 'Object' in the attached conditions did not define or impinge upon the general reinsurance provisions describing the type of cover and the interest covered. Further, the reinsurance provided that cover would follow the terms of the original policy wording as far as applicable, so that the attached conditions were to be understood to relate to the incorporated terms of the direct contract of insurance (which referred to 'Accident' or 'Object' in the specific context of two minor incidental provisions).

Justice Smith held that CCC was not liable for the Visbreaker claim. He was not willing to accept that the terms ('Accident' and 'Object') in the reinsurance policy only related to, and modified, the minor incidental provisions in the direct contract of insurance in which the same words appeared. He surmised [at 58] that:

as a matter of impression it would be surprising first that the parties should decide to tinker with the effect of the follow the terms provision in the reinsurance cover in these two minor respects and ... that they introduced such detailed changes so obliquely.

Accordingly, the effect of the attached conditions was to modify the extent of the reinsurance cover and the Visbreaker claim was therefore excluded from cover. Justice Smith considered that his conclusion was supported by the fact that CCC's underwriter had not seen the wording of the relevant sections of the underlying policy at the time that the reinsurance slip was scratched.

In relation to the reactor claim, CCC sought to deny cover on the basis that the damage to the reactor was caused by an explosion, as defined in an exclusion clause in the reinsurance contract.

The Syndicate argued that the original reactor claim had settled on the basis that an explosion was not the proximate cause of the damage to the reactor, and the 'follow the settlement' provision prevented CCC from disputing the factual basis on which the claim was settled.

Justice Smith found CCC liable for the reactor claim, holding that, as a matter of ordinary usage, the word 'explosion' connoted 'violence and manifest violence ... a shattering destruction' and there was no evidence that any such explosion caused (or was the proximate cause) of the damage. As such, the damage did not fall within the scope of an exclusion for explosions contained in the reinsurance contract and CCC was liable for the damage to the reactor.

In relation to CCC's obligation under the reinsurance to follow the settlement of the original policy wording 'as far as applicable', Justice Smith commented [at 96]:

It is not clear whether the 'as far as applicable thereto' ... qualifies ... the words 'settlements' ... or original policy wording, but on either view it reflects that the reinsurance cover is not fully back to back with the direct cover, and its effect, as I interpret it, is to restrict the effect of the follow the settlement obligations to settlements to which the reinsurance cover is applicable.

Accordingly, Justice Smith noted that if the damage to the reactor was found to have been caused by an explosion, CCC could have relied upon the explosion exclusion in the reinsurance contract despite the follow the settlement clause.

This case demonstrates that a reinsured can be denied cover even with an effective 'follow the settlement' clause. Where reinsurance cover is not back-to-back, reinsurers may question whether a loss settled by the reinsured falls as a matter of fact (and not just as a matter of law) within the reinsurance cover.

Insurers and reinsurers must be careful, when drafting reinsurance contracts, to ensure that the reinsurance provides back-to-back cover to the underlying policy. The decision also demonstrates the importance for a reinsured to ensure that any settlement reached with the original insured complies with the terms of their reinsurance contract.

Construction of reinsurance contract containing struck-through words

Case Name:

Mopani Copper Mines Plc v Millennium Underwriting Ltd & Ors

Citation:

[2008] EWHC 1331 (Comm), England and Wales High Court, Commercial Division, per Clarke J

Date of Judgment:

16 June 2008

Issues:

- Determining the construction of a reinsurance slip when some words struck out
- Inclusion of operational risks coverage in reinsurance contracts covering construction risks

The High Court of England and Wales was required to determine questions relating to the construction of a 'Construction/Erection All Risks' reinsurance contract. The court considered whether it should take into account struck-through words in a reinsurance slip in construing the contract.

Mopani contracted to build a copper smelting plant in Zambia. Pursuant to the contract, Mopani was required to build, test and commission a number of different items (together comprising the plant) in stages prior to the final handover of the project. Mopani insured the project and its insurer obtained reinsurance in the London market.

The risk was described in the original reinsurance slip as 'Construction/ Erection All Risks'. The reinsured was concerned to ensure that there was no gap in cover between the date on which an item of the plant was built and the final handover of the project. Accordingly, the reinsured's broker scratched a new slip, amending the risks being reinsured so that they were 'Construction/Erection and Operation All Risks'. The following condition was also inserted into the new slip:

The whole contract period is deemed to include all projects incorporated into the ... Project **and cover extends to include Operational All Risks for completed phases of the project up** until the final handover certificate is issued.

[Emphasis added]

However, prior to scratching the new slip, the reinsured struck out the words in bold above and inserted the acronym 'TBA' (to be agreed) next to them.

Prior to the final handover of the project, a particular item of the plant was damaged while being operated and, consequently, the reinsured made a claim against the reinsurance contract. The Reinsurers denied cover on the basis that the contract did not provide cover for damage to an item of plant once it had been made operational.

The reinsured claimed that the new slip, which described the risks covered as including 'Operation All Risks', together with correspondence between the parties, provided a basis for the conclusion that the reinsured was entitled to operational cover for the item that had been damaged. It also contended that the court was not permitted to look at the struck-out words in the new slip (which appeared to rule out cover for 'Operational All Risks') to interpret the meaning of the remaining words on the basis that they were inadmissible evidence of pre-contract negotiations and, in any event, were ambiguous.

Justice Clarke held that the reinsurance policy did not cover completed items of the project, including the damaged item, once they had been made operational. In reaching this view, the judge considered the new slip and correspondence between the parties and found that the parties had agreed that items of the plant would not be made operational between their construction and the final handover of the project. As such, the court found that operational risks coverage had not been required under the reinsurance contract. Relevantly, Justice Clarke indicated that it was not necessary to rely on the struck-through words to reach this conclusion, but he indicated that the struck-through words supported his finding because, in combination with the correspondence, they indicated what the parties had not agreed.

Justice Clarke also indicated that he considered it significant that there is a clear distinction between construction and operational risks coverage and that, if operational risks coverage is to be included in a construction reinsurance contract, an application by a reinsured would be expected to specify the items and the length of time for which cover was sought. He also stated that a reinsured would expect to pay a higher premium to reflect that additional cover.

This case highlights the need for caution when negotiating terms of a reinsurance contract insofar as a party purports to have deleted terms of the contract by striking them through. If the words are still visible, the court may in certain circumstances have regard to them in construing the contract. The case also highlights the need for caution when negotiating construction risks policies in relation to multi-stage construction projects to ensure that the coverage does not contain unintended gaps in respect of operational risks.

Compulsory third-party insurance and determining standards of care

Case Name:

Imbree v McNeilly; McNeilly v Imbree

Citation:

[2008] HCA 40, High Court of Australia per Gleeson CJ, Gummow, Kirby, Hayne, Heydon, Crennan and Kiefel JJ

Date of Judgment:

28 August 2008

Issue:

- Relevance of compulsory third-party insurance to the standard of care in negligence in a motor vehicle context.

Chief Justice Gleeson and Justice Kirby separately considered, in proceedings for negligence, the relevance of compulsory third-party insurance to a determination of the standard of care expected of an inexperienced and unqualified driver with respect to a supervising passenger.

The appellant, Paul Imbree, was rendered tetraplegic after a car driven by the first respondent, Jesse McNeilly, swerved off the road and overturned in the Northern Territory. Mr Imbree had been supervising Mr McNeilly, who was then 16 years of age and was not licensed to drive.

Six of the seven judges of the High Court determined that the previous High Court authority in *Cook v Cook*¹⁴ should not be followed and held that the standard of care expected of Mr McNeilly (the **learner driver**) with respect to Mr Imbree (the **supervising passenger**) was the standard of care expected of a 'reasonable driver' and not merely the standard of care expected of an unqualified and inexperienced driver. In reaching that decision, Chief Justice Gleeson and Justice Kirby considered the relevance of the national statutory system of compulsory third-party motor vehicle insurance in defining the standard of care owed. They were divided on its relevance.

Chief Justice Gleeson affirmed the traditional view that insurance follows liability and denied the relevance of compulsory third-party insurance to a question about the standard of care owed by a driver to a passenger. By contrast, Justice Kirby stated that the court should take into account compulsory third-party insurance when considering the standard of care owed, on the basis that it affects the existence and content of the common law duty of care owed by the driver of a motor vehicle to others reliant on that driver's skill.

This case illustrates the division among judges with respect to the relevance of compulsory third-party insurance to a question of the standard of care owed in negligence in a motor vehicle context.

Trains, blame and supermarkets: can public liability extend to a third party for a claim of pure economic loss?

Case Name:

Tesco Stores Ltd v Constable & Ors

Citation:

[2008] EWCA Civ 362, England and Wales Court of Appeal per Tuckey, Thomas and Hughes LLJ

Date of Judgment:

16 April 2008

Issues:

- Public liability policy
- Contract claim coverage
- Meaning of 'in respect of'

The English Court of Appeal considered whether an insurance policy against public liability extended to cover pure economic losses sustained by a third party. The court held that it did not, stating that public liability insurance indemnifies claims that arise in tort and does not extend to matters of contract or matters that relate to pure economic loss.

Tesco Stores Ltd (**Tesco**) began construction of a supermarket over a railway cutting. The railway line was to be enclosed by a tunnel, with the supermarket to be built on the infill site above it. The railway line was owned by Network Rail. Chiltern Railways (**Chiltern**) operated a passenger service on the railway line. During construction, part of the tunnel collapsed, forcing the closure of the railway line for 51 days.

Chiltern brought a claim against Tesco, predominately for loss of passenger revenues during the closure of the line. Tesco sought to rely on its insurance policy, under which it was indemnified for damages in respect of:

- (a) death, bodily injury, illness or disease of any person;
- (b) loss or damage to material property; or
- (c) obstruction, loss of amenities, trespass, nuisance or any like cause.

Tesco was also insured in respect of 'liability assumed by [Tesco] under contract or agreement and which would not have attached in the absence of such contract or agreement', however, it was not covered for liability 'arising solely under fines, pre-determined penalty or liquidated damages clauses in any contract...'

The court held that public liability policies are generally regarded as only covering liability in tort, unless the wording of the policy extended the cover to third-party claims in contract for pure economic loss. In this case, the cover extended only to liability 'in respect of' one or more of the classes set out in (a) to (c) above. The words 'in respect of' required the loss to be directly caused by physical damage to the third-party claimant's person, property or property rights. Tesco had not damaged Chiltern's property or its property interests; any loss suffered by Chiltern was suffered only by the consequence of physical impact on the property and the property rights of others.

This case illustrates that, unless specifically included, public liability insurance will be limited to matters that arise in respect of tort and does not extend to claims for pure economic loss or bare contractual claims.

Effect of settlement in apportionable claims

Case Name:

Arthur John Gunston (trading as AJ Gunston) v Ceri Lyn Lawley

Citation:

[2008] VSC 97, Supreme Court of Victoria per Byrne J

Date of Judgment:

24 April 2008

Issues:

- Apportionment between concurrent wrongdoers under Part IVA of the *Wrongs Act 1958* (Vic)
- Effect of settlement on apportionable claims

The Victorian Supreme Court considered the effect of a plaintiff's settlement of an apportionable claim with one concurrent wrongdoer in a multi-party dispute.

This case concerned an appeal from a decision of the Victorian Civil and Administrative Tribunal (**VCAT**) relating to claims by two owners of a duplex complex (one being Ms Lawley) against the builder, architect, soil engineer and building surveyor who had been involved in constructing the building.

During the trial, Ms Lawley accepted a settlement offer from the building surveyor of \$65,000 plus costs. However, in its judgment, VCAT apportioned Ms Lawley's loss between the builder, architect and the building surveyor such that the building surveyor was responsible only for 6.276 per cent of the total damages (being \$16,024).

On appeal, one of the arguments considered by the court was how it should treat the surplus amount of the settlement (the sum paid by the surveyor in excess of \$16,024, for which VCAT found him to be liable). The architect argued that to the extent that the settlement funds received by Ms Lawley from the building surveyor exceeded the amount apportioned by VCAT, those funds should be used to proportionately reduce the liability of the other wrongdoers.

Justice Byrne rejected this argument. He considered that, under the Victorian proportionate liability regime, a payment by one concurrent wrongdoer is a benefit conferred on the plaintiff independent of its rights of redress against each other wrongdoer. On this analysis, claims against concurrent wrongdoers can be characterised as a series of independent claims, tried together as a matter of convenience.

While not relevant to the facts of this case, Justice Byrne also observed that it may be possible under the Victorian proportionate liability regime for a plaintiff to recover, in aggregate, a sum greater than the amount of his or her loss or damage.

Justice Byrne referred to the following reasons to support the conclusion that the settlement of a claim against one wrongdoer in a proportionate liability claim ought not factor into judgment against other concurrent wrongdoers.

- It would be practically problematic to take into account settlement sums if, for example, the terms of settlement provide for instalments or delayed payment.
- A settlement by a plaintiff with one concurrent wrongdoer at an undervalue could not operate to increase the liability of the other; therefore, settlement at an overvalue should not operate differently.

- If the fact of settlement was relevant to a court or tribunal's determination of the liability of the remaining defendants, it would increase the difficulties of plaintiffs wishing to settle with one of a number of defendants.

Justice Byrne also noted that, where a concurrent wrongdoer settled before trial and therefore takes no part in the proceedings, there is a risk that the settling defendant is fixed with a greater responsibility than otherwise would have been the case. As such, the effect of the settlement would be to reduce the judgments recovered against other wrongdoers.

This decision highlights the fundamental nature of the relationship between plaintiffs and concurrent wrongdoers under a proportionate liability regime.

Scope of 'reasonable precautions' condition in public liability policy

Case Name:

CGU Insurance Ltd v Graeme Robert Lawless

Citation:

[2008] VSCA 38, Supreme Court of Victoria, Court of Appeal, per Maxwell P, Neave and Redlich JJA

Date of Judgment:

13 March 2008

Issues:

- Construction of a 'reasonable precautions' condition in a public-risk indemnity policy
- Test for a failure to take 'reasonable precautions'

In this decision, the Victorian Court of Appeal confirms that a 'reasonable precautions' condition should be construed with regard to the commercial purpose of a policy, and that such condition prohibits an insured from deliberately courting a danger, the existence of which the insured recognises, by refraining from taking any measures to avert it.

The lessees of a farm held a multi-risk insurance policy with the appellant, CGU Insurance Ltd (**CGU**). The policy provided public liability coverage for fencing work undertaken by the respondent, Mr Lawless, and included a special condition requiring Mr Lawless to take 'all reasonable precautions to prevent personal injury'. A step in the fencing process involved Mr Lawless hammering fence posts into the ground with a post-driving machine. In 2002, a post-driving machine being operated by Mr Lawless on the farm crushed the hand of Mr Lawless's 10-year-old grandson.

The grandson brought proceedings against Mr Lawless in the Supreme Court of Victoria for negligence, and Mr Lawless issued a third-party notice against CGU, seeking indemnity under the policy. The Supreme Court gave judgment for the grandson and ordered CGU to indemnify Mr Lawless. As part of its judgment, the court rejected Mr Lawless's evidence that he had been unaware that his grandson was holding the post being hammered by the machine at the time of the accident, but nevertheless found that Mr Lawless had taken 'reasonable precautions'.

An issue before the Court of Appeal was whether the trial judge should have found that Mr Lawless had not exercised 'reasonable precautions', particularly having regard to the judge's rejection of Mr Lawless's evidence that he had been unaware his grandson was holding the post. The court held that the 'reasonable precautions' condition should be construed by reference to the commercial purpose of the policy, which was to indemnify the insured against liability for personal negligence. It also adopted the test used in *Albion Insurance Co Ltd v Body Corporate Strata Plan No 4303*¹⁵, in which it was held that a failure to take reasonable precautions will occur only where there is a deliberate course of action or inaction that an insured realises exposes someone to the risk of being injured by a recognised danger.

In dismissing the appeal, the Court held that, although the trial judge found that Mr Lawless was aware that his grandson was holding the post, it did not follow that Mr Lawless had deliberately or recklessly exposed his grandson to a recognised danger. In this respect, the court accepted that the evidence before the trial judge established that Mr Lawless was very experienced with post-driving machinery and that he was a loving grandfather who was not likely to have deliberately exposed his grandson to danger.

This decision highlights the limitations of standard 'reasonable precautions' clauses in public liability policies. In particular, to avoid the application of such condition, an insured need only prove that it either was unaware of the danger, did not deliberately court the danger, or was indifferent to whether the danger was averted.

To warn or not to warn? That is the question when it comes to a council's duty under the NSW Civil Liability Act

Case Name:

Jaber v Rockdale City Council

Citation:

[2008] NSWCA 98, New South Wales Supreme Court, Court of Appeal, per Tobias and Campbell JJA and Handley AJA

Date of Judgment:

28 May 2008

Issues:

- Whether a warning is required in circumstances of 'obvious risk'
- What constitutes a 'dangerous recreational activity'

The NSW Court of Appeal considered whether a city council owed a duty to warn a plaintiff of the risks associated with diving off a wharf. The Court outlined the appropriate way to determine whether risks are 'obvious risks' and interpreted the phrase, 'dangerous recreational activity', found within the *Civil Liability Act 2002 (NSW)*.

The appellant, Bilal Jaber, sustained spinal injuries when he dived head-first from a bollard at Dolls Point wharf. The wharf was under the management and control of the respondent, Rockdale City Council (the **Council**). While the Council had posted signs warning against the dangers of diving from the wharf, these signs were not visible to those who swam to the wharf from the beach, as Mr Jaber did. He sued the Council for negligence, claiming that it had failed to adequately warn of the danger of diving from the wharf.

The key issue before the Court of Appeal was whether the risk of diving from the wharf, without ascertaining the exact depth of the water below, was an 'obvious risk' within the meaning of section 5H of the *Civil Liability Act 2002 (NSW)* (the **CLA**).

In dismissing Mr Jaber's appeal, the court held that diving off the wharf was an 'obvious risk' in the sense that a reasonable person in Jaber's position would have perceived the risks involved. Thus, the Council was under no duty to warn of such risks. The court explained that a risk of harm can be 'obvious' even if it had a low probability of occurring, as the 'potential for danger' is the relevant consideration.

A secondary issue considered by the court was whether diving, in itself, constituted a 'dangerous recreational activity', under s5K of the CLA. While the court made it clear that diving per se was not dangerous, in these circumstances, where the depth of the water was not appropriately assessed, the possibility of harm was more real than trivial. Thus, since there was a significant risk of harm in diving from the wharf, the action was deemed to be a 'dangerous recreational activity'.

This case shows that the courts are increasingly requiring individuals to take responsibility for their own actions. Additionally, this case defines the correct application of 'obvious risk' and 'dangerous recreational activity' under the CLA. Finally, this case provides some guidance as to how some similar cases may be decided at common law.

Financial Claims Scheme Legislation

Introduction

The Federal Government announced its Financial Stability Package on 12 October 2008, in response to the tumultuous events in the global finance and credit markets. This package introduced the Government's guarantee of deposits in Australian banks, building societies, credit unions and Australian subsidiaries of foreign-owned banks. From an insurance perspective, the main components of the package were the:

- Policyholder Compensation Facility (**PCF**), which provides certain eligible retail policyholders of protected general insurance contracts with access to compensation for claims in the event of the failure of a general insurer;
- judicial management of general insurers, including the power to recapitalise;
- introduction of a levy system for general insurers, which may be called upon to contribute (up to a maximum of 5 per cent of gross premium) to the costs of the Australian Prudential Regulation Authority (**APRA**) administering a PCF; and
- other changes to strengthen prudential regulation and the powers of APRA in relation to general insurers.

The Federal Government passed the *Financial System Legislation Amendment (Financial Claims Scheme and Other Measures) Act 2008* (Cth) (**FCS Act**) and the *Financial Claims Schemes (General Insurers) Levy Act 2008* (Cth) (**Levy Act**) to give effect to the Financial Stability Package.¹⁶

The Policyholder Compensation Facility (PCF)

The FCS Act introduced a new Part VC – Financial Claims Scheme for Policyholders with Insolvent General Insurers, into the *Insurance Act 1973* (Cth) (the **Insurance Act**), to provide for the establishment of a PCF where a general insurer fails.

The PCF, to be administered by APRA, means that eligible beneficiaries can get access to funds in a timely manner when they have a claim, without having to wait for funds to be distributed in the course of a failed insurer's liquidation.

The concept of a financial compensation or claims scheme is not new, and the previous Federal Government had made an in-principle decision to introduce a financial claims compensation scheme as had been recommended by the Council of Financial Regulators in a report presented to Government in November 2005.¹⁷

¹⁶ These Acts received Royal Assent on 18 October 2008

¹⁷ Council of Financial Regulators – Failure and Crisis Management in the Australian Financial System

While the PCF has many features of that proposed by the Council of Financial Regulators, the manner in which the PCF is to be funded and administered is different. In some respects, it borrows aspects of the structure of the ad hoc HIH Claims Support Scheme that was implemented following the collapse of the HIH Group in 2001.

A PCF will only be activated by Ministerial declaration for a specified general insurer that is under judicial management and in respect of which APRA has advised the Minister that it believes the insurer is insolvent.¹⁸

Much of the detail of a PCF, including what may constitute a protected policy and the eligibility criteria for persons claiming under the PCF, will be the subject of regulations and/or declarations by the relevant Minister. However, the Government has stated its intention as to how a PCF should operate in the Explanatory Memorandum to the *Financial System Legislation Amendment (Financial Claims Scheme and Other Measures) Bill 2008* (Cth). The Explanatory Memorandum states that the following classes of policyholders are to be protected and to be eligible for compensation on the failure of the general insurer:

- individuals who are Australian citizens or permanent residents;
- small businesses (with an annual turnover) of less than \$2 million;
- certain family trusts for private and residential purposes or for qualifying small businesses; and
- Australian-based, non-profit organisations.

Consequently, large corporate insureds and policyholders of reinsurance, compulsory state insurance (such as compulsory third party and workers' compensation), insurance-like products (such as those offered by discretionary mutual funds) and insurance provided by unauthorised foreign insurers or Lloyds' Underwriters will not be entitled to make claims under a PCF. These policyholders will be expected to exercise their existing rights to pursue claims against an insurer through the liquidation process or, in respect of Lloyds' Underwriters, under the special security trust arrangements already provided for under the Insurance Act.

As to which policies will be protected policies for the purposes of a PCF, the new definition of protected policy in the Insurance Act adopts an exclusionary, rather than inclusionary, approach. It would appear that all policies will be 'protected policies' for the purposes of the PCF, unless they have been prescribed by the regulations as not being protected policies or APRA has determined that a policy is not a protected policy under s62ZY.¹⁹

Introducing eligibility criteria brings about some potentially problematic demarcation issues for some claimants in respect of certain types of policies. For example, under directors' and officers' insurance cover, cover is usually provided for individual directors and officers, as well as for the company, in respect of

¹⁸ Section 62ZZC applies if it is a foreign general insurer (with an Australian branch) and the general insurer is unable to pay, from its assets in Australia, all of its debts that are liabilities in Australia, as and when those debts become due and payable

¹⁹ Section 3 defines *protected policy*

reimbursement of its indemnity obligations to the directors and officers at law or by contract. It is therefore possible that such policies might be treated as protected policies for some aspects of cover and claims by individuals might be eligible claimants. There may be other types of policies that give rise to this outcome under a PCF.

The FCS Act provides for the Minister to be able to exclude certain classes of policyholders and insureds (eg, such as directors and officers of a failed insurer and those involved in the events leading up to the failure).²⁰ Similarly, APRA will have the power to decline claims where policies have been issued primarily to make the policyholder eligible for compensation.²¹

APRA will determine eligible policyholders' claims by reference to the respective policy's terms and conditions. The FCS Act provides a mechanism for the priority payment of claims of low value (less than \$5,000), with the intention that those individuals most affected by a general insurer's insolvency can have timely access to payments.²² It appears from the drafting of the provisions that APRA is not required to check the eligibility of persons making low-value claims and will be permitted to pay the claim, providing that it relates to a protected policy. However, for claims of value over \$5,000, APRA must determine that the person meets the conditions prescribed by regulations to be made for the purposes of the FCS Act before it pays the claim.²³

Where compensation is paid by APRA, the claimant's rights against the insolvent insurer will be transferred to APRA, which in turn can stand in the shoes of the claimant in the liquidation process, with the same rights of priority.²⁴ These changes do not disturb the rights of subrogation. Such rights will be deemed to be transferred from the claimant to the insurer in the normal way, after a payment is made under a PCF.²⁵

Third parties with cut-through rights under a protected policy to claim directly from the insurer under s51 of the Insurance Contracts Act 1984 (Cth) will also be eligible to seek compensation under the PCF.²⁶ Interestingly, the FCS Act makes no reference to Acts (other than s51) that provide similar cut-through rights to persons, such as s6 of the *Law Reform (Miscellaneous) Provisions Act 1946* (NSW) and s601AG of the *Corporations Act 2001* (Cth) (the **Corporations Act**). Consequently, third parties with claims against insureds who are not natural persons, eg a company, may not in fact be entitled to claim under a PCF.

The changes also provide for a notional deemed extension of cover of the original protected policy for a period of 28 days from the date a general insurer becomes a declared general insurer for the purposes of a PCF.²⁷ The Explanatory

²⁰ Section 62ZZ

²¹ Section 62Z(1)

²² Section 62ZZF(2)

²³ Section 62ZZF(3) and, of course, provided that the claim relates to a protected policy

²⁴ Section 62ZZL

²⁵ Section 62ZZM

²⁶ Section 62ZZG

²⁷ Section 62ZZH

Memorandum²⁸ states that the notional cover is said to be provided only for an entitlement to be paid under the PCF and is not intended to extend the original insurance cover. The purpose of providing an extension is to allow affected policyholders time in which to organise replacement cover following the failure of a general insurer.

Decisions by APRA in relation to the payment of claims under the PCF are not reviewable decisions for the purposes of the Administrative Decisions (Judicial Review) Act 1977 (Cth) so that a claimant would not be entitled to seek a judicial review of a decision made by APRA under the PCF.²⁹ Given that legal proceedings also cannot be commenced against a general insurer under judicial management, it is not clear as to what, if any, avenues of appeal are open to claimants unsatisfied with a decision made by APRA in respect of their claim.

Judicial management of general insurers in financial distress

While general insurers have always been able to be externally administered in the interests of creditors or members under the Corporations Act, the FCS Act introduces a mechanism to provide for the active judicial management of a general insurer – in the interests of its policyholders – before it becomes technically insolvent. This largely mirrors the existing provisions of the *Life Insurance Act 1995* (Cth). However, the changes also provide a judicial manager with the power to recapitalise a general insurer, thereby facilitating the orderly transfer of the general insurance business to another institution, where appropriate.

Consequently, general insurers and life insurers operating in Australia now face a prudential regulator with significantly enhanced powers to deal with insurers in financial distress. Much of the detail concerning the implementation of a PCF will be addressed in regulations which the structure of the FCS Act provides are to be made having regard to the particular circumstances of the insurer in question. Much of the detail concerning the implementation of a PCF will be addressed in regulations. The FCS Act provides that the structure of these regulations must be made by having regard to the particular circumstances of the insurer in question.

The features of judicial management include:

- APRA or a general insurer (on giving one month's written notice to APRA) may apply to the Federal Court for the appointment of a judicial manager.³⁰
- APRA may apply for the appointment of a judicial manager in two scenarios – after it has conducted an investigation of an insurer (s62L) or on other grounds where it is considered that the time needed to conduct an investigation of an insurer would be likely to be such as to prejudice the interest of the policyholders of the general insurer (s62M). These provisions mean that a judicial manager can be appointed to a general insurer before the general insurer becomes technically insolvent.

²⁸ Paragraph 2.119

²⁹ Schedule 1, Section 3(hc) of the *Administrative Decisions (Judicial Review) Act 1997* (Cth)

³⁰ Section 62K

- The Federal Court may make an order appointing a judicial manager in response to an application by APRA under s62L if it is satisfied that, having regard to the results of the investigation, it is in the interests of the policyholders of the general insurer to do so.
- Where APRA applies to the Federal Court under s62M for the appointment of a judicial manager, it will need to satisfy the court that there is evidence to suggest that the general insurer is in some difficulty such that it is, or is likely to be, unable to meet its policy or other liabilities as they become due³¹ or it has failed to comply with a prudential standard or direction from APRA. In addition, APRA will need to convince a court that to conduct or complete an investigation of the general insurer before it applies for the appointment of a judicial manager would take such time as to be likely to prejudice the interests of the policyholders.
- The appointment of a judicial manager takes precedence over other forms of company external administration under chapter 5 of the Corporations Act.³² Further, before a person applies to a court for the appointment of an external administrator of a general insurer, that person must give APRA written notice that the application is proposed; APRA may request that person to provide it with further details; and APRA is entitled to be heard on the application.³³ A person commits a civil penalty offence if they do not comply with the requirement to notify APRA of the intention to apply for the appointment of an external administrator. Similarly, before applying to a court in relation to the winding up of a general insurer, a liquidator must give APRA written notice detailing the proposed application, and APRA is entitled to be heard on the application.³⁴ APRA also has the power to apply to the Federal Court for directions regarding any matter under the winding up of a general insurer with notice to the liquidator³⁵, and APRA may request a liquidator to provide it with information about the winding up of a general insurer.³⁶
- A judicial manager has the power to recapitalise a general insurer that is a company with share capital and is registered under the Corporations Act.³⁷ These powers exist irrespective of conflicting provisions in the Corporations Act, the company's constitution, listing rules or any contract or arrangement to which the company is a party. These powers may be exercised without informing company members but the judicial manager is required to give a written notice to those persons as soon as practicable after exercising any authority. These powers are subject to the judicial manager obtaining a report on the fair value of the shares or rights that are to be varied in accordance with s62ZA. APRA has the power to determine that such a report should not apply if the circumstances are such that compliance would otherwise detrimentally affect policyholders of the general insurer concerned or the stability of the financial system in Australia.

³¹ Or a foreign insurer with an Australian branch is unlikely to be able to meet its liabilities in Australia from its assets in Australia

³² Section 62U

³³ Section 62ZQ

³⁴ Section 62ZR

³⁵ Section 62ZS

³⁶ Section 62ZT

³⁷ Section 62Z

- Under s62V, the vesting of the management of a general insurer in a judicial manager will not allow the contract, or another party to a contract to which a general insurer is party to, to deny any obligations under the contract, accelerate any debt under that contract or close out any transaction in relation to that contract. It is unclear as to whether the prohibition applies only to such actions that would otherwise be undertaken as a **consequence** of the appointment, or whether the prohibition applies generally **following** such appointment, but we think the better view is that it is the former. The section also purports to extend to cover contracts that are subject to the proper law of a foreign country. There may be a real issue as to whether this provision is capable of enforcement against overseas entities. This may have a significant impact on the security of contracts with foreign entities that are reinsurers, reinsureds or co-insurers of the general insurer subject to judicial management.
- Also, while the Explanatory Memorandum³⁸ provides that this section has been included so that a contract with a general insurer cannot be terminated or contractual obligations owed to a general insurer avoided, on the grounds a judicial manager has been appointed, we do not think s62V(2) in fact goes far enough to achieve this protection. For example, the list of prohibited actions under s62V(2) does not include cancellation or termination of a contract and the drafting of this section suggests that the list of prohibited items is an exclusive list.

Levy on the general insurance industry

A PCF will be funded initially by appropriations; however, APRA will seek to recover the cost of any payments made to policyholders under a PCF, its administrative costs in running a PCF and any costs associated with it borrowing funds for a PCF, by proving as a creditor in the liquidation of the failed insurer. If APRA is unable to recover all of those costs from the failed insurer, the Levy Act enables the Government to impose a levy on general insurers up to a maximum of 5 per cent of gross premium received.

Regulations to be made under the Levy Act will detail how the levy is to be calculated. The regulations are to impose a levy on gross premiums received by a general insurer in a *prescribed class*. It is not clear whether this means the levy will be on the basis of different classes of insurer or different classes of insurance business and, if classes of insurer, how such classes will be determined. The Explanatory Memorandum does not provide any information as to the Government's thinking on this issue but we assume that it is acknowledged and contemplated by Government that insurers will seek to pass on the levy to customers. The regulations will also need to clarify what is meant by gross premium – that is, whether gross premium is gross premium after netting out for such items as refunds, cancellations and reinsurance costs.

Similarly, factors such as stamp duty, GST and fire-service levy components of gross premium collected by general insurers will need to be clarified in the regulations, particularly with regard to the fact that insurers will likely pass the levy onto customers.

³⁸ Paragraph 6.39

Strengthening prudential powers

The FCS Act also introduced some changes to the Insurance Act to grant significant powers to APRA to require reasonable assistance³⁹ and obtain information⁴⁰ from general insurers (whether or not a declared insurer) or liquidator for the purposes of its performance of its functions as an administrator of a PCF. While s62ZZO qualifies the assistance that APRA may request as being 'reasonable', there is no such qualifier in s62ZZP dealing with APRA's powers to obtain information from general insurers. Nor are there any explicit references to the remuneration or reimbursement of persons assisting APRA under these provisions, or any carve-out for commercially sensitive information.

Section 62ZZP(3) acknowledges that information requested by APRA may include personal information, but there is no express relief granted from the obligation to comply with privacy laws. Further, and more generally, there are significant civil penalty and criminal provisions that apply to insurers and individuals who are officers of a general insurer and who fail to cooperate with APRA and supply information.⁴¹

The Explanatory Memorandum acknowledges that the civil and criminal penalties for failure to comply are substantial, but states that these are required because assistance and information from general insurers is likely to be vital for the effective implementation of a PCF.⁴²

³⁹ s62ZZO

⁴⁰ s62ZZP

⁴¹ Section 62ZZQ provides for a civil penalty of 10,000 penalty units in the event that a general insurer fails to comply with the requirement to give assistance or information to APRA

⁴² Explanatory Memorandum – paragraph 2.150

The commencement of reforms relating to DOFIs

The reform of Australian law relating to direct offshore foreign insurers (**DOFIs**) has been a long time in the making. In our *Annual Review of Insurance and Reinsurance Law 2005*⁴³, we provided a detailed review of a Commonwealth Treasury discussion paper that proposed significant reforms to the regulation of insurance business carried on in Australia by DOFIs. In the *Annual Review of Insurance and Reinsurance Law 2007*⁴⁴, we noted how the reforms had taken shape in Commonwealth legislation. We also noted that a discussion paper had been released by Treasury, setting out some proposed limited exemptions to the new regime.

Background

The *Insurance Act 1973* (the **Act**) prohibits a person (including a company) from carrying on insurance business in Australia unless it is a general insurer authorised by the Australian Prudential Regulation Authority (**APRA**) to carry on insurance business in Australia under the Act. 'Insurance business' is defined by the Act to include any activities incidental to insurance business.

There is no general prohibition against insureds seeking out and obtaining insurance cover directly from DOFIs. Similarly, there is no general prohibition on DOFIs insuring Australian risks. However, from 1 July 2008, the Act requires that if a DOFI is, in all the circumstances, carrying on insurance business in Australia within the meaning of the Act, then it must become authorised under the Act.

Clarification of incidental activities

When the amendments to the Act came into effect on 1 July 2008, an important part of the reforms was to set out in the legislation some non-exhaustive examples of the kinds of activities that are deemed to be 'incidental' and therefore constitute the carrying on of insurance business. The Act now makes clear that a business will be taken to be incidental to insurance business to the extent that it involves one or more of the following:

- inducing others to enter into contracts of insurance with the person as the insurer;
- publishing or distributing a statement relating to the person's willingness to enter into a contract of insurance as an insurer; or
- procuring the publication or distribution of such a statement.

⁴³ pp 127 - 146

⁴⁴ pp 114 - 118

In addition, the Act also now makes clear that if any of these acts are done outside Australia then they are taken to occur in Australia if they have effect in Australia or are likely to have effect in Australia.

Since 1 July 2008, the 'incidental business' aspect of the reforms has been the source of considerable confusion on the part of DOFIs that insure Australian risks. It is important for those DOFIs to note that while Australian insureds remain free to seek and obtain insurance from DOFIs, if they have been induced to do so because of conduct on the part of the DOFI, or through someone acting on its behalf, then the DOFI may need to be authorised under the Act. Having said that, not all activities relating to insurance business will be deemed to require authorisation. Therefore it is possible for a DOFI to have a representative in Australia handling claims, making payments or holding records on behalf of the DOFI, without triggering the authorisation requirement.

Exemptions

Exemptions to the new reforms have also been given effect from 1 July 2008. They reflect the proposed exemptions set out in the *Annual Review of Insurance and Reinsurance Law 2007*.⁴⁵ The different categories of exemptions are as follows:

- **Contracts for high-value insureds**

An insured will be considered 'high value' if it meets one or more of the following criteria:

- the operating revenue of the insured derived in Australia for a financial year is at least \$200 million;
- the value of its gross assets in Australia at the end of a financial year is at least \$200 million; and
- the number of the employees of the policyholder in Australia at the end of a financial year is at least 500 (a departure from the 300 employees proposed in the discussion paper).

For insurance contracts that name multiple parties as insureds, it is sufficient that at least one of the insureds meets one of the criteria above.

- **Contracts for atypical risks**

An insurance contract will be deemed to insure an atypical risk to the extent that it provides cover for liability arising from one or more of the following:

- nuclear fuel, nuclear material or nuclear waste;
- biological material or biological waste;
- war or warlike activities;
- a terrorist act;
- health-care related research;
- the operation of a space object;

- the ownership or operation of an aircraft (but not loss of the aircraft or its cargo);
 - owning, chartering, managing, operating or being in possession of a vessel other than a pleasure craft;
 - equine mortality or fertility and related risks; and
 - loss or liability incidental to a loss or liability mentioned above.
- **Contracts for other risks that cannot reasonably be placed in Australia**

For this limb to apply, an Australian insurance broker must certify in writing that the risk cannot reasonably be placed with an Australian insurer on the grounds that:

- there is no Australian insurer that will insure against the risk;
 - the terms on which any Australian insurer will insure against the risk are substantially less favourable to the insured than the terms on which the DOFI will insure against the risk; or
 - insurance with an Australian insurer would be substantially less favourable to the insured than with a DOFI because of other circumstances.
- There is then an additional category of **exempted insurance contracts**, being those that are required by the law of a foreign country to be issued by an insurer authorised under the law of that country.

If no exemption applies, then the critical issue to note is that a DOFI will be prohibited from carrying on insurance business in Australia and will not be able to carry on such business, either directly or through another person, unless duly authorised to carry on insurance business under the Act.

APRA releases requirements for the use of internal models by general insurers

On 19 December 2008, the Australian Prudential Regulation Authority (**APRA**) released a package that sets out the requirements that a general insurer must meet if it wishes to seek approval of an internal model-based method (**IMB method**) for determining its Minimum Capital Requirement (**MCR**).

The package consisted of a revised *Prudential Standard GPS 113 Capital Adequacy: Internal Model-based Method* (**GPS 113**), a new *Prudential Practice Guide GPG 113 General Insurance Internal Model-based Method for Determining Minimum Capital Requirement* (**GPG 113**) and a response paper that addresses submissions received from the general insurance industry in relation to the consultation package released in June 2008. The revised GPS 113 will be effective from 31 March 2009.

The general insurance reforms of 2002 first provided for the use of an approved internal model to determine an insurer's MCR, rather than the prescribed method; however, until 2007, no insurers had applied to APRA for approval to use the IMB method. In 2007, APRA was advised that a number of insurers intended to seek approval of an internal model. In light of these prospective applications, APRA published a discussion paper in June 2008, together with a revised draft of GPS 113 and the proposed GPG 113, outlining its proposals for the prudential framework that is intended to be principles-based, rather than specifying detailed requirements.

APRA received eight submissions in relation to that consultation package, and the response paper notes that all submissions were supportive of the direction taken by APRA, and most of the substance of the draft GPS 113 and GPG 113. The final version of GPS 113 incorporates amendments to the sections on operational risk, the planned profit allowance and compliance with certain aspects of the capital standards that reflect comments made by the general insurance industry during the consultation process.

The discussion paper noted that, in APRA's view, the use of internal models to assess risk and economic capital can be a valuable tool in encouraging better risk management. In particular, APRA believes that an insurer's internal model can provide for regulatory capital requirements that better reflect the nature and extent of risks in the insurer's particular business structure and business mix. The IMB method may be used by authorised insurers or by Level 2 general insurance groups.

The discussion paper noted that APRA will not consider giving approval for an insurer to use the IMB method unless the insurer meets the following pre-conditions:

- it has, and maintains, an advanced and stable approach to risk management, including operational risk; and
- it has, and maintains, a prudent approach to capital management.

In considering whether to approve an internal model, APRA will consider the adequacy of the model by reference to how it deals with catastrophe risk, underwriting risk, reserving risk, market risk, credit risk and operational risk. APRA has revised GPS 113 in response to industry submissions received during the consultation process to clarify that diversification benefits between operational risk and other risk categories may be allowed, subject to an insurer demonstrating an adequate process for estimating dependencies (particularly for extreme losses) and applying conservatism in its dependence assumptions commensurate with the uncertainty of the estimates.

The discussion paper noted that while the insurer's internal model may also be used to determine the insurer's target level of capital for internal purposes (which may be based on factors such as the particular insurer's rating, risk measure and risk tolerance), certain aspects of the model and the way in which it is used to determine MCR must comply with APRA's requirements, as set out in GPS 113.

There are three groups of criteria against which a model will be assessed by APRA:

- model governance – the people, processes and systems should be such that APRA is satisfied that the integrity of the model is being maintained;
- model use – the model must play an integral role in the insurer's management and its decision-making processes and its use must be sufficiently embedded in the insurer's operations; and
- model sufficiency – the model must be technically sufficient in order to give a reliable measure of the required capital.

APRA expects that the governance and technical sufficiency of the model will be independently reviewed as part of the application process; when material changes are made to the model or the insurer's business; and otherwise on a periodic basis (approximately every three years).

GPG 113 has been amended to clarify that, as part of the final application for IMB method approval, evidence of support from relevant senior management is required (including the appointed actuary or group actuary as appropriate); however, APRA has not assigned any specific responsibilities to the appointed actuary or group actuary in relation to the internal model.

The discussion paper noted that, in line with the Basel II approach, APRA will be cautious in allowing an insurer to reduce the amount of capital held as a result of the use of an internal model. In particular, for the first two years of use of a model, the MCR determined using the model should be no less than 90 per cent of the insurer's MCR determined using the prescribed method. GPS 113 also requires an insurer to make appropriate public disclosure about the use of an approved internal model. Following concerns raised during the consultation process that these requirements would trigger requirements for external audit of the insurer's model, APRA has amended the disclosure requirements and no longer requires disclosure

of the MCR in financial statements. APRA expects each insurer to make appropriate disclosures on its website or in an annual report or other similar documents.

In the context of international developments in regulatory capital requirements, the discussion paper notes that the International Association of Insurance Supervisors (of which APRA is a member) supports the use of internal models and that the European Solvency II project is also likely to include an internal model option.

APRA anticipates that only a small number of insurers, and in particular those with a relatively high credit rating, will be interested in using an internal model for regulatory capital purposes. At this stage, APRA is not considering approval of the IMB method for specialist insurers such as lenders mortgage insurers or medical indemnity insurers.

APRA releases prudential framework for supervision of general insurance groups

On 17 December 2008, the Australian Prudential Regulation Authority (**APRA**) released its prudential framework for the supervision of general insurance groups. The framework is intended to apply to 'Level 2' general insurance groups, headed by either a Level 1 APRA-authorized insurer (operating holding company) or an APRA-authorized non-operating holding company (**NOHC**) containing general insurance subsidiaries and other controlled entities integral to its general insurance business. The framework does not address APRA's proposed supervision of Level 3 groups, where conglomerate groups are involved in more than one APRA-regulated industry, which will be the subject of a separate consultation process.

The package consists of three new prudential standards, one revised prudential standard and a response paper that addresses submissions received from the general insurance industry in relation to APRA's latest consultation package, released in April 2008. The standards are the result of more than three rounds of consultation with industry on general insurance group supervision, which commenced in 2005. The prudential standards will become effective on 31 March 2009.

For supervision purposes, a Level 2 general insurance group will consist of the global operations of the parent entity and all of its subsidiaries whose activities relate to general insurance business. No part of the group that is upstream of that parent entity in Australia will be consolidated. The foundation of APRA's approach to supervision of general insurance groups is that the consolidated group should essentially meet the same Minimum Capital Requirements (**MCR**) as individual general insurers. Foreign subsidiaries of a Level 2 general insurance group are not required to comply with APRA requirements on an individual basis, but must continue to meet local regulatory requirements.

The rationale for the supervision of Level 2 general insurance groups includes the recognition that associations and dealings with other members of an insurer's corporate group may expose the insurer(s) within the group to contagion risk. The HIH Royal Commission recommended the development of a regime to effectively regulate insurers that operate as part of a corporate group, including minimum capital requirements to be met at a group and individual insurer level, without unduly restricting the commercial aspirations of the group.

The prudential framework for Level 2 general insurance groups includes three new prudential standards and two existing standards. The three new standards are:

- *Prudential Standard GPS 111 Capital Adequacy: Level 2 Insurance Groups*
- *Prudential Standard GPS 221 Risk Management: Level 2 Insurance Groups*
- *Prudential Standard GPS 311 Audit and Actuarial Reporting and Valuation: Level 2 Insurance Groups*

GPS 001 Definitions has been revised to reflect certain new terminology used in the new group supervision prudential framework.

The standards describe the minimum requirements that Level 2 general insurance groups will need to satisfy and should be read in conjunction with the Level 1 prudential standards (ie the standards that apply to all individual, APRA-authorised insurers). In particular, it is important to note that the Level 2 requirements will impose a capital requirement on NOHCs for the first time. Under the proposed framework, responsibility for satisfying the Level 2 prudential requirements will rest with the board of directors of the parent entity of the group in Australia, regardless of whether it is a Level 1 general insurer or a NOHC. The minimum capital requirements for the group may be determined using the prescribed method, or an internal model developed by the group and approved for use by APRA.

Under GPS 221, a Level 2 general insurance group will be required to maintain an over-arching risk management framework that encompasses the risks emanating from all the entities within the group.

GPS 311 requires the appointment of a group auditor and a group actuary (who may be the appointed auditor or actuary of any Level 1 insurer with the group, or where the parent entity is a NOHC, may be the responsible auditor or an actuary that provides services to the NOHC). As a result of submissions received from the general insurance industry in the latest round of consultation, APRA will allow a Level 2 group to apply to APRA to grant a period of transition before the group is required to comply with the requirements in GPS 311.

In addition, two existing standards, GPS 510 Governance and GPS 520 Fit and Proper already apply, both to authorised insurers and NOHCs. During the latest round of consultation, some respondents expressed concern that APRA would apply the requirements of GPS 510 and GPS 520 to all entities in the Level 2 group, even those that are not authorised by APRA. APRA has confirmed in the response paper that it has no intention of applying those requirements beyond the entities that it directly authorises; however, in some cases the requirements may apply to entities controlled by APRA-authorised entities. For example, the definition of a senior manager of a NOHC may well extend to senior persons who have responsibility for material subsidiaries that are not authorised by APRA.

ASIC releases Regulatory Guide 194 – Insurance requirements for registered liquidators

On 26 June 2008, the Australian Securities and Investments Commission (**ASIC**) released a regulatory guide setting out ASIC's policy on how it will administer the insurance requirements for registered liquidators under section 1284 of the *Corporations Act 2001* (Cth) (the **Corporations Act**). Regulatory Guide 194: Insurance Requirements for registered liquidators (**RG 194**) was issued following the 29 February 2008 release of a consultation paper inviting comments and submissions on the topic.

Section 1284 of the Corporations Act requires a person registered as a liquidator, or as a liquidator of a specified body corporate, to maintain adequate and appropriate professional indemnity (**PI**) insurance, and adequate and appropriate fidelity insurance. RG 194 makes clear that the policy objective of the PI and fidelity insurance requirements is to ensure that funds are available to a registered liquidator to compensate creditors and other claimants for loss suffered as a result of the inadequate or improper performance of duties or other legal obligations by the registered liquidator or their staff in connection with externally administered companies.

RG 194 sets out five 'key policy principles' that guide ASIC in determining what is adequate and appropriate PI and fidelity insurance. The principles are as follows:

1. It is the responsibility of registered liquidators to assess what is adequate and appropriate PI and fidelity insurance for their circumstances and obtaining such insurance.
2. 'Adequate and appropriate' broadly means that the insurance is fit to achieve the policy objective and is on usual commercial terms.
3. The insurance should be of an amount sufficient to cover claims against the registered liquidator reasonably anticipated in connection with the external administration of insolvent companies.
4. The 'practical availability' of insurance in the market is an element of adequacy and appropriateness.
5. There is a need for balance between the level of protection for creditors and other claimants, and the cost of insurance for registered liquidators.

For PI insurance, RG 194 sets out ASIC's views relating to the level of cover, level of excesses/deductibles, scope of cover, reinstatements, exclusions and persons covered necessary for PI insurance in order for the PI insurance to be 'adequate' under s1284 of the Corporations Act.

In relation to fidelity insurance, RG 194 makes clear that, although fidelity insurance varies in scope and structure, it is cover against loss of money and similar assets belonging to third parties, attributable to fraud or dishonesty by people for whose misconduct the registered liquidator is liable, that is key to fulfilling the policy objective of s1284 of the Corporations Act. RG 194 also provides guidance relating to the scope of cover, conditions and exclusions for fidelity insurance in order to achieve the 'adequate and appropriate' requirement under s1284.

ASIC updates Regulatory Guide 126 – Compensation and insurance arrangements for AFS licensees

On 28 March 2008, the Australian Securities and Investments Commission (**ASIC**) released an updated version of *Regulatory Guide 126: Compensation and insurance arrangements for AFS licensees (RG 126)*, setting out ASIC's approach to administering the requirements outlined in section 912B of the *Corporations Act 2001* (Cth) (the **Corporations Act**).

Section 912B of the Corporations Act provides that Australian financial services (**AFS**) licensees must have arrangements for compensating retail clients for losses or damages they suffer as a result of a breach by the licensee or its representatives of their obligations in chapter 7 of the Corporations Act (**compensation arrangements**). Regulation 7.6.02AAA of the *Corporations Regulations 2001* (Cth) provides that, to this end, unless an exemption applies, AFS licensees must obtain professional indemnity (**PI**) insurance cover that is adequate, having regard to the nature of the licensee's business and its potential liability for compensation claims.

RG 126 sets out the policy objective of the compensation arrangements requirement as reducing the risk that a retail client's losses (due to breaches for which an AFS licensee is responsible) cannot be compensated by the AFS licensee because of lack of financial resources. RG 126 makes clear that the compensation arrangements are not intended to provide a mechanism by which compensation is provided directly to consumers, rather, the PI insurance cover is intended to protect the insured (ie the AFS licensee) against the risk of financial losses arising from poor-quality services (for example, negligent advice or execution of services) and other misconduct (for example, fraud by its authorised representatives).

ASIC has taken a staged approach to the implementation of the compensation arrangements. During the two year period from 1 January 2008 to 31 December 2009 (the **implementation period**) the PI insurance cover requirements for AFS licensees are less stringent, although RG 126 notes that at the end of the implementation period, ASIC expects AFS licensees to have PI insurance cover that 'reliably delivers on all aspects of the policy objective'.

The key principles that inform ASIC's administration of the compensation arrangements are as follows:

1. 'Adequate' means fit for achieving the policy objective, described above. Whether the PI insurance cover is adequate will depend on the amount of the cover, the scope of the cover, whether the terms and conditions of the cover undermine the overall effect of the cover and whether the AFS licensee has sufficient financial resources to enable the PI insurance cover to work in practice.

RG 126 sets out in some detail ASIC's views about adequacy in relation to each of these factors, and specifies some minimum levels for each criterion in order for the PI insurance cover to be 'adequate'. For example, the PI insurance cover must have an indemnity limit of at least \$2 million for any one claim and in the aggregate.

2. It is the responsibility of AFS licensees to determine what is adequate for them.
3. The practical availability of PI insurance cover is an element of adequacy. ASIC aims to encourage the development of PI insurance cover products that will deliver a high standard of protection, but recognises that this will take time.

The requirement to have compensation arrangements in place is applicable to all AFS licensees, except for general and life insurers regulated by the Australian Prudential Regulation Authority, authorised deposit-taking institutions, and any entity related to any of these AFS licensees if that entity has an ASIC-approved guarantee from that AFS licensee.

AFS licensees can apply to ASIC for approval of alternative compensation arrangements, which will be assessed by ASIC on a case-by-case basis. AFS licensees must also include a statement in their financial services guide (**FSG**) and the FSG of their authorised representatives, describing the compensation arrangements they have in place, and whether those arrangements comply with s912B of the Corporations Act.

RG 126 notes that ASIC is encouraging the insurance industry to respond to the opportunity created by mandatory PI insurance cover by developing new products that will help PI insurance cover fulfil the purposes of the compensation arrangements requirement.

Sanction under the Insurance Companies Ordinance for the transfer of insurance business

Case Name:

Re Transamerica Occidental Life Insurance Co

Citation:

[2008] HKEC 1672, Court of First Instance of the High Court of Hong Kong per Susan Kwan J

Date of Judgment:

8 October 2008

Issues:

- Application of s24 of the *Insurance Companies Ordinance* (Cap. 41)
- Whether it would be appropriate for the court to sanction a scheme transferring long-term business between two insurance companies

Two related insurance companies presented a petition, pursuant to section 24 of the *Insurance Companies Ordinance* (the *Ordinance*), seeking the court's sanction for transfer of long-term business.

The scheme and the petition

Transamerica Occidental Life Insurance Co (**TOLIC**) and Transamerica Life Insurance Co (**TLIC**) were two related insurance companies domiciled in Iowa, in the US, and registered as overseas companies in Hong Kong. The Insurance Authority, a division of the Office of the Commissioner of Insurance and the regulator of insurance in Hong Kong, authorised TOLIC to carry on classes A and C of long-term business from its Hong Kong offices. A merger between the two companies was proposed, in order to increase efficiency and reduce the costs of operating separate legal entities, whereby TLIC would be the successor entity (the **scheme**).

Hong Kong law currently makes no provision for such a merger; therefore, TOLIC and TLIC presented a petition under s24 of the Ordinance. They sought a declaration from the court that would enable the transfer to TLIC of the long-term business of TOLIC that was carried on in Hong Kong. As at July 2008, the transferred policies proposed to be included in the scheme consisted of all of the long-term business of TOLIC carried on in or from Hong Kong, numbering 1,053 direct and reinsurance policies with a total gross sum assured of approximately US\$1.4 billion.

Without sanction of the transfer by the court, TOLIC and its branches in Hong Kong would cease to exist and policyholders would have to rely on Iowa law to enforce their rights against the insurance companies.

The following statutory preconditions were undertaken by TOLIC and TLIC prior to the hearing:

- An independent actuary issued a detailed report and provided an affidavit on the scheme's terms, pursuant to s24(2) of the Ordinance. In the actuary's view, no group of policyholders would be materially adversely affected by the scheme overall; there would be appropriate and sufficient protection of rights and interests of the transferring policyholders; and there were sound commercial reasons for implementing the scheme.
- A notice of the petition, pursuant to s24(3)(a) of the Ordinance, was published in the Hong Kong Government Gazette and two newspapers.
- TOLIC and TLIC had sent to every policyholder a statement setting out a summary of the scheme, pursuant to s24(3)(b) of the Ordinance.

- Copies of the petition and the independent actuary's report were made available for inspection, pursuant to s24(3)(d) of the Ordinance.
- There was, for the purpose of s24(6), a sufficiently immediate authorisation by the Insurance Authority; and there would also be a formal authorisation for TLIO to carry on the long-term business after the sanction was granted.

Although one TOLIC policyholder raised an objection, it was found to be groundless.

*Applying Re Winterthur Life*⁴⁶, and with regard to the commercial judgment of the management of both companies and the views of the independent actuary, the court was satisfied that the scheme was fair as a whole and that it would be appropriate to sanction the scheme.

This case illustrates that the crux for the court in determining whether to sanction such a scheme is whether all statutory preconditions are satisfied and whether the transfer scheme is fair, as a whole, to the parties involved, giving due recognition to the commercial decisions of the companies involved, as well as the view of an independent actuary.

Arbitration clause in an insurance policy transferred to the third party

Case Name:

Ryoden Engineering Co Ltd v New India Assurance Co Ltd

Citation:

[2008] HKEC 135, District Court of Hong Kong per Judge Thomas Au in Chambers

Date of Judgment:

23 January 2008

Issues:

- Proper construction and effect of s2 of the *Third Parties (Rights Against Insurers) Ordinance* (Cap.273)
- Whether a third party claiming under rights conferred by the Ordinance was subject to an arbitration clause contained in the relevant insurance policy

The plaintiff, Ryoden Engineering Co Ltd (*Ryoden*), applied for summary judgment against the defendant, New India Assurance Co Ltd (*New India*), for sums paid in connection with a personal injury claim. New India, relying on an arbitration clause under an insurance policy, sought to stay the proceedings.

Mr Zheng suffered a personal injury at a construction site. It was caused by a truck owned by Mr Kwok, who held a third-party insurance policy (the *policy*) with New India. Mr Zheng claimed against Ryoden as his employer, and against Mr Kwok and the occupier of the construction site. New India was also an interested party to this claim but did not participate directly in the proceedings.

The court found that Mr Kwok was 85 per cent liable, and that Ryoden and the occupier were only 15 per cent liable. Ryoden paid the total sum awarded in the judgment as Mr Kwok was adjudged bankrupt.

Ryoden then claimed against New India for the 85 per cent contribution of the sum paid by Ryoden, since New India was liable to indemnify Mr Kwok under the Policy. Section 2 of the *Third Parties (Rights Against Insurers) Ordinance* (Cap. 273) (the **Ordinance**) effectively vested in Ryoden all of Mr Kwok's rights in the policy, due to his bankruptcy. New India applied for a stay of proceedings for arbitration, pursuant to the policy's arbitration clause.

Applicable law

Section 2 of the Ordinance provides that in the event of the insured (in this case, Mr Kwok) becoming bankrupt, his rights against the insurer under the insurance contract in respect of the liability shall be transferred and vested in the third party to whom the liability was incurred.

The arguments

Ryoden argued that they were not bound by the arbitration clause as they were never party to the policy and that there had been no transfer of the arbitration clause. It also relied on the doctrine of *res judicata* (similar to the 'double jeopardy' principle) to argue that New India was estopped from relying on the arbitration clause by reason of its failure to raise it when it originally joined the action.

New India, in turn, argued that s2 of the Ordinance had the effect of transferring all of Mr Kwok's rights under the policy, including the arbitration clause to Ryoden as the third party. New India argued that the doctrine of *res judicata* did not apply as the relevant issue (Mr Kwok's bankruptcy) was not necessarily apparent in the original action.

Arbitration clause transferred to Ryoden as a whole

The court held that the *The Padre Island*⁴⁷ judgment provided clear authority supporting the argument that Ryoden's claim was subject to the arbitration clause contained in the policy. In *The Padre Island*, Justice Leggatt set out two governing principles that were also applied in this case:

- First, the third party can only be transferred rights formally vested in the insured and no more.
- Secondly, the rights transferred to the third party are subject to the same incidental considerations as when vested in the insured. The consequence of this is that the insured's contractual rights, including the arbitration clause, are transferred to the third party.

The court took the view that the purpose of an arbitration clause was to deal with how remedies could and should be exercised in the case of a dispute, and these remedies were obviously attached to the enforcement of substantive rights. Thus, substantive rights were held to be subject to an arbitration clause in the case of a dispute.

As to the issue of *res judicata*, the court held that, since New India did not actively participate in the original action by reason of a cross-claim or similar, it could not and should not have raised the issue of an arbitration clause since this was purely a matter between New India and Mr. Kwok. As a result, the court did not accept that there was any effective estoppel and held that the doctrine of *res judicata* did not apply.

The court held that Ryoden was bound by the arbitration clause in the policy and therefore its claim against New India should be brought in arbitration as opposed to litigation. The stay of proceedings was granted.

This case illustrates that the proper construction of s2 of the *Third Parties (Rights Against Insurers) Ordinance (Cap. 273)* leads to the transfer of an arbitration clause in an insurance policy to the third party, together with all other rights of the insured.

Liability of insurer: breaches of warranties and waiver by the insurer

Case Name:

Richfine Development Ltd v Hugh Rupert Rivington

Citation:

HCCL 18/2006, Court of First Instance of the High Court of Hong Kong per Stone J

Date of Judgment:

3 July 2008

Issues:

- Rejection of claim by reason of alleged warranty breaches
- What constitutes a waiver of a breach of warranty
- Quantification of claim

This case considered a claim by the insured to cover consequential loss suffered as a result of a robbery. The insurer raised the defence that the policy had never been incepted alleging that the insured had breached a warranty by failing to keep proper records.

The plaintiff, Richfine Development Ltd (*Richfine*), operated a wholesale jewellery business from a small office premises in Sheung Wan trading under the name 'Keng Fai Jewellery'.

Richfine had taken out an insurance policy with the defendant, Lloyds Syndicate 1069 (the *insurer*), as underwriters. The coverage had been arranged through a Hong Kong agent, Anglo East Surety Limited (*Anglo*). A representative of Anglo had held at least two meetings with a director of Richfine in which the operational structure and record keeping methods of Richfine were discussed. Based on the information collected at these meetings, an initial insurance contract was drafted and signed by the parties in 1998.

When the policy became due for renewal in 1999, the director informed the agent that Richfine was stocking 50 per cent less gold than what was listed in the original policy. The agent said there was no reason to amend the policy to reflect this. The renewed policy specified limits of liability at HK\$1.5 million for 'Transits' and HK\$7 million for 'Premises: on Stock'.

In 2000, Richfine made a claim of HK\$6 million on the policy for consequential loss suffered as a result of their premises being robbed. The insurer refused to pay the claim. It argued that the alleged robbery had been fabricated and that even if it had occurred, Richfine was in breach of the contractual warranty to comply with an acceptable standard of record keeping meaning that the policy had never incepted.

Burden of proof

Ordinarily the burden would lay with Richfine, to prove the legitimacy of its claim on the policy on the balance of probabilities. However, given that the insurer claimed that the robbery had been fabricated, the court considered that it should bear the evidential burden of proving the robbery was a 'put-up job'.

Whether the robbery did occur was a question of fact. The court found that on the balance of probabilities, the robbery had not been fabricated.

The alleged breaches of warranties

The insurer alleged that Richfine had breached a warranty (in the form of a 'basic clause' contained in the proposal form and first policy recital) relating to agreed standards of transactional record keeping. The key issue arising from this was whether this alleged breach, if proven, would preclude the inception of the policy.

Expert evidence suggested the system used by Richfine for the keeping of proper records 'in particular areas' was not 'sufficiently robust' so as to provide a true and fair view of Richfine's stock position at any particular time. The crux of the issue to be determined by the court was what constituted a 'proper record'. The court, taking into consideration the relative size, family-run nature and operational practices of Richfine, held that the record keeping methods, though far from perfect, were 'appropriate to the prevailing circumstances'.

The court concluded that keeping proper records was not a 'warranty' or condition precedent to liability therefore no warranty had been breached and the policy was valid at all material times.

Waiver by the insurer

The court found that Anglo, acting on behalf of the insurer, had inspected the accounting papers, invoices and other documents and indicated that Richfine's system had been satisfactory before the first insurance contract was signed. Prior to the renewal of the policy, the agent was aware that the original system was in operation and made no indication to either party that this was unsatisfactory in regards to complying with the policy. The court found that by these actions, the agent (Anglo), on behalf of Lloyds, waived any breach of warranty brought about by Richfine's substandard record keeping at the time of renewing the insurance policy.

This case illustrates that, while the court accepts that any 'true breach' of warranty gives an insurer the right to treat the policy as void from inception, what will constitute a 'true breach' depends largely upon the facts and circumstances of each particular case and is conditional upon the absence of any waiver on behalf of the insurer.

Class action laws in Asia

What is a class action?

A class action is a lawsuit brought by a group of litigants whose cases involve similar facts or legal issues. It is intended to serve as an efficient and cost-effective means of settling the claims of a large number of people with a common cause of action.

Class actions were developed in the United States and have become a popular means of litigating consumer or securities claims. As a result, US class action laws continue to be the model for class actions legislation adopted in other jurisdictions. Key features of US class actions include:

- The class must be large enough that the filing of individual lawsuits would be impractical.
- Lead or representative parties are appointed to act on behalf of the class. Such representatives are charged with the conduct of the litigation and must adequately protect the interests of the class in doing so.
- Members of the class are able to opt out of participating in the litigation. If they choose not to do so, they will be bound by any judgment in the proceedings or any reasonable settlement.

Typically, US class actions tend to involve a large group of consumers or shareholders who have been commonly affected by the actions of a company. For example, class actions are often used to litigate securities claims arising from the failure of a publicly listed company to disclose material information to the market. In this instance, class actions allow the large number of shareholders affected by the company's conduct to initiate a single legal action, rather than making individual claims based on the same factual allegations. This enables both the litigants and the courts to deal with such claims in one set of proceedings.

The current situation in Asia

Class action laws have been adopted in only three Asian countries. However, most important Asian jurisdictions do permit some form of collective litigation. A summary of the relevant laws in each major Asian jurisdiction is set out below.

Jurisdictions with class action laws

Indonesia

In Indonesia, class actions are permitted for tort claims under Article 1365 of the Indonesian Civil Code. Such claims can be initiated under one of the following five laws:

- Law No. 23 of 1997 regarding Environmental Management
- Law No. 8 of 1999 regarding Consumer Protection
- Law No. 10 of 1997 regarding Nuclear Power
- Law No. 41 of 1999 regarding Forestry
- Law No. 5 of 1983 regarding the Indonesian Exclusive Economic Zone.

The Supreme Court Regulation (PERMA) No.1 of 2002 governs the procedure surrounding class actions. It requires that all class actions must pass through a preliminary review in which a judge determines if it satisfies a number of preconditions. These include whether the class is large enough to justify the proceedings and whether the facts and legal issues to be determined for each member of the class are sufficiently similar. If the lawsuit passes through this initial stage, it can then proceed to a substantive hearing. The court will then determine the amount of compensation payable to the class and the procedure for distributing this money to class members.

In practice, very few class actions are initiated in Indonesia each year and many of these do not progress to a hearing. For instance, only 15 cases have gone to trial since class action laws were introduced.

South Korea

Since January 2005, South Korea has allowed shareholder class actions for securities claims. It is regulated by the *Securities Class Action Act*, which applies only to companies listed on the Korean Stock Exchange or organisations registered with the Korean Securities Dealers Association. Class actions can be initiated in relation to:

- the non-disclosure of material information or the disclosure of false or misleading information regarding a listed company; or
- insider trading or the manipulation of the share price of a listed company.

Other requirements include that there must be at least 50 members of the class and these individuals must represent at least 0.01% of all shareholders in the relevant company. A Korean court may also dismiss class actions if it is not satisfied that the lawsuit is an efficient and suitable means of protecting shareholders or if the complaint is not properly drafted.

Thailand

In Thailand, draft legislation to permit class actions was recently submitted to the Committee for Revision of the Civil Procedure Code. The Committee has already completed its consideration of the draft law, which now awaits introduction to the National Legislative Assembly. If passed, the draft law will amend Thailand's Civil Procedure Code and allow class actions to be initiated in the Thai courts.

Jurisdictions without class action laws

China

China does not have class action laws, but it does permit collective litigation under the *1991 Civil Procedure Law (CPL)*. Article 53 of the CPL permits group-based litigation if:

- there are two or more plaintiffs or defendants;
- the relevant group of plaintiffs or defendants have the same interest or similar claims;
- all members of the group consent to the use of collective litigation; and
- the court considers it appropriate for the claims to be dealt with collectively.

There are three specific types of collective litigation. The first is non-representative group litigation (Article 53 of CPL). The second is representative group litigation where there is a fixed number of plaintiffs or defendants (Article 54 of the CPL). Such proceedings require at least 10 plaintiffs or defendants in the group. The third is representative group litigation where the number of litigants is not fixed (Article 55 of the CPL). In both forms of representative group litigation, representative litigants (between two to five people) are appointed to conduct the proceedings on behalf of the group. The acts of these representatives will generally bind all other members of the group.

Under Chinese law, certain claims cannot be litigated collectively. For instance, securities claims involving the non-disclosure of material information can only be brought by individual plaintiffs.

There has been significant growth in multi-party litigation in China in recent years. For instance, official records indicate that the Chinese courts deal with more than 500,000 cases of group litigation every year.

Hong Kong

Multi-party proceedings in Hong Kong are governed by the High Court Rules.

Order 4 Rule 9 provides for the consolidation of non-representative proceedings. It states that the court may order two or more claims to be consolidated if:

- there are common questions of law or facts to be answered;
- the claims arise out of the same transaction or series of transactions; or
- the court considers it desirable to do so.

Order 15 Rule 12 sets out the requirements for representative group proceedings. Such proceedings can be initiated only if multiple parties have the same interest in the proceedings. In such cases, the court may appoint certain parties to act as representatives of the group.

Judgments in such representative proceedings will bind only the parties to the litigation. It will not apply to non-parties who may also share the interests of the representative group. Notably, any party to the proceedings is also entitled to contest liability after the judgment is handed down.

In the Civil Justice Reform Final Report of 2005, the Chief Justice's Working Party criticised Order 15 Rule 12 as a 'restrictive and inadequate' mechanism for dealing with multi-party litigation. As a result of these comments, the Law Reform Commission established a sub-committee in 2006 to consider the introduction of class action laws. A consultation paper is expected to be released on the subject shortly.

Malaysia

The laws governing multi-party proceedings in Malaysia are almost identical to those in Hong Kong. Non-representative group litigation is permitted under Order 4 Rule 9 of the Rules of High Court 1980. Representative group proceedings is also provided for by Order 15 Rule 12.

While the relevant court rules in Malaysia and Hong Kong are largely the same, the application of these rules in each country is significantly different. The Malaysian courts appear to have taken a more flexible approach to multi-party proceedings. For instance, Malaysian courts have permitted the use of representative actions even if parties in the same representative group have different or competing interests. The Malaysian courts have also overlooked issues such as the failure of the initiating party to identify the group or the failure to obtain the consent of other parties to litigate as a group.

Singapore

Singapore permits representative group proceedings under Order 15 Rule 12 of the High Court Rules. This rule is effectively the same as that used in Hong Kong and Malaysia. The Singaporean courts have taken a conservative approach to the application of this rule. In the past five years, only one reported case has involved representative proceedings.

Notably, Singaporean law does not allow non-representative group proceedings.

India

The current law in India enables group proceedings for public interest litigation that is limited to the violation of fundamental rights (but does not encompass civil claims or torts). The Supreme Court or High Court may permit volunteer lawyers or petitioners to bring a case on behalf of marginalised groups that do not have sufficient access to legal services.

India is also considering the introduction of class action laws. A report was submitted to the Ministry of Corporate Affairs on this issue in May 2005.

Japan

Japan has no class action laws. While the introduction of such laws has been considered, it seems unlikely to occur soon. Currently, two forms of collective litigation are available in Japan: consolidated litigation and representative actions.

Article 38 of the Japanese *Code of Civil Procedure* provides that parties may sue or be sued as co-litigants if they have the same interest in the same set of proceedings or if their claims are based on the same facts or law.

Representative actions are governed by Article 30(1) of the *Code of Civil Procedure*. Such proceedings can be initiated if all plaintiffs or defendants share sufficiently common interests and consent to litigate as a group. As in other jurisdictions, the court will generally appoint one party to act as a representative of the group. All parties to a representative litigation are bound by any judgment handed down.

Representative actions are also permitted under the *Consumer Contract Act*. This is specifically limited to consumer complaints. It is intended to protect the rights of consumers against misleading or deceptive conduct.

Taiwan

Taiwan has no class action laws, but collective litigation is permitted under the Code of Civil Procedure. There are effectively four forms of group-based proceedings which can be initiated in Taiwan.

The first is representative group litigation (Article 41 of the *Code of Civil Procedure*). This allows multiple parties with common interests to litigate as a group. In such proceedings, the parties or the court may appoint one or more members of the group to act as a representative party.

The second is consolidated litigation (Article 44-2 of the *Code of Civil Procedure*). This permits the court to consolidate multiple proceedings arising from same facts. Once again, a group of parties with similar interests may appoint a representative to conduct the litigation on behalf of the groups.

The third relates to an incorporated association or body (Article 44-1 of the *Code of Civil Procedure*). It applies to situations where multiple claims have been made by members of an association that does not have legal status. With the court's approval, these claims can be consolidated and a representative appointed to conduct the litigation on behalf of the association.

The fourth allows a representative action to be filed by consumer protection groups for serious breaches of consumer laws and regulations (Article 53 of the *Consumer Protection Law*). This is intended to allow consumer groups or public officials to restrain such breaches or obtain compensation for the individuals affected.

Japanese legal market: insurance in the land of the rising sun

Despite Japan having been Australia's largest trading partner for many years, and Australia remaining one of its most important sources of raw materials, there continues to exist a degree of mutual ignorance about each other's societies and economies.

This often extends to each other's financial industries, including the insurance sector. For example, would most Australians know that the world's largest financial institution – bank or insurer – is, arguably, the Japanese national post office?

In 2007, Japan was the world's third largest insurance market (measured in premium income) behind only the United States and the United Kingdom.⁴⁸ The most recent figures indicate that there are 44 life insurance companies (including subsidiaries of foreign insurers) and 51 non-life insurers (including 22 foreign insurers) operating in Japan. The Japanese insurance market is very mature, with little internal growth; therefore, in recent years Japanese insurers have been focusing on new external markets, or on capturing market share within Japan.

The Japanese insurance market has several notable features that distinguish it from Australia's:

- Japan is a civil law country (it adopted its modern legal system from both Germany and France in the 19th century) and consequently there is no insurance case law, unlike in Australia, the US or the UK. Also, there has traditionally been social pressure to resolve disputes, including business disputes, without resorting to litigation.
- The Japanese financial regulator (in English, referred to as the 'Financial Services Agency' or '**FSA**') assumes a comparatively large role in the administration of insurance. Before deregulation commenced in the early 1990s, the Japanese insurance market was tightly controlled, with the FSA approving all policies. Insurers were not permitted to introduce insurance products that gave them significant advantages over a competitor (referred to as 'the convoy system') and the FSA also tried to prevent Japanese insurance companies becoming insolvent. It is often argued that innovation in the Japanese insurance market was stifled. This heavily regulated and managed insurance industry underwent change in the late 1990s and early 2000s, with the advent of limited deregulation.

- Unlike many other insurance markets, in Japan, non-private sector insurers have significant market share. As discussed below, Japan Post Insurance (and several insurance co-operatives) hold significant portions of the insurance market.⁴⁹
- The Japanese insurance market has two policyholder protection entities: the Non-Life Insurance Policyholders Protection Corporation (NIPPC) and the Life Insurance Policyholders Protection Corporation (LIPPC). If an insurer becomes insolvent, these entities provide financial assistance to any insurer who takes over the failed insurer, or if a new owner is not found, reimburses policyholders between 90 per cent and 100 per cent of the original policy amount. The NIPPC and LIPPC are funded by Japanese non-life and life insurers, respectively.

There are a number of current themes and issues affecting insurance in Japan:

- **The corporatisation and privatisation of the Japanese post office** – in 2005, the then Prime Minister Koizumi began a process to fully privatise parts of Japan Post by 2017. The corporatised Japan Post Group has both a postal bank arm ('Japan Post Bank', *Yucho* in Japanese) and a life insurance arm ('Japan Post Insurance', *Kampo* in Japanese). *Yucho* holds personal savings of ¥109 trillion (approximately A\$1.8 trillion⁵⁰) and has total assets of ¥134 trillion (approximately A\$2.2 trillion⁵¹). *Kampo* has total assets of about ¥112 trillion.⁵² The new Japan Post Group has total assets of ¥327.5 trillion and net assets of ¥8.3 trillion. Upon being established as a company on 1 October 2007, *Kampo* immediately became the largest Japanese life insurance company.⁵³ It is often argued that *Kampo* and *Yucho* together constitute the world's largest financial institution.

Although Japan Post was corporatised in 2007, it has not yet been privatised and the Japanese Minister of Finance is currently the sole shareholder in Japan Post Holdings Co. Ltd., which owns the four new subsidiaries, *Yucho*, *Kampo*, Japan Post Service (ie deliveries) and Japan Post Network (ie the actual post offices).

The privatisation of Japan Post is an extremely political issue because of its: size (the combined group has approximately 240,100 employees); reach (around 24,574 post offices, in every part of Japan); income (ordinary income of approximately ¥10 trillion per annum); and a history of political influence and patronage, particularly in rural areas. Many parts of rural Japan are depopulating as the birth-rate falls and the young move to the cities for work, leading to concern that a privatised Japan Post may not maintain post offices in all areas of Japan. To address this, the Government has promised that every town will have a post office, although this could still mean the closure of many post offices. These factors have caused significant opposition to the Japanese Government's privatisation timetable.

⁴⁹ For example, Zenrosai, a national federation of non-profit cooperative insurers, has 13.9 million members, 36.1 million contracts and a total sum insured of ¥653 trillion (A\$10.88 trillion (at ¥60 to A\$1.00)) [Toa Re, 'Japan's Insurance Market 2007', p. 9]

⁵⁰ At an exchange rate of ¥60 to A\$1.00

⁵¹ Japan Post annual report 2007

⁵² Toa Re, 'Japan's Insurance Market 2008', p. 41

⁵³ Toa Re, 'Japan's Insurance Market 2008', p. 41

Traditionally, Japan Post, as a government institution, has benefited from a range of tax concessions not available to other banks or insurers. This has been of particular concern to foreign insurers operating in Japan, who have argued that they were not competing on a level playing field. There is currently apprehension that a privatised *Kampo* may retain its tax concessions and therefore have an unfair advantage over other insurance companies. It is unclear how this issue will develop.

Kampo has also indicated that it intends to start offering non-life insurance, and non-life insurers are concerned about the effect this will have on their market.

- **The consolidation of the industry** – traditionally, the large Japanese conglomerates (*keiretsu* in Japanese), such as Sumitomo, Mitsui and Mitsubishi, had their own group banks and insurance companies. As a result of financial pressures, initially from the collapse of Japan's bubble economy of the late 1980s and early 1990s, a number of these *keiretsu* insurance companies have merged across *keiretsu* boundaries, forming, for example, the non-life insurer, Mitsui Sumitomo Insurance.
- **The development of new sales channels** – traditionally, Japanese insurers operated through large networks of agents, often housewives working part-time in their own neighbourhood or town. These sales channels are regarded as expensive and inflexible, so there has been a focus on developing alternative ones such as the Internet. Bancassurance (see below) has also been a focus.
- **The entry of foreign insurers into the Japanese market** – the Japanese insurance market is large and mature; however, foreign insurers believe that they have a competitive advantage as a result of innovative products.
- **Expansion into overseas markets** – because the Japanese insurance market is mature and growth is limited (in fact, with its ageing and declining population, it is expected to shrink in the future, rather than grow, even at small rates), Japanese insurers have looked to developing insurance markets in the region; in particular, in China, where a number of the largest Japanese insurers have joint ventures or subsidiaries.
- **Bancassurance** – restrictions on banks selling insurance were removed in December 2007 after a gradual reduction of restrictions from 2001. The main products being marketed appear to be variable annuity insurance and medical insurance. The corporatised Japan Post is marketing bancassurance products that private sector insurers have provided to it.

The Japanese insurance market will continue to evolve in response to the issues discussed above.

