Annual Review of Insurance Law 2000

Allen Allen & Hemsley

LAWYERS

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ARTHUR ROBINSON
GROUP

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Written and published by Allen Allen & Hemsley, Lawyers
The Chifley Tower, 2 Chifley Square, Sydney NSW 2000

Printed by Colourwise Reproductions
300 Ann Street, Brisbane Qld 4000

The summaries published 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 2000 Insurance Annual Review represents the third successive year of this publication. The publication is offered as part of our ongoing service to our clients in the insurance industry. We have received much encouragement from the tremendous response provided by our clients and others in the insurance industry to our 1998 and 1999 Insurance Annual Review. We trust the 2000 Insurance Annual Review will continue to provide clients with a valuable reference tool.

Allens' insurance practice has continued to grow throughout the year 2000. With the addition of Andrea Martignoni as a partner from 1 July 2000, the practice now comprises 3 partners in Sydney as well as 2 in Brisbane. The practice has also benefited from a growing team of dedicated insurance lawyers, many of whom have contributed to this publication.

The year 2000 has seen a number of developments in the legislative and regulatory area which are likely to have a significant impact on insurers. So far as court decisions are concerned, insurers are still awaiting a decision from the High Court in *FAI v Australian Hospital Care* and *Einfield v HIH Casualty* (see the summaries contained on pages 1 to 5 of our 1999 Insurance Annual Review). Those cases were heard by the High Court in 2000 and a decision is imminent. The outcome of these decisions ought to put to rest the uncertainty which exists as to the scope of section 54 of the Insurance Contracts Act and enable insurers to determine the extent to which the courts can, in effect, rewrite the terms of claims made and notified policies to extend to circumstances not notified.

As in past years, most of the decisions we have reported are Australian or New Zealand cases, but we have identified a number of United Kingdom decisions which we consider to be relevant and important to our jurisdiction. The publication also incorporates a number of decisions made in 1999 which have been identified since publication of our 1999 Insurance Annual Review. As in past years, our aim has been to include cases which are of particular interest to the insurance industry or which represent a significant development in the law. We have in general refrained from providing analysis or criticism of the decisions made. We have concentrated on summarising the important issues and commenting on the impact of the decision on the insurance industry.

We would like to thank the following persons who contributed to the publication – Melita Simic, John Edmond, Malcolm Stephens, Matthew Skinner, Mark Lindfield, Simon Writer, Jacqueline Downes, Matthew McLennan, Noga Bernstein, Helen Condon, Avryl Lattin, Kylie Virtue, Jonathan Downes, Luisa Uriate, Sergio Freire, Terence Walsh and Simon Dewberry.

We hope you find this publication both interesting and useful as a reference tool. We welcome any feedback or comments from readers.

Andrea Martignoni
Editor
Insurance Partner (Sydney)

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Section 54: when will a loss of opportunity give rise to prejudice to the insurer?

Case name:

QBE Insurance Limited v Moltoni Corporation Pty Limited

Citation:

[2000] WASCA 82 Supreme Court of Western Australia Wallwork, JPP and Murray JJ

Date of judgment:

3 April 2000

Issues:

- s54 of the Insurance Contracts Act
- loss of opportunity to reduce liability
- meaning of "prejudice" to insurer

The Court in this case held that for the purpose of section 54 of the Insurance Contracts Act an insurer need not show, on the balance of probabilities, that it has suffered prejudice but is entitled to show that it has merely lost an opportunity to reduce its liability.

The facts

An employee of the insured was injured on 7 November 1992. The insurer was not informed of the injury until 6 April 1994. Were it not for section 54 of the Insurance Contracts Act, the insurer would have been entitled to deny liability due to this delay.

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

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

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

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

The decision

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

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

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

(a) the court must determine, *on the balance of probabilities*, whether the insurer suffered a prejudice;

(b) having determined that some prejudice would have been suffered, the loss of the opportunity would be relevant in determining the value of that prejudice.

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

It was common ground between the two judges who considered the issue that a loss of opportunity is relevant in determining whether an insurer has suffered a prejudice under section 54. They took different approaches, however, as to what stage of the reasoning process one should take into account the lost opportunity.

Ipp J held that the loss of an opportunity constitutes the prejudice in itself, whereas Murray J held that the loss of an opportunity was only of relevance in determining the value of a prejudice. This issue therefore remains unresolved. Special leave to appeal has been granted by the High Court.

What is an act or omission of the insured for the purpose of section 54 of the Insurance Contracts Act?

Case name:

De Vito v Commercial Union Assurance Co Limited

Citation:

(2000) 11 ANZ Ins Cas 61-470, District Court of South Australia, per Bright J

Date of judgment:

1 June 2000

Issues:

- motor vehicle insurance
- construction of exclusion clauses
- whether s54 of the Insurance Contracts Act applies to exclusion clause relating to attributes of driver

The facts

The plaintiff insured his prime mover with Commercial Union Assurance Co Ltd (the *insurer*). General exclusion 8 of the policy provided that the insurer would not pay claims for loss where the insured vehicle was driven by, or in the control of, a person who had held the relevant licence for less than two years. General exclusion 10 excluded loss sustained by a driver who was not acceptable to the insurer. The policy imposed an obligation on the insured to notify the insurer of all drivers prior to their driving the vehicle.

The plaintiff had entrusted the vehicle to his employee, Mr E, to drive it to Brisbane. Mr E permitted his then partner, Ms G, to drive. She was at the wheel when it crashed. Mr E was approved as a driver. However, no approval was sought in respect of Ms G until after the accident. The insurer then refused to approve her on the basis that she had not held the relevant licence to drive a heavy articulated vehicle for two years.

The plaintiff made a claim under the policy for repairs to the prime mover. The insurer did not cancel the policy but denied liability for the claim.

The decision

Bright J held that the insurer could have done little more to make plain its attitude to drivers in respect of whom it had not given any approval. Not only were its requirements set out in the original policy, but also on the renewal notice.

Consequently the claim came within general exclusion 8. However, as the insured had not permitted Ms G to drive, the claim did not come within general exclusion 10.

Bright J then considered whether s54 of the Act restricts any right the insurer may have to refuse to pay. Even if s54 applied, subsection (2) of that section permits an insurer to refuse to pay where the act could reasonably be regarded as being capable of causing or contributing to the loss. Bright J considered that the insurer need only show a fairly tenuous link where it points to what could reasonably be regarded as being capable of causing, or contributing to the loss. The insurer was not required to prove that the act was in fact the cause, or a substantial (or other) cause, of the loss.

Bright J categorised Ms G as an inexperienced driver of trucks. It was held that her inexperience could reasonably be regarded as capable of having at least contributed to the loss within the meaning of s54(2). Consequently, the insurer could refuse to pay the claim.

In invoking s54 of the ICA for consideration, Bright J implicitly accepted that the exclusion clause related to "acts or omissions" of the insured or "some other person". He appears to have relied upon a failure by the insured to prevent Ms G from driving. However, an alternative construction (which the insurer had contended for) was that the exclusion clause had nothing to do with acts or omissions, it was simply defining the scope of the cover by reference to the circumstances of the driver. If the approach taken in this decision is correct, it could open the way for insureds to invoke s54 of the ICA to many kinds exclusion clauses to which arguably it was not intended to apply.

Claim held not to arise out of occurrence notified where claim made against different (but related) corporate entity

Case Name:

John Connell Holdings Pty Ltd v Mercantile Mutual Holdings Limited

Citation:

(1999) 10 ANZ Ins Cas 61 – 454, Supreme Court of Queensland, per de Jersey CJ, McPherson JA, Fryberg J

Date of Judgment:

15 October 1999

Issues:

- notification of occurrence
- whether claim arose out of occurrence
- whether waiver or estoppel precluded insurer's denial of liability

An appeal was brought by two insureds against a decision denying the insureds' claim for damages against their insurers for breach of two insurance contracts. The appeal was dismissed by a majority of the Court of Appeal.

The decision of Chesterman J at first instance (10 ANZ Insurance Cases 61-407) was reviewed in our 1998 Annual Review.

The facts

The insureds, Conasoc and John Connell Holdings (***JCH***), were two related companies who carried on civil and structural engineering businesses. The insureds were sued in respect of a defective building which was designed by Conasoc. After works were complete JCH took over from Conasoc as consulting engineer.

The insureds were insured under 2 separate policies. Under each policy, the insurers agreed to indemnify the respective insured in respect of breach of professional duty. Each policy provided for notification of a claim as a condition precedent to the right to indemnity.

In 1980 JCH gave notice of an occurrence to the insurers. The notice stated that the owner of the building was suggesting that JCH had been negligent in designing the building. No notice was given by Conasoc.

In 1983 the owner of the building commenced proceedings against JCH, claiming that JCH had negligently designed the foundations of the building. The claim against JCH was misconceived as Conasoc (and not JCH) had designed the foundations. The insurer indemnified JCH in respect of that claim.

Claim by JCH

JCH's claim against the insurers (which failed at first instance) arose from the insurers' failure to indemnify JCH following a reformulation of the claim by the owner of the building (in 1989) against JCH. The new claim was that JCH had negligently advised the owner of the building that movement in the foundations was localised to one pier and could easily be rectified. The owner alleged that it decided to purchase the building in reliance on that advice.

A majority of the Court of Appeal (Fryberg J dissenting) agreed with the trial judge's decision that the 1989 claim against JCH could not be regarded as a claim "arising out of" the occurrence as notified by JCH in 1980, as negligently designing the foundations was altogether different from a failure to appreciate and advise that foundations designed by someone else were inadequate.

Claim by Conasoc

Conasoc appealed against the trial judge's finding that the notice given (in 1980) by JCH was not also notice by Conasoc. Conasoc argued that the insurance cover extended by the two policies in reality covered both companies, so that notice given by one of the companies effectively operated for the benefit of the other.

The decision

The Court of Appeal agreed with the trial judge's decision that the insurance policies did not cover both companies. It was held that there were substantial commercial reasons why the two companies maintained separate policies. Specifically, Conasoc paid a lower premium than JCH. In addition, liability under the two policies was mutually exclusive. Consequently, the notice given by JCH was for its benefit alone.

Conasoc also argued that because the insurers initially accepted JCH's claim for indemnity, the insurers became bound (by reason of waiver or estoppel) to indemnify Conasoc in respect of any claim for negligence associated with the foundations of the building. Accordingly, Conasoc argued, the insurers could not rely on non-fulfilment of the notice requirements.

The Court of Appeal agreed with the trial judge's decision that this argument failed as there was simply no claim against Conasoc in 1983 which could give rise to a claim for indemnity. The only claim was against JCH. Moreover, it was held that the performance of obligations found in one contract does not amount to a representation that the party performing the obligations would perform other obligations which might arise under another contract with another party.

This case illustrates the need for insureds to ensure that notice of an occurrence extends to each corporate entity which may be subject to a claim. The case also highlights the need for insureds to consider whether the notification correctly describes the circumstances from which a claim may subsequently arise and highlights the uncertainty which can surround this question.

Deregistration: as good as dead under the Insurance Contracts Act

Case name:

Norsworthy & Encel v SGIC

Citation:

[1999] SASC 496; Supreme Court of South Australia per Olsson J

Date of judgement:

30 November 1999

Issues:

- third party claims
- marine insurance – whether the Insurance Contracts Act could apply by reference
- whether section 51 of the Insurance Contracts Act applies to deregistered corporations

This case considers the ability of a plaintiff to pursue a corporation's insurer directly where that corporation has been deregistered

The facts

The Glenelg Scuba Diving Club organised a diving excursion upon a chartered boat named the "Blue Devil" which was owned and operated by Glenelg Dive Charters Pty Ltd (***GDC***).

The appellants alleged that during the excursion the boat was swamped, capsized and thrown onto a reef resulting in injuries to two passengers and loss of or damage to equipment.

The Blue Devil was the subject of a policy of insurance issued by the South Australian SGIC, entitled "Marine Insurance". The policy primarily covered hull damage but also purported to provide cover for, amongst other things, liability arising from loss or damage to property or personal injuries.

Separate actions were commenced by the appellants in respect of personal injuries and property damage. Following an attempt to enforce the default judgment against GDC, it went into liquidation and was eventually deregistered. SGIC eventually became a defendant in both actions after GDC was deregistered.

The issues

The following questions arose:

1. Were the plaintiffs at common law entitled to claim the benefit of any insurance indemnity available against SGIC?
2. Did the provisions of the ICA apply or was the contract governed solely by the Marine Insurance Act (***MIA***)? The ICA did not extend to such contracts.
3. If the ICA did apply, did s51 confer in the plaintiffs a right to sue SGIC directly?

Did the appellants have a claim against SGIC at common law?

In *Trident General Insurance v McNiece Brothers* a third party who was named as a beneficiary under the policy was able to sue the insurer directly.

Olsson J held that the principle in *Trident v McNiece* did not apply in this case as the appellants were not one of the defined insureds under the relevant policy.

The appellants also sought to maintain an action directly against SGIC on

the basis of the decision in *J N Taylor Holdings Ltd (In Liquidation) v Bond*. In that case the plaintiff was able to join the defendant's insurer on the basis that there were common issues relevant to the question of the defendant's liability to the plaintiff and the insurer's liability to indemnify the defendant. That was not the case here. Accordingly, Olsson J would not exercise his discretion to join the insurer.

Did the Insurance Contracts Act apply?

The policy contained a specific provision stating "*where applicable this insurance is subject to the provisions of the Insurance Contracts Act 1984 as amended and/or the Marine Insurance Act 1909*".

Olsson J held that the effect of the above clause was to incorporate the provisions of the ICA or the MIA as appropriate into the agreement between the parties as contractual rights.

The ICA does not cover contracts falling within the MIA. Olsson J considered whether the policy of insurance concerned fell within the MIA, notwithstanding that it covered property damage and personal injuries in addition to traditional marine risks.

He pointed out that "the statutory definition of a contract of marine insurance seeks to characterise the contract of insurance and not the individual risks spanned by it, extracted and considered individually". That is, the character of the policy as a whole must be considered.

He concluded that the contract did fall under the MIA, as the primary object of the policy was the "*hull, engines, trailer and special equipment of the Blue Devil*", and the other provisions were merely incidental, optional coverage.

Could section 51 of the Insurance Contracts Act apply?

Although the judge concluded that the MIA applied, and that as such, the ICA did not, he nonetheless went on to consider whether, if he was wrong, section 51 of the ICA could apply in these circumstances.

Generally speaking, section 51 allows a third party to recover directly against an insurer, under a contract of liability insurance, where the insured "*has died or cannot, after reasonable enquiry, be found*".

The judge held that the reference to an insured who "*cannot, after reasonable inquiry, be found*" includes a deregistered corporation.

He considered that the intention of s51 was "*to empower a party having a valid claim against an insured to recover directly against the insurer when the insured no longer exists*". This applied whether that insured is a natural person or a corporation.

The judge nevertheless held that section 51 could not assist the appellants in this matter. GDC was sued in respect of the property damage whilst it was still registered. Further, it could have been sued in respect of the claim for personal injuries whilst it was still registered, but was not. At the relevant time, therefore, the insured existed and could be found.

The most significant aspect of this case is Olsson J's comments (albeit obiter) that section 51 of the ICA can extend to deregistered companies even though the natural meaning of that section would not appear to contemplate those circumstances.

The case also demonstrates that the terms of the ICA or the MIA could be incorporated by agreement into a policy of insurance, even if they would not otherwise apply.

The case also provides some guidance on the application of the MIA to insurance contracts providing cover beyond traditional marine insurance.

When can a third party plaintiff join the defendant's insurer?

Case name:

Nguyen v Hiotis and City of Charles Sturt

Citation:

[2000] SASC 260 Supreme Court of South Australia (Civil) per Burley J

Date of judgment:

9 August 2000

Issues

- joinder of insurer to proceedings
- whether insurer needs consent to assignment of right to indemnity
- Court's jurisdiction/ discretion to make declaratory orders

This case deals with the principles relevant to the Court's exercise of its discretion to allow a third party plaintiff to join the defendant's insurer. It is particularly relevant where the defendant is insolvent.

The facts

The plaintiff was rendered a paraplegic due to injuries sustained from an assault while attending a function at the Woodville Town Hall. The plaintiff sued the defendant in negligence on the basis that it was the security firm hired to provide security for the function. However, the defendant was bankrupt and its insurer had refused to indemnify it in respect of the plaintiff's claim on the grounds of misrepresentation.

In support of its application the plaintiff relied on the decision of the Full Court of the South Australia in Supreme Court *JN Taylor Holdings Limited (In Liquidation) and Anor v Bond and Ors* (1993) 59 SASR 432. In that case the Court used its discretion to permit joinder of an insurer who had wrongfully refused to consent to the assignment from the defendant to the plaintiff of the right to be indemnified. Burley J noted that it does not follow from that case that an assignment of the right to indemnity requires the consent of the insurer.

The insurer argued that the decision in *JN Taylor* must be confined to its facts and that subsequent case law (*Beneficial Finance Corporation Ltd v Price Waterhouse* (1996) 68 SASR 152, and *Glenmont Investments Pty Ltd and Others v Lend Lease Insurance Ltd* (1999) 74 SASR 152) has had the effect of imposing a substantial limit upon the exercise of the discretion to join an insurer as a defendant. Burley J disagreed. He considered that those cases merely stated that where an insurer has not refused to indemnify the insured, it would not normally be necessary to join the insurer as a defendant.

However, Burley J held that to establish a case for joinder based on *JN Taylor*, there is an onus on the plaintiff to establish an overlap of facts in relation to the questions of liability as between the plaintiff and the defendant, and the determination of liability between the defendant and its insurer. The judge found that no such overlap had been shown by the plaintiff – hence the plaintiff's need for discovery from the insurer relating to questions of indemnity. Accordingly, the plaintiff's application for joinder was dismissed.

This case may assist insurers in resisting joinder by third party plaintiffs. It will often be open for the insurer to argue that the question of its liability to indemnify the defendant is unaffected by the issues to be tried between the third party and the defendant, and that those issues should therefore be tried without the involvement of the insurer.

Insured unable to unilaterally waive privilege enjoyed jointly with insurer

Case name:

FAI General Insurance Company Limited v ACN 010 087 573 Pty Ltd & Anor

Citation:

11 ANZIns Cas 61-464
Supreme Court of Queensland Court

Date of judgment:

21 December 1999

Issues:

- joint privilege between insurer and insured
- waiver of privilege

In this case the Court of Appeal considered the issue of joint privilege between insurer and insured, and in what circumstances that privilege may be waived.

The facts

Interchase Corporation Limited (in liquidation) (***Interchase***) commenced proceedings against Colliers Jardine (Qld) Pty Ltd (***the insured***) and against Hillier Parker in respect of valuations prepared of a property it subsequently purchased. Interchase alleged that it had paid an excessive price in its purchase as a result of the negligent valuations. Hillier Parker claimed contribution against the insured as a possible co-tortfeasor.

Colliers' insurer, FAI General Insurance Company Limited (***FAI***), without confirming indemnity under the policy to the insured, nevertheless conducted the insureds' defence against Interchase and against the contribution claim from Hillier Parker, reserving its right ultimately to refuse indemnity. During this period various documents were generated including independent valuers' reports, copies of which were provided to FAI and the insured. Indemnity was subsequently refused.

After FAI's solicitors ceased to act in the matter the insured negotiated a settlement with Interchase. Thereafter, Interchase continued its action against Hillier Parker, who in turn continued its claim for contribution against the insured. As there was no longer any issue between Interchase and the insured, Interchase's solicitors assumed conduct of the insured's defence of the contribution claim.

In support of Interchase, the insured was prepared to waive its privilege in the valuers' notes and correspondence held by FAI's solicitors. Although FAI was not a party to the action it opposed any order for the production of documents for inspection, in order to prevent public disclosure which would effectively defeat any later claim of privilege.

The trial judge ordered FAI's solicitors to provide the insured with access to the documents that they had created or received in acting for the insured. FAI appealed.

The decision of the Queensland Court of Appeal

In allowing FAI's appeal, the Queensland Court of Appeal made the following findings:

- The insurer enjoyed joint legal professional privilege with the insured, and neither could unilaterally waive that privilege.

- The insured was entitled to access the material held by the joint solicitor, but was not entitled to use the material, or to waive privilege to allow others to use the materials, for an ulterior purpose.
- In this case the insured's right of access was confined to access for the purpose of defending against liability to Interchase or contribution to Hillier Parker for which indemnity was sought from the insurer. The insured's intention of waiving privilege to assist Interchase was ulterior to this purpose, and therefore in breach of its duty of confidence.
- The doctrine of utmost good faith restrained the insured from using the material to the prejudice of FAI particularly in circumstances where FAI had not authorised such use expressly and/or impliedly.
- Byrne J, with whom McPherson JA agreed, held that to give business efficacy to a tripartite arrangement among a solicitor, the insurer and the insured, it might be necessary to imply into the policy a term that information shared in the common cause of resisting a third party claim cannot, without consent, ordinarily be used in an indemnity contest.

This case illustrates the limited use which either party may make of material subject to joint privilege between insurer and insured without the consent of the other party.

Fraud of one insured defeats interest of joint insured

Case name:

MMI General Insurance Limited v Baktoo & Anor

Citation:

(2000) 11 ANZ Ins Case 61-466, Supreme Court of New South Wales, Court of Appeal, per Sheller JA, Mason P and Beazley JA

Date of Judgment:

11 April 2000

Issues:

- joint insurance policy
- whether an innocent joint policy holder is entitled to indemnification for damage caused by the other insured in respect of their proportion of the loss

The facts

The plaintiffs were partners in a business. They had a joint insurance policy with MMI for their Indian restaurant and retail shop and for their neighbouring residence. The premises were badly damaged by fire and the plaintiffs sued MMI to recover damages for MMI's refusal to pay the claim. MMI argued that it was entitled to reject the claim because the fire had been deliberately lit and the claim fraudulently lodged.

At first instance, Patten DCJ found that Mr Baktoo had deliberately lit the fire which damaged the premises but that Mrs Baktoo had played no part in lighting the fire and was not privy to the fraud. Pursuant to s56(1) of the Insurance Contracts Act and the conditions of the policy, Mr Baktoo could not benefit under the policy. However, Patten DCJ held that as an innocent party Mrs Baktoo was entitled to indemnity for her proportion of the loss, in this case one-half of what otherwise would have been MMI's liability. MMI appealed this decision.

The decision

Sheller JA delivered the judgment on behalf of the Court of Appeal. He dismissed Patten DCJ's reliance upon US and Canadian cases that took a "socially realistic approach" and enabled an innocent "joint assured" to recover a proportion of a joint loss. Instead he categorised the policy held by Mr and Mrs Baktoo as a joint policy because it applied indifferently to both separately owned and jointly owned property. In these circumstances he held that MMI's obligation to Mr and Mrs Baktoo was a joint one only and the inability of one joint insured, namely Mr Baktoo, to recover under the policy by reason of fraud defeated any claim by the other joint insured.

Sheller JA distinguished a joint policy from the case of a composite policy where there is one insurance but a number of people have different interests in the subject matter. Where a composite policy exists and one co-insured has deliberately caused loss by his own fraudulent act that does not necessarily prevent an innocent co-insured from recovering under the policy.

Of particular importance in this case was the fact that Mr and Mrs Baktoo were in partnership. If Mrs Baktoo were to recover under the policy she would not have any personal claim to the insurance moneys because the insurance moneys are recoverable as an indemnity for the loss of partnership property. Accordingly, as a partner Mr Baktoo would have an interest in the moneys recovered. Sheller JA concluded that the orders

made in the District Court allowing Mrs Baktoo to recover would therefore defeat the principle that a fraudulent party should be prevented from profiting from the fraud. On these grounds, MMI's appeal was allowed.

This case demonstrates that Courts are reluctant to distinguish separate interests under a joint insurance policy. Sheller JA expressly rejected the application of a socially realistic approach to joint policies. He recognised that the characteristic feature of a joint insurance is that the interests of the joint insured are treated as one. Accordingly, where one party is unable to recover because a claim is fraudulent, the other party, even though they had no knowledge of the fraud, is also unable to recover.

How far does an insurer's obligation of good faith extend?

Case name:

Norwich Union Life Insurance Society v Qureshi and Qureshi

Citation:

[1999] QBD (Com Ct) 263; Queen's Bench Division (Commercial Court) per Rix J

Date of judgment:

8 June 1998

Issues:

- duty of good faith
- duty of disclosure
- unconscionable conduct

The first defendant was an underwriter at Lloyd's. In November 1989, the first defendant entered into an arrangement with the plaintiff, NU Life. The arrangement was a property backed guarantee plan marketed to Lloyd's underwriters and consisting of three linked elements: a guarantee for £400,000 in respect of the first defendant's liabilities to Lloyd's; a mortgage over the first defendant's home; and a life policy.

The offer made to the first defendant provided for a life policy in the sum of £69,504 with monthly premiums of £258. Any payment made by the plaintiff to Lloyd's under the guarantee could be treated as a sum advanced under the mortgage on which interest would be payable.

The first defendant was a member in a number of syndicates which suffered disastrous losses. As a result, Lloyd's made calls upon the guarantee provided by the plaintiff until it was exhausted. The first defendant was unable or unwilling to maintain both the premiums payable on his life policy and the interest payable on the sums which the plaintiff debited to the mortgage on his home. The plaintiff subsequently commenced proceedings against the first defendant and his wife (who was also a party to the mortgage).

The first defendant brought a counterclaim, alleging that two companies in the same group as the plaintiff conducted insurance and reinsurance business with persons operating within the Lloyd's market. The first defendant alleged that through interlocking directorships, the plaintiff had been well aware at the time he entered into the plan that several Lloyd's syndicates were about to incur substantial losses. He claimed that if he had been aware of this information, he would have immediately ceased or limited his underwriting activities and would not have entered into the plan. The plaintiff owed the first defendant a duty of disclosure and had not complied with that duty.

The first defendant pleaded four separate defences. First, as the plan involved as one of its elements a life policy, the plaintiff as insurers of the first defendant's life owed him a duty to disclose what they knew about the Lloyd's market. Rix J considered it was not the case that, on the question of the plaintiff's requisite knowledge, the first defendant could not succeed. Rather, the question was whether information which might be material to a prospective plan customer's decision whether to underwrite at Lloyd's is information which must be divulged in good faith to that customer, in circumstances where the requirement of good faith only became relevant because the life policy was an element of the overall plan. Rix J held that the requirement of good faith did not extend that far. The first defendant's underwriting at Lloyd's was not material to the risk

on his life, nor was it relevant to his ability to recover a claim from the plaintiff under the policy. The first defendant had agents who had the responsibility of advising him about underwriting at Lloyd's, but the plaintiff was not among them.

Second, the first defendant argued that the plaintiff was taking unfair advantage of a position of inequality so as to render the plan an unconscionable bargain. It was contended that the plaintiff did so by encouraging the first defendant to enter into the plan through aggressive marketing, for its own commercial benefit, without disclosing to him their knowledge about the Lloyd's market or ensuring that he was aware of what it knew. This argument was also rejected. The first defendant was neither young, poor, ignorant or bereft of any adviser. There was nothing alleged against the plaintiff which was oppressive, over-reaching or exploitative and the plan was not unconscionable or in any way unusual. In the absence of a duty of disclosure, it could not be said that the plaintiff acted unconscionably.

Rix J held that the third plea, founded upon s47 of the Financial Services Act 1986 (UK), was unsustainable as the section did not afford an investor a private action for damages. Under that section, any person who, in relation to an investment contract, dishonestly conceals material facts, or recklessly conceals facts, is guilty of a criminal offence.

Finally, the first defendant pleaded that the plaintiff had been notified of clear fraud at Lloyd's before payment under the guarantee. There had been no finding that fraud had in fact occurred and the heavy burden of showing clear fraud had arguably not been met.

This case helps define the boundaries of an insurer's obligation of good faith and the duty of disclosure to their customers. The Court held that the duty of disclosure which applied to the life policy (merely one element in the overall plan) did not necessarily spill over into the wider aspects of the linked transaction. Accordingly, the first defendant's attempts to avoid the plan failed.

Fire insurance: insurer unable to prove arson based on expert evidence and circumstantial evidence

Case name:

Dixon v Commercial Union Assurance Company of Australia Limited

Citation:

Supreme Court of Tasmania [1999] TAX SC 104 per Wright J

Date of judgment:

15 October 1999

Issues:

- fire insurance
- arson
- burden of proof – circumstantial evidence

The Supreme Court of Tasmania has recently rejected a defence of arson fraud in a fire insurance claim.

The facts

Mr Dixon was a retiree who smoked roll-your-own cigarettes and had over the years built, bought, leased and sold various properties. In December 1997 he bought a property with a view to establishing dog kennels as a means of providing employment for his daughter. His development application for that purpose was rejected by the local council. In June 1998 he sold much of the land and on 27 July 1998 he had received an expression of interest to purchase the remainder of the property. On 28 July 1998 the premises were destroyed by fire. On 29 July 1998 Mr Dixon made a claim on his home insurance policy. The insurer denied the claim alleging that Mr Dixon had deliberately set fire to the property.

The evidence was that the fire had originated in the laundry area and in all probability behind the washing machine which was in its normal position at the time of the fire. The laundry was located at the rear of the house. When the fire started the power supply to the home was interrupted due to damage to the local power system. For that reason the power was off and ignition from an electrical source was not a possibility. There were two wood heaters in the house and Mr Dixon's evidence was that he had lit the wood heater in the sunroom using sticks and pine cones which were stored in bags in the laundry. His evidence was also that he never used firelighters and that he did not have any in his home. The insurer's expert's opinion was that the fire had started some time in the morning. Mr Dixon's evidence was that he had left home some time between 12.30 and 1 o'clock and he was seen by various witnesses in town at times consistent with that. Significantly one witness recalled seeing Mr Dixon in town at about 11.30am and the judge was quite impressed that Mr Dixon refused to accept that that witness was correct in his timing. As the judge said:

> *"Had he wished to establish a better alibi than he otherwise had, he may well have agreed with Mr de Jong that he was in Smithton around 11.30am or 11.45am as Mr de Jong said. Mr de Jong was an impressive witness in all respects and with support from the plaintiff as to times, his estimates may well have been accepted."*

The insurer's expert gave evidence that scientific tests showed the presence of Jiffy firelighters in the southwest corner of the laundry, that the fire did not start adjacent to the heater in the dining room and that an ember or spark from that source could not have been the cause of ignition in the laundry.

The decision

Wright J held that in a civil trial he was required to be convinced affirmatively on the balance of probabilities the Mr Dixon started the fire. The existence or non-existence of a motive was an important factor. As the case was a circumstantial case he found that it was necessary to view all the evidence together rather than isolating specific aspects of the evidence and considering the weight of each piece of evidence as a discrete issue.

After considering all the evidence Wright J found in favour of Mr Dixon for the following reasons:

- the insurer's expert appeared not to have been aware of various important features of the house and of the effect of gusty winds. For this reason the judge was not convinced by the expert evidence that the fire must have commenced in the morning. He felt that whilst the expert evidence was not inconsistent with the possibility that Mr Dixon was at home it was not conclusive of that fact;
- he did not accept the insurer's assertion that there was a strong motive for Mr Dixon to set the fire. The rejection of the development application for a dog kennel was not sufficient. He found that there was no evidence that Mr Dixon was in financial difficulty or having serious difficulties in selling the house;
- he considered three other possibilities for the fire:
  - (a) that a malicious third party entered the premises in Mr Dixon's absence and set the place on fire – he thought that that possibility was so remote and improbable that he rejected it;
  - (b) that the fire in some way started from an ember from the wood heater in the dining room or from some unidentified external source – whilst the expert evidence was that this was not a possible cause of the fire the judge felt that a spark could have come from the fire and blown into the laundry onto the pine cones thus starting the fire;
  - (c) that Mr Dixon unintentionally dropped a cigarette near flammable materials in the laundry – he felt that this was not a farfetched possibility and that a strong draught under the back door under a glowing butt near the pine cones may well have started the fire;
- he felt that the Jiffy firelighters might have been left in the house by a prior occupant and were not necessarily connected with the starting of this fire;
- there was no evidence that Mr Dixon had ever purchased or possessed Jiffy or similar firelighters;
- sentimental possessions and other property of Mr Dixon was not removed from the premises before the fire and was destroyed in it;
- witnesses gave a graphic description of Mr Dixon's shock and distress on arriving home such that Mr Dixon must have been "*capable of giving an Oscar winning performance if he was indeed the arsonist*".

The case illustrates the difficulty of proving arson or fraud particularly where circumstantial evidence is relied upon and a very clear motive cannot be persuasively established. The case also demonstrates the importance of ensuring that expert witnesses are aware of all relevant facts.

A joint interest in rotten fruit

Case name:

Nicholson & Ors v Icepack Coolstores Limited

Citation:

(1999) 10 ANZ Ins Cas 61-449

Date of judgment:

16 April 1999

Issues:

- legal professional privilege
- joint privilege between insurer and insured
- waiver of joint privilege

The New Zealand High Court considered whether privilege can be invoked between an insured and its solicitor to the detriment of the insurer, where the solicitor in question acts jointly for insurer and insured.

The facts

This claim arose out of the storage by the plaintiffs, growers of some Nashi pears, in the premises of Icepak in early 1998. The pears were damaged while in Icepak's coolstore. The plaintiffs sought to recover damages from Icepak for the losses arising from the damage to the pears.

Icepak had public liability insurance with State Insurance Ltd, who had agreed to indemnify Icepak and instructed a firm of solicitors, Tompkins Wake.

After the commencement of the action, Tompkins Wake received briefs from the plaintiffs that suggested that the director of Icepak, Mr Van Eden, had made a false statement to Tompkins Wake, and had made a number of admissions to the plaintiffs. On advice from Tompkins Wake, the insurer then declined to indemnify Icepak on the basis that Mr Van Eden was in breach of a condition of the policy. The condition provided that the insured had a contractual responsibility to provide "*all such information and assistance*" as required by the insurer. Icepak instructed new counsel and joined the insurer as a third party.

The question before the Court related to the admissibility of Tompkins Wake's intended evidence in the proceedings. Icepak challenged the admissibility alleging that it had a solicitor and client relationship with Tompkins Wake and that communications between it and Tompkins Wake were the subject of legal professional privilege.

Having noted that the privilege was that of the client, not of the client's legal adviser, and accordingly may be waived by the client only, Penlington J found that the case raised two basic questions being what was the role of, and what were the obligations of Tompkins Wake in the circumstances?

Finding no case on point in NZ, Penlington J examined the state of the law in other jurisdictions. He concluded that the preponderance of judicial opinion, apart from the USA, favoured the view that an insurer-appointed solicitor became the solicitor for the insured. Penlington J referred specifically to the situation in Australia. He noted that with one exception, the Australian judiciary appears to favour the creation of a solicitor and client relationship between the insurer-appointed solicitor and the insured.

The High Court of New Zealand granted Icepak's appeal, finding that Tompkins Wake were solicitors for both the insurer and insured. Once that relationship existed, communications passing between the director

of Icepak and Tompkins Wake in relation to the litigation were confidential communications attracting privilege. The fact that Icepak did not select Tompkins Wake as solicitors and was not responsible for their fees did not preclude the existence of a client solicitor relationship. As a result the evidence was held to be privileged and therefore inadmissible. The Court also noted that Tompkins Wake was in a likely conflict situation and in those circumstances should have ceased to act for both parties and should not have disclosed to the insurer the information gleaned from the insured.

This case highlights the importance of making proper enquiries before indemnity is confirmed. In any case where the insurer cannot be confident that further facts may reveal an entitlement to deny indemnity, it may be open for insurers to agree to indemnify the insured on the basis that should the insurer subsequently become aware of any entitlement to deny indemnity, the insured waives its privilege over the information and consents to any solicitor which is engaged to act for both the insurer and the insured ceasing to act for the insured but continuing to act for the insurer. Whether in fact it would be appropriate for the solicitor to cease acting for either the insured or the insurer or both (in view of potential conflicts) will depend upon the facts.

The function of the Superannuation Complaints Tribunal

Case name:

National Mutual Life Association of Australasia Limited v Campbell

Citation:

[2000] FCA 852; Federal Court of Australia per Black CJ, Emmett J and Hely J

Date of judgment:

10 December 1999

Issues:

- superannuation funds
- whether member retired as a result of "total and permanent disablement"
- review of function of Superannuation Complaints Tribunal

This case considered whether the Superannuation Complaints Tribunal had exceeded its function by exercising judicial power (that is, by declaring or enforcing the parties' legal rights) rather than making its own determination.

The facts

National Mutual Life Association of Australasia Limited (***National Mutual***) was the insurer of the ANI Group Superannuation Fund, established for the benefit of employees of ANI Limited. Ronald Campbell was a member of the Fund and a Life Assured within the meaning of the Fund's trust deed.

The trust deed provided that a member was entitled to the payment of a certain benefit if he or she retired before the age of 60 as a result of his or her "total and permanent disablement". The term "total and permanent disablement" was defined to mean:

> *"… having been absent from employment with [ANI Limited] through injury or illness for six consecutive months and in the opinion of [National Mutual] after consideration of medical evidence having become incapacitated to such an extent as to render the Life Assured unlikely ever to engage in work for reward in any occupation or work for which he is reasonably qualified by education, training or experience."*

Campbell was employed by ANI Limited as a leading hand for ten years. On 26 February 1994, he lodged a claim for a total and permanent disablement benefit. National Mutual advised Campbell that he did not satisfy the definition of "total and permanent disablement". The trustee of the fund subsequently rejected Campbell's claim and that decision was affirmed on internal review. Campbell lodged a complaint with the Superannuation Complaints Tribunal (the ***Tribunal***) under the Superannuation (Resolution of Complaints) Act 1993 (the ***Act***).

Proceedings before the Tribunal

The area of contention was the Tribunal's finding that Campbell suffered from post-traumatic stress disorder. Three psychiatrists' opinions were presented to the Tribunal: two were obtained by National Mutual, the other from Campbell's treating psychiatrist. One of the reports obtained by National Mutual concluded that Campbell did not suffer from post-traumatic stress disorder or any other serious or permanent mental disorder. The other accepted that Campbell suffered moderate anxiety symptoms but that the symptoms were not sufficient to prevent him from working. In contrast, Campbell's treating psychiatrist's diagnosis was that his patient suffered from post-traumatic stress disorder. Given the severity

of Campbell's symptoms, the psychiatrist was of the opinion that Campbell was totally and permanently disabled for all work.

The Tribunal chose to prefer Campbell's psychiatrist's opinion on the grounds that, as Campbell's treating psychiatrist, he examined Campbell on a regular basis and Campbell now placed his trust in the psychiatrist. The Tribunal found that National Mutual and the trustee had not given sufficient weight to Campbell's psychiatrist's opinion and accordingly, their decisions to reject Campbell's claim were not fair and reasonable. The Tribunal set aside the decisions of both the trustee and National Mutual and substituted its decision that Campbell was entitled to payment of the total and permanent disablement benefit. National Mutual appealed to the Federal Court on a question of law in accordance with s46 of the Act.

The Federal Court proceedings at first instance – Heery J

The object of the Tribunal is to provide a mechanism for resolutions of complaints. Under s14(2) of the Act, a person may make a complaint that a decision of a trustee "*is or was unfair or unreasonable*". Under s37(1), for the purpose of reviewing a decision of the trustee the Tribunal has all the powers, obligations and discretions that are conferred upon the Trustee. Under s37(3), the Tribunal must make a determination in writing either affirming the decision, referring it to the Tribunal for reconsideration, varying it or setting it aside and substituting another decision for the decision.

Under s37(4) of the Act, the Tribunal only has the power to exercise its determination-making power for the purpose of placing a complainant as nearly as practicable in such a position that the unfairness or unreasonableness of the trustee's decision no longer exists. Section 37(6) of the Act requires the Tribunal to affirm a trustee's or insurer's decision if it is satisfied that the decision, in its operation in relation to the complainant, was fair and reasonable in the circumstances.

National Mutual argued that in the circumstances the Tribunal could not substitute its own decision. National Mutual also contended that the Tribunal had asked itself the wrong question (that is, whether Campbell had retired as the result of total and permanent disablement) when the proper question for the Tribunal was whether the trustee's decision was fair and reasonable. It further argued that the Tribunal could only upset the trustee's decision if it was so unreasonable that no reasonable decision maker could have come to it.

Heerey J found that the Tribunal decided that it was unfair, in the sense of being unjust, to reach a determination adverse to Campbell by rejecting the opinion of his treating psychiatrist who was much more familiar with Campbell than the psychiatrists engaged by National Mutual. In doing so, the Tribunal had not exceeded its functions under the Act. Accordingly, Heerey J dismissed National Mutual's application.

The decision before the Full Court

On appeal, the Full Court upheld Heery J's decision. Its reasoning was as follows:

(a) If National Mutual's arguments were correct, the Tribunal would be exercising judicial power. The High Court had held in *Attorney General (Cth) v Breckler* (1999) 163 ALR 576 that this was not the case. The determinations of the Tribunal do not declare or enforce the legal rights of the parties. They merely create new rights based on considerations of fairness. The Tribunal makes its own decision.

(b) The Tribunal did not ask itself the wrong questions. In the course of its deliberations it had to make findings of fact.

This case illustrates the wide powers available to the Superannuation Complaints Tribunal. The Tribunal is entitled to make its own decisions, and is not confined to determining whether the decision which was made was lawfully open.

Work injuries: can the employee choose who must pay?

Case name:

Bosner v Melnacis, Vacc Insurance & Maroochy Shire Council

Citation:

[2000] QCA 13; Supreme Court of Queensland, Court of Appeal per de Jersey CJ, Thomas JA and Helman J.

Date of judgment:

8 February 2000

Issues:

- WorkCover Queensland Act 1996
- personal injuries sustained in the course of employment
- whether a third party can obtain a contribution from the employer

The Queensland Supreme Court considered whether the inability of the plaintiff to sue the employer, due to the operation of certain provisions of the WorkCover Queensland Act 1996, defeats the right of the defendant to sue the employer for contribution.

The facts

Whilst in the course of his employment as a traffic controller for Maroochy Shire Council (the ***employer***), the plaintiff suffered personal injuries after being hit by a motor vehicle driven by the first defendant (the ***defendant***) on 9 September 1997. Both the employer and the defendant were guilty of negligence causing the plaintiff's injuries.

The defendant and her insurers appealed against a refusal to issue a third party notice against the employer. The District Court had refused the application on the grounds that on the facts, the employer's liability for the injuries had been abolished by the provisions of Chapter 5 Part 2 of the WorkCover Queensland Act 1996.

Under the *WorkCover Act* scheme, a right to seek damages from an employer comes into existence only if the worker complies with prescribed steps dealt with in sections 253 to 274. A worker must obtain a notice of assessment from WorkCover or, in the case of a worker who has not lodged any application for compensation, a damages certificate. Then, if a worker has a "*certificate injury*" (one which results in a work-related impairment of 20 per cent or more), he has the right to accept a lump sum compensation and also to proceed with a claim against the employer for damages. If the worker has a "*non-certificate injury*" (one which results in a work-related impairment of 20 per cent of less), he must elect to either accept a lump sum payment offered by WorkCover or to sue the employer for damages. The plaintiff in the present case did not follow the prescribed procedures.

s253(2) provides that "*The entitlement of a worker…to seek damages is subject to the provisions of this chapter.*"

s253(3) states that "*To remove any doubt, it is declared that ss(1) abolishes any entitlement of a person not mentioned in the subsection to seek damages for an injury sustained by a worker.*"

The decision

The Court of Appeal held as follows:

(a) The main question was whether the employer was "*a tortfeasor who … would if sued have been liable*" to the plaintiff in respect of the same damage for which the defendant was liable, within

the meaning of the relevant contribution legislation. If so, then the defendant could sue the employer for contribution.

(b) The effect of the WorkCover Act scheme was to abolish any entitlement on the part of an injured worker to commence proceedings against the employer and provide that such a right comes into existence only upon compliance with the prescribed steps.

(c) It followed that the employer had no "liability" to the plaintiff (even "if sued") which could form the basis of a claim for contribution.

The case highlights the difficulties which can arise in dealing with liability between an employer and a defendant who are joint or concurrent tortfeasors. An employee could refrain from taking steps to enable a claim to be made against an employer where it will be easier and more expedient to pursue a third party target against whom some negligence can be established. The injured worker, by applying or failing to apply for an assessment, can effectively dictate where the eventual loss will fall.

Motor vehicle insurance: insurer bound to continuous cover

Case name:

FAI General Insurance Company Limited v Spannagle & Anor

Citation:

[2000] 11 ANZ Ins Cas ¶61-459

Date of judgment:

14 January 2000

Issues:

- third party liability insurance for motor vehicles
- Motor Accident Insurance Act 1994 (Qld)
- whether insurance can be required to exist retrospectively

The facts

Mr Spannagle was the owner and driver of a Toyota utility. He had registered and insured his vehicle with Queensland Transport Administration for the year 20 February 1996 to 20 February 1997. He paid an amount of $437.70 to effect that registration and insurance. For the subsequent year, the required payment for registration and insurance was raised to $516.60.

On 6 March 1997, after the expiration of his vehicle's registration, but before the end of the grace period, Mr Spannagle posted a cheque in the amount of $437.70 intending that the payment be for the renewal of the registration and insurance for the vehicle.

Transport Administration returned the cheque to the owner's bank on 20 March 1997. On 2 April 1997, a motorcyclist collided with the Toyota utility and as a result was injured. On 9 April 1997, after the accident, the owner's bank advised him that the cheque had been returned. The owner instructed the bank to re-submit the cheque to Transport Administration and supplemented it with an additional cheque for the difference. The amounts were banked on 23 April 1997. On 13 May 1997 Transport Administration issued a receipt and a certificate which indicated that the vehicle had been registered from 20 February 1997 to 20 February 1998 and that FAI was its compulsory third party insurer. FAI ultimately received payment in respect of the Toyota from Transport Administration.

In the following months, the owner notified FAI of the accident. The Nominal Defendant was advised of the claim on the basis that at the relevant time the vehicle was uninsured. Subsequently, the motorcyclist issued a writ claiming damages for injuries he sustained against FAI and the Nominal Defendant as the insurers of the motor vehicle.

The decision

Chesterman J held that the vehicle was covered by a policy of insurance for the relevant period. This finding was based on a number of factors which included:

- the fact that the term for the period of insurance and registration was fixed by statute;
- when FAI received and kept the cheque for the complete amount, which included the premium in respect of the insurance, it could be taken to have agreed to revive the policy and cover the insured for the entirety of the statutory period of cover;and
- in reviving an insurance policy, it is a question of the intention of the parties as to the period which the policy will cover. The period could run either from the date of the expiration of the previous policy (thus giving continuous cover) or from the date on which the policy was reinstated.

In providing the amount to Transport Administration, the insured was requesting registration and insurance for the period specified by the Motor Accident Insurance Act. Transport Administration was acting in the capacity of agent for the insurer for the purpose of effecting and renewing compulsory third party policies. As Transport Administration's activities were regulated by statute, the insurer was not in a position to revoke or limit its authority to effect policies in accordance with the provisions of the Act. According to the legislation, Transport Administration was explicitly authorised to register and insure for the period specified in the Act and that period only.

This judgment is of interest because of its consideration of the position of insurers in relation to compulsory third party schemes. Insurers are effectively constrained by the limitations imposed by the relevant legislation and the policies implemented by the relevant department in achieving the ends for which the legislation was designed. Therefore, an insurer may be bound in certain circumstances, where it would not ordinarily be bound, due to the requirements of public policy and by operation of the relevant Act.

Insurer must give fair notice of termination of agency

Case name:

Harding v EIG Ansvar Limited

Citation:

(2000) 11 ANZ Ins Cas 61-460

Date of judgment:

20 January 2000

Issues

- retainer of insurance agent
- termination of retainer
- requirement of fairness

The facts

In February 1998 the plaintiff entered into an agency agreement with Ansvar. The agreement provided for a 30-day notice period for any termination of the agreement. Ansvar was the only insurer for whom the plaintiff acted.

The plaintiff had a troubled relationship with Ansvar and had voiced continuous criticism of the company throughout his period as an agent. On 19 October 1998, Ansvar wrote purporting to terminate the agreement based on his attitude to the company. The agreement later came to an end after a further notice given on 4 December 1998.

In October 1998 the plaintiff sought interim relief but this was refused on the basis that damages would be an adequate remedy. The claim was determined on the final hearing.

The issues

The plaintiff argued that the termination provision of the agency agreement was “unfair” or “harsh” within the meaning of s127A of the Workplace Relations Act 1996. The plaintiff argued that, by terminating the agreement, Ansvar had caused him to lose the commissions otherwise available to him on those policies that he had written for Ansvar and that Ansvar was able to appropriate his business to itself without paying for it.

Ansvar argued that the agreement was in the form provided by the Insurance Council of Australia, the relevant industry regulator, and was of universal application in the general insurance industry. Furthermore, Ansvar argued that the plaintiff had plenty of opportunity to review the agreement before signing it and was aware of the 30 days’ notice requirement.

The decision

The Judge held that the question of unfairness or harshness had to be addressed at the time the contract was made. The Judge refused to accept that there was significant inequality of bargaining power or undue influence at the time the contract was made, or that there was any reason to think that the contract was harsh or unfair on that basis.

However, the Judge noted that at the time the contract was made the plaintiff acted solely for Ansvar and Ansvar knew this. As a consequence, provisions that might not have been unfair if the plaintiff had chosen to accept agencies from other insurers could be unfair. The Judge found that the 30 days’ notice was unfairly short in the circumstances and did not allow sufficient time for the plaintiff to realise the asset value of his client register by transferring it to another agent.

This case is of interest to insurers as it highlights the need to ensure that any agency arrangements are fair. What is fair will depend upon the circumstances. Where the agent acts only for one insurer, provisions which might be fair in relation to multiple-insurer agents may not be fair.

Elf overturned: insurer able to recover in full from contractors primarily liable to insured

Case name:

Caledonia North Sea Limited v London Bridge Engineering Limited and Others ("Piper Alpha")

Citation:

Scottish Inner House of the Court Sessions [2000] Lloyds LR 249 per Caplan, Rodger, Southerland, Coulsfield and Gill LJJ

Date of judgment:

17 December 1999

Issues:

- subrogation
- contribution
- contractor's indemnity clause

This case considers whether an insurer can exercise its right of subrogation to sue a third party who under a clause in a contract agreed to indemnify the policy holder for the loss in question.

Are agreements to indemnify contracts of insurance? Should they be treated as equivalents so that the rules of double insurance and contribution apply in the case of a policy holder who has insurance and has the benefit of an indemnity clause in its business contracts?

The facts

In 1988, the Piper Alpha Oil platform in the North Sea exploded, killing 165 people and injuring others. Other people were also killed or injured during the rescue operations. The operator of the platform was Caledonia North Sea Limited (the ***appellant***). Many of those people killed were employees of contractors hired by the appellant.

After the disaster, the appellant settled a large number of claims made by those who were injured or the families of those killed. These settlements were paid directly by the appellant's insurers.

The agreement between the appellant and the contractors provided that the contractors would indemnify the appellant for any payments made to those injured or killed in the case of such a disaster. Therefore, after the settlements, the appellant's insurers brought a subrogated action against the contractors in respect of the amounts paid to those injured or killed.

In the original judgment in *Elf Caledonia Limited v London Bridge Engineering and Others*, the Court held that although the contractors were liable to the appellant in respect of any loss suffered by reason of the relevant clause in the contact, the appellant had *not* in fact suffered any loss because all payments to those deceased or injured had been paid by the appellant's insurers. Accordingly, the insurers could not bring a subrogated action against the contractors – rather, the insurer could only bring a separate action of contribution (i.e. sharing of losses) against the contractors under the insurer's own name, an action which would now be impossible due to the relevant statutory limitation period.

The insurer appealed.

Appeal judgment

The Appeal Court upheld the appeal on the basis that the insurers were entitled to bring a subrogated claim against the contractors.

All four judges held that whether or not a policy holder was insured was irrelevant to the question of a third party's liability to the policy holder. Ultimately, the issue to be decided was whether the contractor's obligation under a contractual indemnity clause to indemnify the appellant was equal

to or co-ordinate with the insurer's obligation under an insurance policy to indemnify the insured. In the case of parties with co-ordinate liabilities, equitable principles of contribution would govern any claims between them. In that instance, the insurer (having indemnified the insured) would be able to bring an action against the contractors for contribution based on the contractors "co-ordinate liability".

The Court held that although all obligations of insurance are obligations of indemnity, not all obligations to indemnify are obligations of insurance. Further, the rationale behind insurance policies was that they were secondary forms of relief – a back-up which allowed the policy holder to reduce its loss in case the guilty party (who had the ultimate obligation to indemnify) was unable to fully compensate the policy holder's loss. That meant that the obligation of the contractor to indemnify the appellant was the *primary* obligation. The insurer's obligation was to pay under a claim *subject to the right to recover in the insured's name from the other party who had the liability for the loss*. Therefore, the contractors could not successfully argue that the insured had suffered no loss merely because the insured had the foresight to enter into an insurance policy to safeguard themselves in the event that the contractors would not pay. The ultimate liability rested on the contractors and the insurance policy was for the benefit of the policy holder only, not the contractors.

Further, the Court stated that it was settled beyond doubt that an insurer can only bring an action against the third party under the policy holder's name. This was because the payment of a claim under a policy of insurance did not transfer the policy holder's rights to the insurer. However, the law gave the insurer the right to insist that the policy holder authorise the insurer to use the policy holder's name in proceedings against those ultimately responsible for the policy holder's loss.

This case is good news to insurers. It holds that an insurer's right of subrogation can be used to pursue third parties who are contractually bound to indemnify the insured. The insurer's rights will not be limited to a right of contribution unless the indemnity agreement between the third party and the insured amounts to a contract of insurance. Of course, the result may be different in cases where the policy wording or the wording of the indemnity clause in the agreement with the contractor lead to a different construction.

When will the policy restrict a subrogated claim?

Case name:

Larson-Juhl Australia LLC v Jaywest International Pty Limited

Citation:

[2000] NSWC 524 Supreme Court of New South Wales Equity Division per Master Macready

Date of judgment:

15 March 2000

Issues:

- waiver of subrogation
- construction of policy
- defence of circuity of action

This case examines the limitation which may be placed on an insurer's right of subrogation against a co-insured as a result of a waiver of subrogation clause in an insurance policy.

The facts

The plaintiff purchased a picture framing business from the defendants which was conducted in leased premises. Subsequently, the plaintiff had to re-locate the business because the roof started to sag and the premises were deemed unsafe by the local council.

The defects in the leased premises were not caused by either the plaintiff or the defendants.

The plaintiff recovered in excess of $1M pursuant to the business interruption cover under its Industrial Special Risks Policy (the ***Policy***).

Pursuant to its rights of subrogation under the Policy, the insurer commenced proceedings against the defendants for breach of the business sale agreement and for breaches of the Fair Trading Act and the Trade Practices Act.

The defendants were co-insureds under the Policy.

The issues

The following issues were referred for separate determination:

1. Whether the waiver of subrogation clause under the Policy (Clause 14.8) prevented the insurer from bringing any proceedings against the defendants.
2. Whether the defence of circuity of action was available to the defendants.

Waiver of subrogation clause

Clause 14.8 provided:

> *"The insurer shall waive any rights and remedies or relief to which it is or may become entitled by subrogation against:*
>
> *4. any co-insured (including its directors, officers and employees);*
>
> *5. any corporation or entity (including its directors, officers and employees) owned or controlled by any insured or against any co-owner of the property insured."*

Macready M held that Clause 14.8 resulted in a waiver of subrogation by the insurer in respect of all rights and remedies or relief the insurer may otherwise have had against any co-insured (including the defendants). Clause 14.8 was in wide terms and not limited to merely a waiver of subrogation with respect to matters related to the risks insured against under the Policy. Macready M found support for this construction of the clause by the fact that the clause referred to "*any co-owner of the property insured*" and that such persons were not co-insureds under the policy.

Macready M considered that logically the extent of a waiver of a right of subrogation can only be restricted by limiting:

- the person in favour of whom there is a waiver; or
- the nature of the claims that are waived.

He considered that any limitation on the nature of the claims that are waived must be expressed either as a temporal limitation; a limitation as to the nature of the cause of action; or a limitation as to the facts on which the cause of action is based. None of these limits arose on a proper construction of the present policy.

Circuity of action

Although it was not necessary to decide the issue, Macready M considered whether the defence of circuity of action were available to the defendants. He identified the elements of that defence as follows:

(a) Precisely the same amount of damages would be awarded in the defendant's proposed action against the plaintiff as in the plaintiff's action against the defendant;

(b) both the plaintiff and the defendant must be suing each other in the same right;

(c) both actions must be actions at law, not one in law and one in equity; and

(d) either the cause of action must be complete, or alternatively the defendant so obviously has an action as a result of the finding for the plaintiff that it would be scandalous to put the defendant to the trouble of starting a fresh action.

In the present circumstances, the defendant's claim against the plaintiff would not be for the same amount of damages as the plaintiff's action against the defendants. Accordingly, the defence was not available in this case.

This case illustrates how a waiver of subrogation clause may prevent a subrogated claim even where the events which give rise to the subrogated claim would not themselves have been covered under the policy. Insurers must take care to place limitations on any waiver of subrogation clause if it is not intended to operate in this manner.

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

Case name:

GPS Power Pty Ltd v Gardiner Willis Associates Pty Limited

Citation:

Supreme Court of Queensland, per Mackenzie J

Date of judgment:

13 March 2000

Issues:

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

The facts

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

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

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

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

The relevant provisions provided:

> *(c)* *In the event of the insurers indemnifying or making a payment to any insured(s), the insurers shall not exercise any rights of subrogation against any other insured(s) hereunder.*
>
> *(d)* *The insurers agree to waive any rights and remedies or relief to which they become entitled by subrogation against –*
>
> *(ii)* *Any insured named or described by this policy.*

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

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

The decision

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

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

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

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

Fraudulent misrepresentation allows an insurer to recover the benefit paid under a policy

Case name:

Tyndall Life Insurance Co Limited v Chisholm

Citation:

(2000) 11 ANZ Ins Cas 90-104 – Supreme Court of South Australia per Debelle J

Date of judgment:

15 October 1999

Issues:

- fraudulent misrepresentation
- fraudulent non-disclosure
- Insurance Contracts Act s29(2)

In this case an insurer sought a declaration that it had validly avoided a policy of life insurance and to recover from its insured a benefit it had paid under the policy. The insurer's claim was based on fraudulent non-disclosure and fraudulent misrepresentations.

The facts

The insurer offered a policy of life insurance whereby a benefit of $500,000 was paid if the insured suffered a "medical event". A "medical event" was defined in the policy to mean death and a number of major illnesses which included cancer.

The insured submitted a proposal for the policy in early June 1991. The insured's proposal was accepted and a policy was issued, taking effect from 1 July 1991. In May 1992, the insured was diagnosed with cancer. On 1 June 1992 the insured gave notice of a claim under the policy. On 17 June 1992 he lodged his claim and the claim was paid on 25 August 1992. The insured received the full benefit of $500,000.

As a result of receiving certain information, the insurer investigated the insured's application for the policy in 1991. On completing its investigations, the insurer sent a letter to the insured stating that he had been guilty of fraudulent non-disclosure and fraudulent misrepresentation and that the insurer purported to avoid the policy from its inception.

The insurer had discovered the following:

1. In 1983 the insured consulted a Dr Anderson concerning rectal bleeding. Dr Anderson made a diagnosis that the bleeding was caused by haemorrhoids. The insured continued to experience episodes of rectal bleeding on an irregular basis from 1983 to June 1992. After the consultation in 1983 the insured did not consult either Dr Anderson or any other doctor about the rectal bleeding.
2. In early June 1991 the insured participated in a Detectacol test. The test was designed to detect conditions, including cancer, which might cause bleeding of the colon. The Detectacol test provided a means by which individuals could submit samples for analysis without consulting a doctor. The test was sold at pharmacies and the participant was advised of the results in writing. When the insured submitted his test he gave a false name and birth date. He was subsequently informed that the test produced a positive result and advised to consult a medical practitioner.

As a part of the application for the insurance, the insured completed a medical report. It was necessary for the insured to answer a number of questions on the report and then arrange for a doctor to complete the

balance. The allegations of fraud by the insurer were based on the insured's answers to two questions in the application for insurance: (a) during the last 5 years have you had any tests, including blood tests?: No. (b) have you ever had any passage of blood from the bowel or in the urine?: Yes. Opposite question (b) he inserted: "*Past traces of blood from bowel*".

The insured consulted a Dr Hume to complete the report. The form required Dr Hume to comment on any unfavourable features, to which he stated: "*History of PR blood – but this appears to have been adequately investigated with no cause found.*" Dr Hume also added a note to amplify the answer given by the insured to question (b). He added the words "*occasional with defaecation – examination by Dr Anderson – no abnormality found*".

The decision - fraudulent misrepresentation

Section 29(2) of the Insurance Contracts Act (the ***Act***) provides that if the misrepresentation was made fraudulently the insurer may avoid the contract. A fraudulent misrepresentation is a representation which is false and which is made either knowingly, or without belief in its truth, or recklessly, not caring whether it be true or false and with the intention that it should be acted upon by the insurer.

Debelle J held that, in this case, the insured knew that his answer to question (b) was false. He considered that the answer painted the picture that the bleeding was a past and not a present condition, and would have deflected the insurer from making further enquiry. Given that an episode of rectal bleeding had recently occurred, the insured could not have honestly believed that his answer was true.

Debelle J went on to determine whether the insured made a fraudulent misrepresentation concerning his participation in the Detectacol test when answering question (a). Debelle J held that by giving a false name and date of birth the insured took steps to conceal his participation in the Detectacol test. Debelle J concluded that the insured had acted fraudulently in answering question (a).

Fraudulent non-disclosure

Whilst it was unnecessary for Debelle J to decide whether the insured had fraudulently failed to comply with the duty of disclosure, he nevertheless dealt with the issue. Debelle J considered that there will be a fraudulent non-disclosure if the insured knowingly or recklessly fails to disclose a matter which the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and if so on what terms.

Debelle J found that the insured knew that his ongoing rectal bleeding and his participation in the Detectacol test were relevant to the insurer in deciding whether to accept the risk. Debelle J also found that a reasonable person would, in the circumstances, have known both to be a relevant factor. Debelle J held that the failure of the insured to disclose both the fact that he had had recurrent episodes of rectal bleeding and had just recently experienced another and the fact that he had participated in the Detectacol test constituted non-disclosure. Moreover, Debelle J found that the insured knew the answer to question (a) was false and he therefore fraudulently failed to comply with his duty of disclosure.

This case illustrates how fraud may apply both in respect of representations which are false and in respect of representations which are true in a literal sense, but which paint a misleading picture.

Non-disclosure: the importance of proper communications between claims staff and underwriting staff

Case name:

Carling v CGU Insurance

Citation:

[1999] NSWSC 1043 New South Wales Supreme Court per Hunter J

Date of judgment:

22 October 1999

Issues:

- non-disclosure
- knowledge of insurer
- Insurance Contracts Act s21(2)(c)

This case illustrates the importance of proper communications between an insurer's claims staff and its underwriting staff, particularly where an insurer's internal policy guidelines call for such communications. Otherwise, an insurer may be unable to complain of non-disclosure where matters were known (or ought to have been known) to claims staff but were not communicated to underwriting staff.

The facts

The plaintiff insured owned a recreational paddle steamer which was insured under the defendant insurer's "Boat Insurance Policy" (the ***Policy***).

The vessel sank in its mooring in 1993 as a result of the hull snagging a submerged tree. The vessel was refloated only to sink again in April 1994. Subsequently, the vessel was towed to a slipway for repairs. In March 1995, the insurer indemnified the insured for damage sustained by the vessel as a result of the sinkings (the ***Sinking Claims***).

The Policy was renewed in 1994 and 1995.

In 1996, Mr Loftus suffered serious personal injuries while performing restoration work on the vessel for the insured. Mr Loftus commenced proceedings against the insured for which the insured sought indemnity from the insurer pursuant to the public liability cover under the renewed Policy.

The insurer denied indemnity primarily on the basis of non-disclosure by the insured arguing that had it been aware that the vessel had been on a slipway for an extended period of time and that extensive restoration work would be conducted, it would not have renewed the Policy.

Section 21(2)(c) of the Insurance Contracts Act prevents an insurer from relying on any non-disclosure by the insured where the relevant matters were known or ought in the ordinary course of the insurer's business to have been known to the insurer.

The decision

Hunter J held that the insured had disclosed all material matters to the insurer or alternatively, the matters were known (or ought in the ordinary course of the insurer's business to have been known) by the insurer. In reaching this decision, Hunter J found the following facts to be relevant:

- the underwriting section was informed by the insured's broker that the vessel remained on the slipway and was being gradually repaired;

- the insurer's claims staff were aware that the vessel was being extensively renovated from:
  - photographs taken by the loss assessor in relation to the Sinking Claims which showed that the insured had commenced extensive renovation work on the vessel;
  - information conferred by the loss assessor that the insured intended to carry out renovations; and
  - the area and general physical features of where the vessel was slipped were well known to the insurer's claim staff and at least one member of the underwriting staff.
- the insurer had implemented guidelines which provided for claim staff to regularly liaise with underwriting staff such that in the ordinary course of the insurer's business, underwriters would be fully informed of issues relevant to renewing policies.

As a result of the insurer's guidelines, Hunter J held that the information held by the claims staff would have been matters that in the ordinary course of the insurer's business would have been reported to the underwriting staff.

Hunter J commented that an insurer will not necessarily be deemed to have the knowledge held by its loss assessor. In the present case, the authority of the loss assessor was to assess the claim and negotiate settlement of the Sinking Claims and did not entail authority to fix the insurer with knowledge of any statements made to the loss assessor by the insured concerning his intention to remodel the vessel.

Where an insurer has implemented guidelines requiring claims staff to liaise with underwriting staff in relation to unsatisfactory underwriting features of a claim, it is important that this in fact occurs in practice. This case demonstrates that in such circumstances, an insurer will have difficulties arguing material non-disclosure against an insured where its claim staff has knowledge of the material information.

When is an insurer unable to rely on non-disclosure of a moral risk?

Case name:

Commercial Union Assurance Company of Australia Limited v Beard & Ors

Citation:

(2000) 11 ANZ Ins Cas 61-458; Supreme Court of New South Wales Court of Appeal per Meagher JA, Davies AJA and Foster AJA

Date of judgment:

25 November 1999

Issues:

- public liability insurance
- non-disclosure of moral risk
- knowledge of insured v knowledge of insurer
- burden of proof

The facts

This claim arose from a fire which occurred at a backpackers hostel in Kings Cross. The hostel was operated by the insured. The fire was held to have been caused by the insured's negligence and the plaintiffs were awarded substantial damages against the insured.

The insurer was joined directly to the proceedings on the basis of section 6 of the Law Reform (Miscellaneous Provisions) Act 1946. That section creates a charge in favour of third parties in respect of insurance monies that are or may become payable in respect of liability to the third party. Subsection (4) of section 6 provides for the charge to be enforceable against the insurer in the same way and in the same court as if the action were an action to recover damages or compensation for the insured.

In its defence, the insurer raised the issue of non-disclosure by the insured. It alleged that a well known Sydney identity, Mr Abraham Saffron, had an interest in the hostel by virtue of his holding the shares in its owner, Vendomatic Limited. The insurer asserted that had it been informed of that fact it would not have accepted the risk. It asserted that, pursuant to section 28(3) of the Insurance Contracts Act (***ICA***), its obligation to indemnify the insured against the liability to the plaintiffs was reduced to nil.

The burden of proof

The Court of Appeal held that when defending a claim by a third party under section 6 any matter which is relied upon by the insurer to extinguish or reduce the insured's liability shall be raised by the insurer and that the onus will be on the insurer to establish it. The insurer had submitted that there were policy reasons for holding the onus was on the plaintiffs. It was submitted that in a third party action the insurer is unable to avail itself of procedural steps such as particulars, discovery of documents and interrogatories to obtain information as to the insured's state of knowledge. The Court did not accept this argument, pointing out that the injured plaintiffs would suffer a similar disadvantage if the onus were on them.

The materiality of the alleged non-disclosure

The Court went on to consider the materiality of Mr Saffron's interest in the hostel. There was evidence that the insurer had accepted the risk notwithstanding a survey report which noted the presence of the Pink Panther, a strip club and the Persian Room (an establishment of low repute) in the building and the fact that the building was situated in the heart of Kings Cross. The evidence suggested that these matters conveyed a degree of moral risk. There was also evidence that the premium charged for the insurance was more than double that which would be quoted for a modern motel of equivalent size. Nevertheless, the Court accepted that there was adequate evidence for the trial judge to conclude that Mr Saffron's interest in the hostel was material.

The insured's knowledge

The Court accepted that the insured knew of Mr Saffron's interest in the hostel. It was in this respect that the burden of proof became important. The Court held that there was no evidence from which it could be concluded that the insured knew that Mr Saffron's interest was relevant to the decision of the insurer. It emphasised that there was no evidence that Mr Saffron was involved in the insured's business. Furthermore, the evidence suggested that Mr Saffron's reputation was a matter more known to the insurers than the insured.

In reaching its decision, the Court was influenced by expert evidence to the effect that the ownership of a building is not, in general, a matter relevant to the public liability of a person operating a business in the building. In these circumstances, it was incumbent upon the insurer to make enquiry as to the ownership of the premises.

The insurer's knowledge

An issue had also arisen as to the insurer's knowledge. The trial judge had made a finding that the insurer knew of Mr Saffron's interest in the property on the basis of a newspaper article which appeared amongst its files contained in its survey department. The Court of Appeal overturned that finding. It emphasised that knowledge of the insurer for the purposes of section 21(2)(c) of the ICA requires that the matter be known "*to an appropriate officer or agent of the insurer*" or "*contained in current official records*". Ordinarily, the appropriate officers will be those who were handling the particular insurance on behalf of the insurer: see *Meridian Global Funds Management Asia Limited v Securities Commission* [1995] 2 AC 500. The court also considered that Mr Saffron's interest in the ownership of the building was not a matter which, in the ordinary course of business, the insurer ought to have known. It emphasised that the insurer was not a specialist in hard-to-place liability in Kings Cross. Foster AJA did not agree with the majority that a matter may be known to an insurer within the meaning of section 21(2)(c) if it is "*contained in current official records*". However, he was satisfied on the evidence that Mr Saffron's interest in the building was a matter that the insurer, in the ordinary course of business, ought to have known (within the meaning of section 21(2)(c)). He emphasised the high risk area, the high premium required and the increased "*moral risk*" posed by the businesses conducted on the premises.

The case highlights some important principles insurers must bear in mind when seeking to rely on non-disclosure of a moral risk. In particular:

(a) the insurer will bear the burden of proof, even where the action is brought by a third party;

(b) the insured must know the risk to be material to the insurer;

(c) the insurer must not be aware of the risk whether through its claims division or its underwriting division. In this respect, the case illustrates the importance of proper communication between the claims division and the underwriting division.

Failure to notify insurer of a material alteration to the risk

Case name:

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

Citation:

Supreme Court of Queensland per Moynihan J

Date of judgment:

10 November 1999

Issues:

- condition requiring notification of material change in risk after commencement of policy
- whether insured had notified insurer of material change in risk via its broker
- Insurance Contracts Act 1984, ss54 and 60(2)

The facts

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

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

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

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

The decision

Moynihan J was satisfied that the plastics manufacturer entering into occupation of the building constituted a material change of the risk so as to require notification under the policy. He accepted evidence that in general insurers regard the use of plastics in manufacturing as high risk because of the use of heat and the generally flammable nature of the material involved. Having regard to the industry's attitude towards the insurance of risks associated with a plastic manufacturer's occupation, the judge was satisfied that had Mercantile Mutual been notified of the material change in the risk it would have declined the risk.

Moynihan J then had to consider whether Gibbs had given notification of the material change in risk to Mercantile Mutual via the broker. He had to decide between two conflicting versions of the events leading up to the

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

As Gibbs was in breach of the condition of the policy, Mercantile Mutual was entitled to cancel the policy under section 60(2) of the Insurance Contracts Act 1984 (Cth) (the ***Act***). That section permits such a cancellation where the policy requires the insured to notify the insurer of a specified act and the insured fails to do so. However, s54 of the Act provides that where a policy allows an insurer to refuse to pay a claim by reason of an act or omission of the insured after the policy is entered into, the insurer may not refuse to pay the claim only because of that act or omission but its liability is reduced by the extent to which its interests were prejudiced as a result of the act or omission.

Having decided that Mercantile Mutual would have gone off risk had it been notified of the plastic manufacturer's occupation, Moynihan J held that the prejudice suffered by Mercantile Mutual was equivalent to its prima facie liability under the Act which was thus reduced to nil. The actions against Mercantile Mutual and the broker were accordingly dismissed.

This decision illustrates the importance for insureds of clearly communicating to their broker material changes relating to the nature of their business which have the effect of increasing the risk. The difficulties that arose in this case due to the conflicting versions of events could have been avoided if the insured had made the notification in writing.

Waiver: how quickly must an insurer act?

Case name:

Callaghan & Hedges v Thompson & Ors

Citation:

2000 2 LRIR 125 English Queen's Bench Division per Steel J

Date of judgment:

3 November 1999

Issues:

- broker acting under a binder
- non-disclosure – moral risk
- waiver

This case considered two issues of significance to Australian insurers and brokers:

- **for what purpose is a broker acting under a binder nevertheless an agent of the insured?**
- **when will an insurer waive a right to avoid an insurance contact?**

The practice both in England and Australia is that a broker acting under a binder can be the agent for the insured as well as the insurer. It is important that brokers be alert to the possibility of conflicts of interest arising out of such retainers, particularly when acting for the insured in the collection of claims.

The facts

In *Callaghan*, the insureds were owners of a nightclub. The insurers were a Lloyd's syndicate. A group of broking companies, known as Manson, held a limited binding authority granted by the Lloyd's syndicate. This agreement essentially meant that Manson could act, subject to the limited terms of the binder, as if it were Lloyd's underwriters and use their slips. Accordingly, Manson issued a slip pursuant to the binder and the insurers accepted 50% of the risk for the syndicate. The remaining 50% was underwritten by the companies market.

In September 1989, the nightclub was totally destroyed by fire and the insureds claimed over £1.5 million in damages under the policy.

Shortly after the fire, Manson was instructed by the underwriter to appoint loss adjusters, THS. The nightclub needed to be demolished and ultimately, on Manson's recommendation and with the insurers approval, certain interim payments were made on a "without prejudice" basis. On 21 March 1990, just prior to Manson making the last interim payment, the insurers learned from a second firm of loss adjusters they had appointed that one of the insureds had been convicted in 1976 of armed robbery, although he had been convicted under the name of O'Callaghan. This fact had not been disclosed to the defendants on the proposal form. This fact was not confirmed formally until 10 April 1990, when the insurers received a detailed report in respect of the investigations carried out by the second loss adjusters.

On 16 May 1990, the insurers sought to avoid the policy on grounds of non-disclosure. In response, the insureds argued that the lost interim payment was made by Manson as agent for the insurer. As the second interim payment was made after the insurer learnt of the undisclosed criminal record, the insurer waived its right to avoid the policy. Alternatively, even

if Manson was not acting as the agent of the insurer when the second interim payment was made, the insurer in any case waived its right to avoid the policy.

Who was the broker acting for?

Steel J held that where a broker acts as agent of the insurer for limited purposes under a binder, the broker's status is still that of agent of the insured in respect of placement of risk and collection of claims. Accordingly, if the broker makes an interim payment to the insured after the insurer gains knowledge of material non-disclosure, that payment is made as the broker as agent of the insured and cannot give rise to a waiver by the insurer.

Steel J criticised the practice of insurers using brokers such as Manson to instruct and obtain reports from loss adjusters. In accepting such instructions, the brokers were acting as agents of the insurers. Accordingly, this placed the broker in a conflict of interest.

When will an insurer waive a right to avoid an insurance contract?

On the basis that the broker was found not to be acting as the insurers' agent, the claimants argued:

1. that the insurers' failure to notify the insureds immediately of their intention to avoid the policy upon gaining knowledge of the non-disclosure was an election to affirm it;
2. that the insurers, by authorising the second interim payment, admitted liability; and
3. that it was not necessary for a party to communicate to the other that it was making an "informed choice" to keep the contract alive.

In respect of the first argument, Steel J accepted the insurers argument that although the underwriter became aware of the first claimant's conviction on 21 March 1990, the information was of such an informal nature that it required verification, particularly given its grave nature. Steel J held that the insurer was entitled to a reasonable time to investigate the information and to decide whether to avoid the policy. The period from 21 March until 16 May 1990 was not unreasonable. It is the general rule that in order to avoid for material non-disclosure, a party must have knowledge of the facts which give rise to the right to elect to avoid. It is clear from this decision that an insurer is not bound to act immediately on receiving information, but is allowed a reasonable period to make enquiries.

As to the second argument, Steel J held that the second interim payment which was scratched "without prejudice" was not an admission of liability and could not constitute an unequivocal election to affirm. The fact that the payment was made "without prejudice" was construed as a complete reservation of rights and this was supported by the lack of any other evidence that liability had been admitted by that stage.

As to the final argument put forward by the insureds, Steel J held that an unequivocal demonstration of an intention to proceed with a contract can only be exhibited if the other party appreciates that a choice has been made. By way of example, Steel J considered that it would not constitute affirmation if a party, learning of a misrepresentation justifying avoidance, decides simply in his own mind not to avoid and then sends a letter to the other party which is consistent with the contract being alive. That letter would not exhibit to the other party any election or choice at all.

This decision highlights the fact that in England, a broker acting under a binder and acting outside the scope of its limited agency with the insurer acts as the insured's agent. In Australia the position is similar. Brokers must be careful in such circumstances to limit their role in claims handing to avoid potential conflicts of interest. In particular, when making payments to the insured, brokers must be careful to preserve any reservation of rights expressed by the insurer.

The case illustrates that an insurer will have a reasonable time to act but what is reasonable will depend upon the circumstances. Insurers gaining knowledge of a possible material non-disclosure should proceed diligently with any investigations and should not under any circumstances sit on the information. Otherwise the insurer might waive its entitlement to avoid the contract.

When can a liability insurer deny indemnity on the basis of fraud not alleged by the claimant?

Case name:

MDIS Limited v Swinbank – London and Edinburgh Insurance Company Limited – Aegon Insurance Company (UK) Limited

Citation:

English Court of Appeal, Queen's Bench Division per Gibson, Judge and Clarke LJJ

Date of judgment:

19 July 1999

Issues:

- professional indemnity policies
- construction of insuring clause
- fraud raised by insurer not alleged by claimant

In this case, the Court considered the construction to be given to the insuring clause in a professional indemnity policy.

In addition to providing guidance on interpretation to be given to similar clauses in other indemnity policies, the decision also comments on the judicial approach to interpreting insurance contracts generally.

The facts

MDIS Ltd (the ***insured***) carried on a software business. It contracted with a paint manufacturer (***Silkolene***) for the development and supply of software and certain hardware. Silkolene commenced proceedings against the insured for breach of contract essentially based on alleged misrepresentations and non-delivery. The insured settled proceedings at an early stage for £863,000 and sought indemnity under its professional indemnity policy.

Silkolene had not made or threatened any claim against the insured in respect of fraud. However, the insurer considered that the circumstances suggested that fraud was involved. The insurer declined indemnity on the basis that the claim did not fall within the insuring clause.

The policy

The insuring clause relevantly provided:

> *The Underwriters will indemnify the Assured…against any claim for which the Assured may become legally liable …arising out of the professional conduct of the Assured's business…alleging:*
>
> *(a) Neglect, Error or Omission*
>
> *any neglect or omission including breach of contract occasioned by same.*
>
> *(b) Dishonesty of Employees*
>
> *any dishonest, fraudulent, criminal or malicious act(s) or omission(s) of any person employed at any time by the Assured.*
>
> *The Assured will not be indemnified against any claim or loss, resulting from the dishonest, fraudulent, criminal or malicious act(s) or omission(s) perpetrated after the Assured could reasonably have discovered or suspected the improper conduct of the employee(s).*
>
> *No indemnity shall be provided to any person committing any dishonest, fraudulent, criminal or malicious act(s) or omission(s).*

The issues

The issue for resolution was whether the insured had to prove it was legally liable to Silkolene in respect of "*neglect including breach of contract occasioned by the same*" or whether it was sufficient for liability to be in respect of a claim alleging such neglect. It was accepted that sales staff of the insured had been dishonest. However there was an issue as to whether their dishonesty was to be attributed to the insured for the purpose of the policy.

The insured argued that it was unnecessary to prove that the proximate cause of the loss was the neglect itself because it was sufficient if the liability was for or in respect of a claim *alleging* such neglect. To hold otherwise, according to the insured, would be to disregard or to give insufficient weight to the word "*alleging*" in the insuring clause.

The insurer relied primarily on the underlying nature of the policy as a contract of indemnity to argue that the loss must be proximately caused by a peril insured against, namely neglect.

The decision

The judge at first instance found in favour of the insurer. While this decision was unanimously upheld by the Court of Appeal, the Court of Appeal was divided on the rationale.

Clarke LJ (with whom Judge LJ agreed) conceded that the insured's interpretation of the insuring clause was attractive if attention was focused on the words of the introduction. However, he noted that the particular language used in a clause is the starting point only and that in determining the construction to be given to a phrase, it is necessary to consider the phrase in context of the particular clause as a whole and then consider the clause in the context of the policy as a whole, having regard to the circumstances.

In the circumstances, Clarke LJ did not consider that the underwriters had agreed to indemnify the insured where the claim alleges neglect but the loss (whether arising by settlement or determination of the claim) was proximately caused by dishonesty. Clarke LJ observed that claimants may have many reasons for choosing to put their case against an insured in a particular way irrespective of the true proximate cause of the claim. He emphasised that the underwriter's liability must depend on the facts and not simply upon the way in which the claimant chooses to put its case. Accordingly, the interpretation put forward by the insured was not sensible or commercial in the present circumstances.

Clarke LJ did acknowledge that it would be possible to devise a clause which had the effect contended by the insured.

In contrast, Peter Gibson LJ found in favour of the insurer on the basis that the proviso in clause 2(b) extended to claims alleging negligence in addition to claims alleging fraud. Clarke LJ supported this approach as an alternative basis for finding in favour of the insurer.

This case is helpful to professional indemnity insurers. It is not uncommon for claimants to plead only negligence for breach of contract against insureds even where there is an element of fraud. In such circumstances, insurers should look behind the pleadings to see whether there may be a basis for denying liability. In practice it may be difficult for insurers to prove fraud, but this case shows that the courts will be receptive to evidence of fraud adduced by the insurer even where none had been adduced by the claimant.

Coverage for legal costs

Case name:

Thornton Springer v NEM Insurance Company Limited

Citation:

[2000] Lloyd's Rep IR 590, Queens Bench Division per Colman J

Date of judgment:

6 March 2000

Issues:

- professional indemnity policies
- defence costs
- where claim against insured fails

This case involves the construction of clauses in a standard professional indemnity policy relevant to recovery of legal costs. It considers whether costs may be recovered in respect of claims which are capable of falling within the scope of indemnity at the time they are made but which are ultimately found to arise out of circumstances not covered by the policy.

The facts

A firm of accountants successfully defended an action on the basis that the relevant partner was engaged in personal business rather than providing professional advice as a member of the firm. The insurer argued that, as the firm was not liable, the policy did not apply and the insurer was not liable for its legal costs.

The insurer therefore sought to reclaim the costs it had paid in defending the action. The insured in turn sought to recover further legal costs from the insurer.

The insured sought to recover its costs on numerous grounds. Some of these were based on the terms of the policy, others were based on correspondence between the insurer and the firm of accountants. Relevant to both arguments was a letter from the insurer's solicitors to the effect that the insurers were prepared to indemnify the insured for both the costs which have been incurred to date and future costs.

The decision

The most important discussion for present purposes was a consideration of different terms of the insurance policy and whether they provided cover for legal costs.

The primary argument of the insured was that is was covered under a special condition which provided: *"underwriters shall in addition indemnify the Assured in respect of all the costs and expenses incurred with their written consent in the defence or settlement of any claim made against the Assured which falls to be dealt with under this Certificate".*

The insurer argued that, even though it had consented in writing to the costs, because there was no liability, the claim did not "*fall to be dealt with under this certificate*". Colman J rejected this argument. He held that the special condition did apply as the claim was *"in substance one capable of falling within the scope of indemnity under the Insuring Clauses".* In particular, he noted that this special condition also applied to the settlement of a claim. If the insurer's construction of the clause were correct, the insured might incur costs with the insurer's consent, settle the claim and then have the insurer refuse to reimburse the costs on the basis that the

claim was not shown to be covered by the policy. Colman J considered this would be "*quite absurd*". The insured was therefore entitled to recover its costs.

The insured had also put forward an alternative argument that the primary cover of the policy itself also provided cover for its legal costs. This clause provided cover to the insured "*against any claim or claims first made …in respect of any civil liability whatsoever or whensoever arising(including liability for claimant's costs) incurred in connection with the conduct of any Professional Business…*"

Colman J held that the words "*civil liability…incurred*" referred to a liability actually incurred and not a potential liability.

Two other important findings in this case were:

- the insurers contractually bound themselves to pay the insured's costs as the promise to do so was given in return for the insured not commencing proceedings against the insurer; and
- the insurer was liable for all costs except those which were incurred exclusively in respect of claims that were not covered by the policy.

It is likely that a court in Australia would follow the same reasoning as Colman J. There are good policy reasons for this approach. If an insured can only recover legal costs if it is unsuccessful, this is not much of an incentive to defend a claim properly.

Professional liability policies: an employee's dishonest act is caused by negligence of the employer

Case name:

Rouleston Clarke Pty Limited (In Liquidation) v FAI General Insurance Company Limited

Citation:

[2000] TASSC 63; Supreme Court of Tasmania (Full Court) per Underwood, Crawford and Slicer JJ

Date of judgment:

8 June 2000

Issues:

- construction of professional indemnity policy
- objective intention of parties from consideration of wording of the policy
- fraudulent conduct of employee covered only by fidelity extension

The facts

FAI issued a policy of professional indemnity insurance to the appellant which carried on a financial planning, investment advisory and tax agent's business and was a licensed dealer in securities. The policy followed a fairly typical structure which incorporated the following elements:

(a) by insuring clause 1(a), FAI agreed to indemnify the insured against any claims arising by reason of any negligence committed by it or its employees. The policy limited the extent of the indemnity to $1 million for any one claim or claims in the aggregate;

(b) exclusion clause (b) expressly excluded from the indemnity claims for dishonest, fraudulent, criminal or malicious acts or omissions of the appellant or its employees, except to the extent provided in the extensions to the policy;

(c) extension clause 4 (dishonesty) purported to delete exclusion clause (b) and to extend indemnity in respect of claims for damages for breach of professional duty arising out of or contributed by the dishonest, fraudulent, criminal or malicious conduct of employees, but excluding "claims for loss of money, negotiable instruments" etc. up to a limit of $1 million; and

(d) extension clause 5 (fidelity) purported to indemnify the appellant against any "loss of money, negotiable instruments" etc. belonging to the appellant or for which the appellant was legally liable.

An employee of the appellant (***Badger***) converted to his own use negotiable instruments entrusted to him by 14 of its clients, to a total value of $685,728.06.

The appellant accepted that it had failed to take reasonable care in supervising Badger's activities and to maintain proper business systems for supervision of receipts and checking of monies etc.

The question for the Court was whether the claim for indemnity was covered by the fidelity extension, in which case it was restricted to $250,000, or whether it could be covered elsewhere under the policy.

The appellant contended that since the defalcation by Badger was made possible by a failure of supervision and control systems of the appellant,

the loss was occasioned by negligence and thereby covered by the policy clause 1(a). By reason of clause 4, read literally, exclusion clause (b) had been deleted, with the effect that there was nothing left in the policy excluding the operation of the indemnity provided by ensuring clause 1(a) extending to the clients' claims in this case. The appellant submitted that if the losses suffered by the clients were at least partly caused by a breach of professional duty in the conduct of the appellant's practice by reason of any negligence, insuring clause 1(a) operated, entitling the appellant to be indemnified under that clause, which had a limit for any one claim in the aggregate of $1 million, and, according to clause 2, the claims were to be aggregated into a single claim (to enable the appellant to avoid the obligation to pay the excess of $5,000 in respect of each of the 14 claims).

The decision

Despite what Crawford J described as the "superficial attractiveness" of the appellant's argument, the Full Court unanimously rejected it, essentially by reading the policy as a whole by reference to the well-recognised principles applicable to insurance policy interpretation.

The Court considered that the nature of the claims brought against the appellant by clients were based on breach of duty and negligence, but the claim against FAI by the appellant was for "loss of money" occasioned by an act of dishonesty.

The Full Court distinguished the case cited in support of the appellant's argument of *HIH Casualty & General Insurance Ltd v Waterwell Shipping Inc* (1998) 43 NSWLR 601 (reported in our 1998 Annual Review) in which Sheller JA (with whom the other members of the Court of Appeal agreed) had concluded that *"where there are competing proximate causes and loss from one is insured against and none of the others is expressly excluded, the insured is entitled to recover"*. Clearly that was not the case here where one of the causes which the appellant asserted was a proximate cause of the clients' losses was expressly excluded by the terms of the policy. Accordingly, the provisions of the policy comprised in clause 1(a) did not encompass the circumstance where a dishonest act gave rise to a claim which included negligent supervision.

As a result, the appellant was entitled to be indemnified for the 14 claims pursuant only to Extension clause 5 (fidelity) for which FAI's liability was capped at $250,000 rather than $1 million, and an excess was payable of $5,000 in respect of each of the 14 claims.

The case is of some comfort to professional liability insurers. It suggests that insureds will be restricted to reliance on any relevant dishonesty or fidelity extension where a claim arises out of a dishonest act of an employee, even if that act would not have occurred but for some negligence on the part of the employer.

Pension mis-selling: many claims or one claim?

Case name:

Lloyds TSB General Insurance Holdings Limited & Ors v Lloyds Bank Group Insurance Company Limited

Citation:

English Commercial Court; Queens Bench Division per Moore–Bick J

Date of judgment:

5 October 2000

Issues:

- professional indemnity insurance
- single negligent act or series of acts?
- aggregation clauses

The facts

The claimants provided personal pension plans in England to members of the public. A large number of claims were made against the claimants by investors who complained that they had been mis-sold personal pensions in that they had not been given best advice and had been wrongly advised to take out personal pensions rather than to join or remain in occupational pension schemes provided by their employers.

The UK Securities and Investments Board (***SIB***) carried out a review of personal pension sales. During the course of the review it emerged that representatives of the claimants had not given best advice to investors as they were obliged to do under the relevant legislation.

The claimants sought to recover under professional indemnity (***PI***) policies issued by the defendants in relation to the claims made against them by investors. The PI policies contained a deductible, set at £1 million or £2 million. This was considerably in excess of the investors' claims against the claimants most of which did not individually exceed £15,000.

The PI policies further contained an aggregation clause which provided that a series of third party claims resulting from a single negligent act or omission or related series of acts or omissions should be considered as a single claim for the purposes of the application of the deductible.

The issues

A preliminary issue was ordered to be tried as to whether the investors' claims against the claimants were a series of claims resulting from a single act or omission or a related series of acts or omissions and were therefore to be treated as a single third party claim subject to a single deductible.

The claimants asserted that all of the claims made against them resulted from a single act or omission or a series of acts or omissions – namely the failure to provide proper training to their representatives and employees.

The insurers argued that each separate claim arose from the failure by the claimants representative or employee to give "best advice" and that those failures were different and unrelated in each particular case. The significance of this was that if each claim brought by investors against the claimants was a separate claim, then the policy deductible would not be breached and so the policy would not be triggered.

The decision

Moore–Bick J. held that the claims resulted from a single act or omission of the claimant's officers or employees and were therefore all to be considered as a single third party claim subject to a single deductible.

Moore-Bick J considered that in common sense terms all of the third party claims resulted from a failure on the part of management of the claimant to provide the training required. Each of the third party claims was made against the claimant because the claimant failed to ensure that its representatives gave best advice. The failure of the claimant to provide proper training was a dominant, effective or real cause and not a remote cause of each claim. Because the PI policy covered the claimant against the consequences of its failing to ensure that its employees and representatives acted properly, the court said that it was difficult to see how the policy could work at all if the claimant's own omission which itself led to the employees' failure to give best advice could not be regarded as the proximate cause of the loss.

This case illustrates what may be regarded as a related series of acts or omissions and is important to professional indemnity insurers. It highlights the way in which aggregation clauses operate to the benefit of insureds faced with many claims. Where possible, the Courts will often be willing to infer that those clauses have a common cause and therefore may be the subject of a single claim under the policy. A further illustration of this principle was provided in the case *Pacific Dunlop Limited v Swinbank* reported in our 1999 Annual Review.

Contaminated peanuts: policy covers loss caused by need to protect against further contamination

Case name:

PMB Australia Limited v MMI General Insurance Limited & Ors

Citation

[2000] QSC 329, Supreme Court of Queensland per Mullins J

Date of judgment:

26 September 2000

Issues:

- industrial special risks policy
- proximate cause of business interruption
- need to restructure plant to prevent further occurrences
- concurrent causes of business interruption

This case considers what is the proximate cause of loss where an interruption to business is caused by an insured event and also from the need to restructure the plant as a result of a new appreciation of the risk of further events occurring.

The facts

PMB Australia Limited (***PMB***) manufactured and distributed peanuts in Queensland. PMB provided roasted shelled peanuts to Kraft Foods Limited (***Kraft***) for use in its peanut butter products. Between March and June 1996 the salmonella bacteria was discovered in Kraft's peanut butter and the outbreak was ultimately traced to the peanuts provided by PMB. Peanut butter products were recalled by PMB's customers and Kraft advised PMB that it would not take any further delivery of PMB's peanuts. Shortly thereafter the Queensland Health Department (***QHD***) prohibited PMB from despatching peanuts to any customers before PMB had met certain testing requirements. PMB ceased roasting peanuts for all customers on 6 July 1996. Immediately after the incident and on receiving the requirements of the QHD and advice from its own consultants, PMB commenced revising and changing processing systems in the plant.

The most likely cause of the outbreak was "*a slug of rodent contaminated material*" from equipment that had been stored outside the plant and which was later used to feed fines into the roasted peanuts. Although there was scientific knowledge of the risk of salmonella contamination in roasted peanuts prior to the incident, the need to take active steps to eliminate that risk had not been addressed by the existing manufacturing processes of PMB.

By letter dated 20 July 1996, the QHD permitted PMB to recommence production subject to a regime of batch testing on PMB. On 21 July 1996 production recommenced. Kraft also conducted environmental testing of PMB's plant and its sampling revealed traces of the salmonella bacteria still present in the plant. As a result of these positive tests, Kraft did not start re-ordering product from PMB until 27 September 1996. The QHD concluded its regular testing programme on 12 November 1996.

The primary effect of the outbreak on PMB was the shutdown and cleaning of the plant. The secondary effect was the imposition of a testing regime by the QHD that included recommendations for the short, medium and long term. This testing revealed salmonella at the plant which resulted in further halts to operations, cleaning and restarting.

The policy

PMB held an industry special risks insurance policy underwritten by a number of insurers (the ***insurers***). The policy contained an indemnity clause

which indemnified PMB for business interruption in consequence of loss, destruction or damage to its property by any cause or event not excluded. The policy also contained an extension clause in an endorsement. The extension clause indemnified PMB for loss "*directly resulting from interruption of or interference with the business*" in consequence of one of three trigger events. The closure of part of PMB's plant by the QHD was a trigger for the extension clause.

PMB claimed it was entitled to be indemnified for $4,795,000 under the policy in respect of all losses arising during the period 30 September 1995 to 30 September 1996.

It argued that the words "*in consequence of*" in the indemnity clause only required proof that the interruption or interference to its business resulted from the damage (ie. the salmonella outbreak) and once that was shown it was not necessary to show a direct causal relationship between the loss and the interference.

The insurers, on the other hand, submitted that the use of the word "*directly*" and the phrase "*in consequence of*" in the endorsement imported the notion of proximate cause.

The decision

Mullins J proceeded on the basis that, subject to the terms of the policy, it is a fundamental rule of insurance law that the insurer is liable only for losses proximately caused by an insured event. He considered that, properly construed, the indemnity clause and the extension clause did not displace this general rule. Mullins J considered that the indemnity clause required the insured to prove two stages of causation:

(a) an event which is the proximate cause of the interruption to the business; and

(b) interruption to the business which causes the loss.

By reason of the extension clause, the loss in (b) must result "directly" from the interruption to business.

The judge then considered whether or not the interruption to business could be said to have been proximately caused by the outbreak.

The insurers argued that the salmonella outbreak ceased to have effect after the plant reopened on 21 July 1996 and thereafter the cause of any business interruption was the new appreciation of the risk of salmonella which required changes to PMB's plant and processes. There was expert evidence to the effect that the plant should always have been structured to avoid the possibility of cross contamination between raw and processed product. A large part of the claim related to steps taken to restructure the plant in this way.

PMB contended that the entirety of the business interruption was due to the outbreak, whether caused directly by the outbreak itself or by the new-found knowledge of the need to take steps to guard against contamination.

The Court considered that the QHD made its recommendations concerning PMB's plant and processes because it was concerned about the risk of salmonella contamination in the future. That concern, it reasoned, was triggered by the outbreak but the cause of the concern was the new awareness of the risk of salmonella contamination. The Court also found that the direct consequences of the outbreak were the shutdown of the plant, the cleaning of the plant and the imposition of the testing and clearance regime imposed by the QHD in its letter of 20 July 1996. The regime was a direct response to the contamination and subsequent positive tests for salmonella. Each interruption caused by these tests was a consequence of the outbreak. Further, the business suffered in other respects as the attention of its principals was occupied with responding to the outbreak.

Therefore, a significant cause of the interruption to PMB's business after 20 July 1996 was the new awareness of the risk of salmonella contamination however the outbreak continued to contribute to the disruption of PMB's business after 20 July 1996. Both factors were operative causes of the interruption to the business, yet the outbreak was still a proximate cause. It followed that PMB was entitled to indemnity in respect of the loss arising from the need to restructure its plant.

Assessment of loss

PMB submitted that its business was interrupted for 12 months from 24 June 1996 when Kraft advised that deliveries of peanut products should cease immediately. Significantly, PMB's policy provided for an indemnity period of no more than 12 months from the date of the trigger event, in this case the outbreak.

However, Mullins J found that by early 1997 other unrelated factors commenced having an effect on PMB's business. Accordingly, he allowed the claim for disruption to business only until 31 March 1997, the end of the 1996 peanut season.

Mullins J considered that, properly construed, the policy required an apportionment of the loss to be made where there were two or more causes of the loss.

This case illustrates how under industrial special risks policies where an event occurs, insurers may become liable to indemnify insureds in respect of losses (or at least a portion of such losses) due to the need to upgrade plant equipment or processes in order to prevent further occurrences of the kind which triggered the loss. In each case it will be a question of identifying the proximate cause(s) of the loss and examining whether the policy covers such cause(s).

Can a public liability policy cover a third party when the principal insured is not vicariously liable?

Case name:

Hollis v Vabu Pty Limited

Citation

[1999] NSWCA 334, New South Wales Court of Appeal per Sheller, Giles and Davies JJA

Date of judgment:

5 November 1999

Issues:

- section 6 of Law Reform (Miscellaneous Provisions) Act 1946
- vicarious liability between principal and independent contractor
- who the "insured" is entering into the policy

In this decision, the Court held that an independent contractor was not a person who entered into his principal's insurance policy. This was so even though the policy wordings defined "*Insured*" to include "

" and even though the independent contractors were levied each week by the principal for contributions to the policy. The Court therefore held that section 6 of the Law Reform (Miscellaneous Provisions) Act 1946 (the *Law Reform Act*) did not apply to a claim against an independent contractor who was covered by his principal's insurance policy.

The facts

The appellant had been knocked down onto the footpath by a bicycle courier wearing the respondent's uniform and suffered physical injuries. It was accepted that the couriers were independent contractors and not employees of the respondent. Employers are generally vicariously liable for negligent acts or omissions by employees but not for those by independent contractors, except in limited circumstances. Nevertheless, the appellant alleged that on the facts the respondent was vicariously liable for its courier's negligence.

The appellant was unable to identify the particular courier. However, he sought to invoke section 6 of the Law Reform Act to join the respondent's insurer in the proceedings. Section 6 of the Law Reform Act creates a charge in favour of a claimant over insurance monies payable to an insured in respect of any liability of the insured to pay damages or compensation to the claimant. Sub section (4) provides that the charge is enforceable by the claimant directly against the insurer.

The issues

The appellant alleged that even if the respondent was not vicariously liable for the courier's negligence it was the courier who was the insured, as well as the respondent.

To support his argument, the appellant highlighted the following facts:

- the courier was really the one who took out the insurance policy, since each courier paid a levy to be applied by the respondent in paying the policy premium; and
- the policy described "*Insured*" as including "*sub-contractors in respect of work done on behalf of [the respondent]*".

The decision

The Court (by majority) dismissed the appellant's argument as the courier did not "enter into" the insurance contract as required by section 6(1) of the Law Reform Act. The Court did not accept that there was evidence which substantiated the appellant's claim that it was the courier who took out the insurance policy, rather than the respondents. The Court also did not accept that the evidence showed that the courier had paid the insurance premium.

On the question of vicarious liability, the Court reaffirmed the view that a principal is not vicariously liable for unauthorised wrongdoings of its independent contractors. The majority also held that the respondent, in running a business of bicycle couriers, did not have a general tortious duty to pedestrians.

Davies J delivered a dissenting judgment.

This case illustrates an interesting limitation on the ability of a claimant to pursue an insurer under section 6 of the Law Reform Act. It suggests that a claimant will be unable to use that section to pursue a person covered by a relevant policy unless that person (and not someone else on his/her behalf) entered into the policy.

Insurance broker found negligent for failing to alert its client to significant terms of the policy of insurance and to under-insurance

Case name:

JW Bollom & Company Limited v Byas Mosley & Company Limited

Citation

Lloyds Law Reports [2000] 136 Queen's Bench Division (Commercial Court) per Moore-Bick J

Date of judgment:

9 February 1999

Issues:

- duties of insurance brokers
- where loss of chance to recover in full from the insurers
- under-insurance
- contributory negligence

This case considered whether an insurance broker owed a duty to its client to warn of the existence and significance of certain clauses of the insurance policy and to under-insurance.

The facts

W Bollom & Co Ltd (***Bollom***) manufactured paints, inks and similar materials. In 1985, Bollom installed a yard alarm at its premises. However, there were frequent false alarms and over a weekend in August 1996, Bollom decided to disarm the alarm system. Bollom's premises, plant and machinery and stock were severely damaged by fire while the alarm had been switched off. The total loss caused by the fire was just less than £8 million.

The insurance underwriters considered that they were entitled to repudiate Bollom's policy on the ground that the yard alarm had not been set at the time of the fire. The policy provided that setting off the alarm when the premises were left unattended was a condition precedent to the insurers' liability. There also appeared to be substantial under-insurance. However, the underwriters agreed to a settlement of £5 million with Bollom.

The proceedings

Bollom brought proceedings against its insurance broker, Byas Mosley & Company (***Byas Mosley***). The central issue was whether Byas Mosley had breached its duty to Bollom in failing to take reasonable steps to draw Bollom's attention to the existence and significance of the clause in the policy relating to the yard alarm. Byas Mosley had not provided Bollom with a copy of the standard policy wording; a facsimile had been sent to Bollom advising that there was to be an "alarms and protection" clause, but the facsimile did not set out the terms of the proposed clause; and Byas Mosley was aware that Bollom had never received a copy of the policy.

The decision

Moore-Bick J held that Byas Mosley ought to have been aware of the existence of the relevant clause of the policy and warned Bollom of the consequences of failing to set the alarm. Accordingly, Byas Mosley had breached its duty to Bollom.

The Judge went on to consider whether the breach had caused Bollom's loss. He was satisfied that, had Bollom been made aware of the consequences of failing to set the alarm, it would have ensured the alarm was operational. It followed that Bollom's failure to set the alarm was a direct consequence of Byas Mosley's breach of duty.

In assessing damages, Moore-Bick J recognised that the measure of damages awardable to Bollom could be reduced if it could be shown that there was a chance that the insurers would have relied upon an alternative defence (other than the breach of the "alarms and protection" clause).

Byas Mosley put forward two alternative defences. First, it argued that under the policy, Bollom would have opted for indemnity rather than reinstatement. The practical effect of this would have been that Bollom would have accepted a cash settlement, which would have been a substantially lower sum. On this point, the Court decided that Bollom would have opted for indemnity on the buildings and reinstatement for plant and machinery. Secondly, Byas Mosley argued that Bollom was under-insured for its risks, which would have afforded the insurers a partial defence by virtue of the fact that the policy was subject to an "average" clause. Byas Mosley argued that the claim against the insurers was therefore reduced as a result of the under-insurance. Moore-Bick J rejected this argument on the basis that Byas Mosley had breached its duty by failing to alert Bollom of the risk that it was under-insured and that the "average" clause would have prevented Bollom from being fully indemnified for any loss.

Finally, Moore-Bick J considered the issue of whether Bollom had been contributorily negligent by virtue of either failing to set the yard alarm or the fact that it had been under-insured. He held that unless it were reasonably foreseeable that Byas Mosley might fail to perform its duties, there can be no basis for reducing Bollom's damages. On the facts, he refused to make a deduction.

This decision illustrates the obligations brokers have to inform their clients of the significant terms in a policy of insurance and of the consequences of failing to observe those terms.

Particular attention should be paid to terms which, if inadvertently breached by the insured, might provide the insurer with a defence.

Broker acting in an advisory role liable for whole of reinsured's loss

Case name:

Aneco Reinsurance Underwriting Limited (in liquidation) v Johnson & Higgins Ltd

Citation:

[2000] 1 LLR 12 English Court of Appeal per Evans, Aldous and Ward LJJ

Date of judgment:

30 July 1999

Issues:

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

As a general rule, a broker who fails to obtain cover in accordance with his instructions will be liable for the shortfall arising from any gap in coverage. However, where that would still leave the insured out of pocket the broker may be liable for the full extent of the insured's loss.

The facts

In late 1988, Mr Norman Bullen, the lead underwriter representing four Lloyd's syndicates sought excess of loss cover for his marine accounts under a facultative/obligatory treaty (the ***Bullen Treaty***). Reinsurers generally regard fac/oblig treaties as unattractive because they allow for the possibility of the practice known as anti-selection This arises because a fac/oblig treaty permits the reinsured to choose which risks to declare. When declared, the reinsurers are bound to accept them within the treaty limits. Consequently the reinsured can choose to declare only the poorer risks. This differs from a quota share treaty where the reinsurer takes a proportion of the reinsured's account, which would include good risks as well as bad.

Faced with this general market resistance, the broker, Johnson & Higgins (***J&H***) approached Aneco Reinsurance Underwriting Limited (***Aneco***) as a potential reinsurer. Aneco made it clear to J&H that it would only consider participating in the Bullen Treaty if Aneco could itself obtain acceptable retrocessional cover. J&H therefore, acting as Aneco's agents, obtained quotations for such cover totalling more than US$23m (taking into account two reinstatements).

On 30 December 1988, only when it was certain that the majority of its own retrocessional protection had been placed, Aneco signed the slip evidencing its participation under the Bullen Treaty.

The Bullen Treaty gave rise to considerable losses for Aneco. These came to more than US$30m. As claims were presented, Aneco looked to its retrocessionaires for the sums due under the retrocessions (ultimately being about US$11m). A problem arose when Aneco's retrocessionaires denied indemnity and avoided the contracts on the grounds of misrepresentation and non-disclosure of material facts at placement. In particular, the retrocessionaires complained that J&H had misled them into thinking that Aneco were writing a quota share treaty as opposed to a fac/oblig treaty.

The decision at first instance

Because the retrocessions included an arbitration clause, Aneco was compelled to bring arbitration proceedings against its retrocessionaires. The retrocessionaires successfully established their avoidance argument. This

arbitration award was confirmed at first instance by Cresswell J who also held that J&H were negligent in the placement of the retrocessions. The judge went on to find that Aneco was only entitled to recover from J&H the amount which it would have been able to recover under the retrocessions if they had been properly placed (i.e. the figure of c.US$11m).

The appeal

Aneco appealed, claiming that the loss actually suffered by them was the US$30m figure. The argument put forward by Aneco was as follows:

1. J&H had approached Aneco with the deal in the first place;
2. Aneco made clear to J&H at the outset that it was only prepared to participate in the Bullen Treaty if acceptable retrocessional cover could be placed on its behalf;
3. if J&H had given a fair presentation of the risk, no potential retrocessionaire would have offered terms;
4. in the market climate at the time, J&H would have been unable to obtain alternative security for Aneco; and
5. in those circumstances, Aneco would not have agreed to participate in the Bullen Treaty at all and would therefore not have suffered losses in the region of US$30m.

In considering this argument, the Court of Appeal had regard to two specific issues, one of fact, one of law.

The factual issue

Aneco contended that alternative cover would not have been available to Aneco in late 1988. The court considered the expert evidence and the evidence of the actual underwriter at Aneco. In overruling Creswell J, all three Judges agreed that reinsurance cover of the kind which Aneco required could not have been achieved at rates which would have been regarded as commercially sensible for Aneco to pay.

Evans LJ made particular reference to evidence of comments by underwriters scratched on another slip (in respect of a different treaty) being circulated by J&H at the time. This slip disclosed that the underlying risk was fac/oblig and not quota share. In refusing to offer terms, some underwriters had scratched comments such as "*no fac/oblig*" or, more pointedly, "*must be potty*" or "*need like a hole in the head*".

The legal issue

The Court considered what damages, as a matter of law, were recoverable as a result of J&H's breach of duty. Evans LJ stated the general principle that J&H could only be liable for that part of the loss which is regarded as a consequence of the information or advice that had been given wrongly. In the ordinary course of events, where a broker is merely requested to obtain cover and does so without giving a fair presentation of the risk, the usual consequence of giving incorrect information at placement is that the reinsurer would be entitled to avoid and the broker would be liable to the reinsured for the cover it had been deprived of.

Aneco did not submit that that general rule should be altered in any way, rather, it contended that because of the facts of this case, J&H's duty was wider than the broker's ordinary duty. Because J&H undertook to advise Aneco on the course of action which it should pursue and because J&H were so inextricably linked to the whole deal, the Court of Appeal decided by majority (2:1 Aldous LJ dissenting) that J&H had conducted itself in such a way that it was acting as an adviser to Aneco as opposed to a mere agent through which Aneco obtained retrocessional cover. In those circumstances it was incumbent on J&H to report to Aneco the current market assessment of the risks it was proposing to undertake.

In essence, it followed from the evidence that Aneco would not have entered into the Bullen Treaty at all had J&H not been negligent; it would never have obtained the retrocession cover that it wanted. The Court of Appeal therefore held that Aneco was entitled to recover from J&H the full amount of $30m representing the entirety of its loss from participating in the Bullen Treaty.

This decision highlights the exposure which brokers face when acting in an advisory role, particularly in the area of reinsurance. Having regard to recent Australian authorities involving the rights of lenders against negligent valuers (and in particular, the decision of the High Court in *Kenny & Good v MGICA (1992) Ltd* 73 ALJR 901 reported in our Insurance Annual Review 1999), it seems likely that the reinsured in Aneco's position may not even have to prove that the broker acted in an advisory role. It may be sufficient to show that had the broker not been negligent the loss would not have occurred.

Misleading and deceptive conduct: can damages be reduced where the plaintiff is partly at fault?

Case name

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

Citation:

[2000] QCA 383; Supreme Court of Queensland Court of Appeal per McPherson, Pincus and Thomas JJA, Moynihan SJA and Atkinson J

Date of judgment:

22 September 2000

Issues:

- reduction of indemnity payouts where plaintiff at fault
- relationship between sections 87(1) and 82 Trade Practices Act 1974 (Cth)

This decision concerned an appeal by I&L Securities that its damages award for loss on a loan should not be reduced by virtue of the fact that I&L Securities was aware of the precarious financial position of the borrower.

This appeal arose out of a valuation of property proffered as security for a loan. Relying on the valuation, I&L Securities Pty Limited (***I&L***) advanced the sum of $950,000 to Camworth Pty Limited. Following the borrower's default on loan repayments, it emerged that prior to advancing the funds I&L had documents indicating the true state of the borrower's finances, yet had not made any further inquiries and had not ensured that its own conditions of lending were met.

I&L succeeded in proving that the valuation was misleading with the meaning of s52 of the Trade Practices Act 1974 (Cth) and caused I&L's loss within the meaning of s82. However, the Court also found that another cause of the loss was I&L's poor assessment of the risk.

The Court at first instance made an award pursuant to s87(1) of the Trade Practices Act apportioning damages between the plaintiff and defendant according to the factual findings on responsibility for the loss, namely two-thirds attributed to the valuer and one-third to I&L. Section 87(1) empowers the Court to "*make such orders as it thinks appropriate*" against a person contravening a relevant provision of the Act if the Court considers the orders will compensate the plaintiff "*in whole or in part for the loss or damage or will prevent or reduce the loss or damage*". I&L commenced an appeal on the grounds that there was no authority granted to the Court under s87 to apportion damages in the manner it did. I&L acknowledged that the express wording of s87(1) conferred power to make an award of damages other than for the whole loss suffered, but argued that s82 of the Trade Practices Act imported implicit limitations into the application of s87(1).

I&L argued that section 82(1) establishes an "all or nothing" rule where the loss or damage was caused by the relevant contravention, and to s87(1) had to be read subject to that rule. The Court rejected this argument, largely on the basis that section 87(1) would be rendered redundant if I&L's analysis was accepted.

Referring to extracts from law reform recommendations and relevant High Court authority, the Court considered that the function of the provision, in essence, was to ensure a fair outcome. The Court considered that an all-or-nothing approach would negate that intention. The Court concluded that the most appropriate circumstances for the application of section 87(1) were in fact where the plaintiff was partly at fault.

This case has significant implications for insurers. If followed, it means that s87 will be available as a mechanism to reduce damages where the plaintiff is partially responsible for the loss. This, in effect, provides for a defence of contributory negligence under the Trade Practices Act. This may have a significant impact on the way in which claims under the Trade Practices Act are defended.

"Busy-bodies" win standing to sue corporation for breaches of the Trade Practices Act

Case name

Truth About Motorways Pty Ltd v Macquarie Infrastructure Investment Management Ltd

Citation:

[2000] HCA 11; High Court of Australia per Gleeson CJ, Gaudron, McHugh, Gummow, Kirby, Hayne & Callinan JJ

Date of judgment:

9 March 2000

Issues:

- validity of law conferring standing to seek relief to enforce laws prohibiting misleading and deceptive conduct
- applicant with no direct or special interest in subject matter of proceedings

This decision confirms the constitutional validity of sections 80 and 163A of the Trade Practices Act (the *TPA*) and guarantees the rights of persons to bring court proceedings to enforce the laws which prohibit corporations engaging in misleading or deceptive conduct.

The facts

The respondent was the manager of two unit trusts. One of the assets of those trusts was a project for the construction and operation of a toll road in Sydney known as the "Eastern Distributor". In November 1996 the respondent issued a prospectus inviting members of the public to purchase units in the trusts. The prospectus contained representations that traffic volume on the Eastern Distributor was anticipated to build up rapidly, that the average daily traffic volume on the Eastern Distributor would be nearly 60,000 vehicles by 2006, and that traffic volume would build up more slowly after 2006.

The applicant commenced proceedings in the Federal Court, contending that the respondent's conduct in making those representations was misleading and deceptive and in breach of section 52 of the TPA and two related provisions of Part V. The applicant had no special interest in the subject matter of the dispute. It had not suffered any loss or damage as a result of the respondent's conduct. It claimed that it had standing to bring the proceedings by invoking the jurisdiction of the Federal Court under sections 80 and 163A of the TPA. The respondent challenged the applicant's standing to bring the proceedings.

The issues

The primary question before the Court was whether sections 80 and 163A of the TPA were invalid insofar as they purported to confer standing on the applicant to bring the proceedings.

Section 80 of the TPA provides that the Federal Court may grant injunctive relief where, on the application of the Australian Competition and Consumer Commission *or any other person*, the Court is satisfied that a person had engaged, or was proposing to engage, in conduct that constituted a contravention of Part V. Section 163A of the TPA also provides that *a person* may institute a proceeding in the Federal Court seeking, in relation to a matter arising under the TPA, the making of a declaration in relation to the operation or effect of (amongst others) a provision of Part V, and that the Federal Court has jurisdiction to hear and determine the proceeding.

The respondent relied on sections 76(ii) and 77 of the Constitution in support of its argument that sections 80 and 163A of the TPA did not validly confer on the applicant standing to bring the proceedings. These provi-

sions empower the Parliament to make laws conferring original jurisdiction on the High Court or another federal court in any matter arising under any laws made by the Parliament. The respondent argued that there was no "matter" and accordingly, the purported conferment of jurisdiction was invalid. The respondent contended that for proceedings with respect to a public wrong to constitute a "matter", a private individual must have a direct or special interest in the subject matter of the proceedings. In the absence of such a special interest, there was no justiciable controversy.

The decision of the High Court

Although the applicant had no private right or special interest in the case, the Court held that there was nonetheless a justiciable controversy that was determinable by a federal court. In doing so, the Court rejected the respondent's argument that the words "any other person" in s80 of the TPA and "a person" in section 163A of the TPA should be read down to mean that only persons affected by a breach of Part V could seek relief under those provisions. The Court also rejected the argument that the constitutional concept of "matter" requires that the parties to litigation have mutual or reciprocal interests in rights and duties that are in issue in the litigation. So long as there is a remedy which is appropriately related to the wrong in question, nothing in the Constitution prevents the federal parliament from modifying the general rule that only the Attorney-General may bring proceedings with respect to a public wrong.

Nor were the judges troubled by the argument that allowing any person to seek the relief afforded by sections 80 and 163 of the TPA would open the floodgates of litigation. "Busy-bodies" would be discouraged from instituting litigation in which they have no legitimate interest by the obligation to pay legal costs (including, where appropriate, security for costs) and to submit to orders as to costs of failed proceedings. The courts also retain significant powers to quickly dispose of obviously meritless claims or to impose strict conditions on their continuance.

In holding that the validity of sections 80 and 163 of the TPA were valid notwithstanding that they confer standing on a "person", a number of judges were influenced by the public policy objectives which underlie the relevant provisions of the TPA. The public interest in promoting honesty in commercial dealings is broader than the protection of the private interests of particular consumers. There is no valid reason why instituting litigation to enforce these laws should not be done by any person who has the inclination and the resources to do so. In practical terms the decision increases the exposure of corporations to be liable for conduct that is in contravention of the Trade Practices Act. This could in turn expose corporations to large numbers of small claims by individuals who acted in reliance on the misleading conduct. Such individuals may be less inclined to bring claims if they had to prove that the relevant conduct was misleading.

Duty of care not discharged by reliance on third party

Case name:

Stevedoring Industry Finance Committee v Gibson

Citation:

[2000] NSWCA 179 per Mason P, Stein and Heydon JJA

Date of judgment:

24 July 2000

Issues:

- duty of care
- liability of statutory authority ("Crimmins" duty of care)

The facts

Mr Gibson was employed as a waterside worker in the Port of Sydney between 1956 and 1991. Between 1956 and 1974, Mr Gibson was exposed to asbestos dust and fibre while discharging cargoes. His highest exposure to asbestos occurred in the years 1956-1967.

In 1994, Mr Gibson was diagnosed as suffering from an asbestos-related disease. In 1996, he commenced proceedings in the Dust Diseases Tribunal against:

- Stevedoring Industry Finance Committee (***SIFC***), the successor to the liabilities of the Australian Stevedoring Industry Authority (the ***Authority***);
- Association of Employers of Waterside Labour (***AEWL***), the industrial association of stevedoring companies;
- Stevedoring Employers of Australia Pty Ltd (***SEA***), his employer from December 1967 to March 1983 (except a period in 1974); and
- Patrick Operations Pty Ltd (***Patrick***), his employer from 1956 to 1967 and for a brief period in 1974.

The claim against the AEWL and the SEA were discussed. Curtis J found that 75% of Mr Gibson's exposure to asbestos had occurred during his employment with Patrick and that Patrick had breached its duty of care to Mr Gibson. Curtis J further found that SIFC had also breached its duty of care to Mr Gibson and was liable for the additional 25% of his damages.

SIFC appealed this decision on a number of grounds, including Curtis J's decision that SIFC owed a duty of care to Mr Gibson and could be sued for breach of that duty.

"Crimmins" duty of care

The Authority was established under the Stevedoring Industry Act 1956 (Cth) (the ***Act***). Its statutory functions were to be performed and its powers used with a view to "*securing the expeditious, safe and efficient performance of stevedoring operations*." It had the power to take direct action and regulatory powers which allowed it to control the conduct of employers and workers in the stevedoring industry. These powers included the powers to investigate safety issues, warn workers, provide safety equipment, and compel employers to provide safe working conditions.

In *Crimmins v Stevedoring Industry Finance Committee* [1997] IJCA 59, the majority of the High Court held that this statutory framework and the powers available to SIFC gave rise to a "*continuing duty . . . in the exercise of its statutory functions . . . to take reasonable care to avoid foreseeable risk of injury to the health of the plaintiff*" (per McHugh J).

The decision

The Court of Appeal held that Mr Gibson's case did not differ substantially from that of Mr Crimmins, and applied the reasoning of the High Court in finding that SIFC owed Mr Gibson a duty of care. SIFC argued that its duty of care was discharged by its membership of the Federal Advisory Committee on Waterfront Accident Prevention (***FACWAP***), an umbrella body of employers, employees and the Accident Prevention Association of the Central Committee of Interstate and Overseas Shipowners. FACWAP was a forum in which waterfront employment issues, including safety issues, were discussed. The Court of Appeal held that this did not discharge the Authority's duty of care and that, if anything, its membership of FACWAP made it more aware of the dangerous conditions experienced by workers such as Mr Gibson. There was considerable evidence to suggest that FACWAP was aware of the dangers but did nothing to address them.

The Court found that the Authority had actual knowledge of the health hazard associated with asbestos cargoes. This hazard was preventable by the Authority if it had exercised the powers available to it. The condition of Mr Gibson's health was a natural consequence of the Authority's failure to use its powers to intervene on the waterfront and protect the class of persons including Mr Gibson. Accordingly, the Court found that the Authority had breached its duty of care to Mr Gibson and dismissed SIFC's appeal.

The case illustrates how the duty of care of a statutory authority will often require action on its part which goes further than engaging a third party to recommend what steps should be taken.

Dangerous chattel and intervening acts

Case name:

Muller v Lalic

Citation:

New South Wales Court of Appeal [2000] NSWCA 50 per Handley JA, Powell JA and Stein JA

Date of judgment:

22 March 2000

Issues:

- what precautions should be taken in relation to inherently dangerous chattel
- what constitutes an "intervening act"

It was negligent to store a rifle as it was loaded with ammunition, even though the rifle was locked away and there were only adults in the house. The chain of causation was not broken by the intervening act of someone taking out the rifle and pulling the trigger.

The facts

Mr Lalic owned a rifle. Although there is some uncertainty about the precise arrangements, the rifle was securely locked.

It was Mr Lalic's practice to leave the rifle unloaded. His adult son, who knew both how to access the rifle and that it was normally unloaded, took out the rifle, pointed the gun at a "friend" and pulled the trigger. The friend was seriously injured.

There was no dispute that the son was negligent. The trial judge found that the father was not negligent as the rifle was kept in a secure location. Furthermore, he held that even if the father was negligent, there was an intervening act when the son pulled the trigger, and the father should not be responsible for that act.

The decision of the Court of Appeal

The Court of Appeal held that a higher degree of care was required by those who choose to install dangerous articles where others will come into contact with them. In the present case the rifle was stored negligently because:

(a) the bolt was neither removed nor stored separately from the rifle; and

(b) the rifle was loaded.

The fact that the rifle was not stored in compliance with the Firearms Act 1989 was also relevant in determining that the rifle was stored negligently.

Furthermore, there was no intervening act when the son took the rifle out of its secure storage and pulled the trigger. The court did not discuss in much detail what does constitute an intervening act. However, it appears from the judgment that the following factors were particularly important:

- Mr Lalic told his son that the rifle was not loaded; and
- the son believed the rifle was not loaded.

The negligence of the son in pulling the trigger might be regarded as the natural consequence of the father stating that the gun was not loaded. Unfortunately the court did not decide whether the son's actions would have been an intervening act if the son had known that the gun was loaded.

This case may be relevant to many instances where damage is caused through use of dangerous chattels. In this case a clear link could be drawn between the negligence in storing the rifle loaded and the resulting accident. There will undoubtedly be further cases before the courts where people are injured as a result of guns or other dangerous chattel being negligently stored. The circumstances in which a person pulling a trigger will be held to break the chain of causation has been left to a future case.

Product liability: farmers able to recover money spent to prevent damage to crop

Case name:

Wilkins v Dovuro Pty Ltd

Citation:

(1999) 169 ALR 276, Federal Court of Australia per Wilcox J

Date of judgment:

23 December 1999

Issues:

- product liability
- duty of care
- causation
- misleading and deceptive conduct

The facts

A group of farmers in Western Australia proceeded against Dovuro (a supplier of canola seed) in negligence and for contravention of s52 of the Trade Practices Act 1974 (Cth) (***TPA***). The applicants alleged that the respondent knew, or ought to have known, that the canola seed it supplied contained, or might contain, undesirable weed seeds; but failed to warn the applicants of that fact. It was alleged that this inadmission was negligent and, under the circumstances, constituted misleading and deceptive conduct.

The weeds were controllable by a herbicide called Triazine. However, Triazine adversely effected the strain of canola traditionally grown in Western Australia. In 1994, a Triazine tolerant strain of canola was developed in New Zealand. Dovuro supervised the production of this seed and then sold it to the applicants. The seed bags sold by Dovuro had labels attached, which stated "minimum 99% purity".

Analyses made in New Zealand of the Dovuro seed showed 3 species of weed. Quarantine authorities in Western Australia only checked the weed seeds shown in the New Zealand certificates against its list of prohibited imports. As the 3 species of weed seed were already present in the eastern states of Australia, there was no prohibition on the importation of the seeds into Australia. These species were then virtually unknown in Western Australia and had never been the subject of a Western Australian prohibition or declaration. In the absence of a relevant prohibition or declaration, and without further inquiry, the Western Australian quarantine service released the seed for distribution.

Following complaints by farmers of weed seeds in Dovuro's product, the Western Australian agricultural department released an information package for weed control in canola. The applicants followed the recommendations contained in the information package. This involved spending considerable time inspecting the areas sown with the seed and additional expense for chemical sprays. There was no evidence that the weed seeds had in fact caused any problems. However, the applicants sought recovery of the money spent in taking steps to prevent apprehended harm to their crop.

The decision – negligence

Dovuro accepted that it was under a duty of care to those to whom it supplied the seed in relation to its nature and quality; but denied that it breached that duty. Dovuro argued that the agricultural department overreacted in sending out the information package, and any expenses and losses stemming from following the recommendations contained in the package were not, therefore, caused by a breach of duty by Dovuro. Justice Wilcox J rejected this claim on the strength of evidence given by the department's experts.

Dovuro further argued that it relied on the quarantine authority to ensure the canola was safe to use. The issue was whether relying on the quarantine authority was sufficient to discharge Dovuro's duty of care.

In addressing this issue, Wilcox J noted that Dovuro had knowledge of a potential problem of weed contamination through inspections of the foundation crop in New Zealand. Wilcox J also noted that Dovuro had knowledge that the decisions on importation by the quarantine authorities were made by reference only to whether identified seeds appeared on the relevant list of prohibited or declared plants.

In finding that Dovuro breached its duty of care to the applicants, Wilcox J held that it was not enough that Dovuro relied on "broadbrush government controls." That could not be sufficient to discharge its duty of care.

The decision – misleading and deceptive conduct

The applicant's trade practices claim was based on Dovuro's failure to inform purchasers of the presence of the weed seeds. The claim hinged upon the labelling of Dovuro's canola seed bags, which claimed the contents of each bag delivered to the applicants where 99% pure; that is, at least 99% of the contents constituted canola seed. It was not suggested that this claim was incorrect. The complaint was that Dovuro did not identify the nature of the remaining 1%; in particular, it did not reveal that the remaining 1% contained seeds of plants that would be regarded as problematic in Western Australia.

Wilcox J rejected the section 52 claim. He stated that the applicants had not established that the information being given by Dovuro on the label was a "half truth". Rather, Dovuro's fault was to fail to obtain authoritative information about the acceptability of particular foreign seeds, or alternatively to put purchasers on notice of the identity of those seeds so as to enable them to make their own enquiries or to assess the risk of failing to do so. Consequently, there was a failure to take care not to cause damage to purchasers, but not misleading or deceptive conduct.

This case illustrates the important principles relevant to product liability. Firstly, damage need not have occurred before a claim can arise. Money spent to avoid damage from a defective product will be recoverable where the expenditure is a reasonable preventative measure. Secondly, the fact that a product passes tests set by government or regulatory authorities cannot of itself suffice to absolve the distributor from liability.

Sports injuries: what is fair game?

Case name:

Agar v Hyde

Citation:

High Court of Australia [2000] HCA 41 per Gleeson CJ, Gaudron J, McHugh J, Gummow J, Hayne J and Callinan J

Date of judgment:

3 August 2000

Issues:

- duty of care
- factors to be considered in determining whether a duty of care exists

The members of the International Rugby Board did not owe a duty of care to individual players to make the game safer

The facts

Mr Hyde and Mr Worsley (***the plaintiffs***) broke their necks playing rugby. In each case the injury was caused when the opposing pack engaged in a scrum before the plaintiff's pack was ready. The plaintiffs commenced proceedings against 9 different defendants (or groups of defendants) including the opposing players, the referee and his association and various rugby bodies.

One group of defendants were the individual members of the International Rugby Football Board (***IRFB***). It was alleged that these members should have amended the laws of rugby to make scrums safer. A preliminary issue for the High Court to determine was whether there was an arguable case that these members owed a duty of care to the injured players.

The judgment of the High Court

The members of the IRFB could not be liable to the plaintiffs unless they owed them a duty of care. In a joint judgment Gaudron, McHugh, Gummow and Hayne JJ considered the following circumstances to be relevant in determining whether there existed a duty of care:

(a) The alleged duty of care is owed to an individual. If the member of the IRFB owed a duty to the plaintiffs then they would also owe a duty to every rugby player in the world – a finding that would be "*so unreal as to border on the absurd*".

(b) The law distinguishes between a positive act causing damage and a failure to act which results in damage. The courts are more reluctant to impose a duty of care where, as here, there is merely a failure to act. The members of the IRFB *"no more owed a duty of care to each rugby player than parliamentarians owe a duty of care to factory workers to amend the factories legislation."*.

(c) The members of the IRFB acted as representatives of their member unions, rather than in a personal capacity.

(d) The IRFB had no direct legal or practical control over the relevant games. There were a number of decision making bodies who operated between the promulgation of the rules by the IRFB and the games themselves, including the national union, the local union, the association which organised the competitions and the referees in control of the games.

(e) The relevant injuries were caused by third parties. In the case of Mr Hyde, those third parties were breaking the rules of the game. The members of the IRFB did not have sufficient control over the plaintiffs' opponents to justify making the members responsible for the opponents' conduct in breaking the rules. Such a finding *"would dilute the notion of individual responsibility which lies at the core of the law of negligence."*

(f) Mr Worsley was injured notwithstanding his opponents abiding by the laws of the game. Mr Worsley chose to participate in a sport which he knew to be dangerous. The laws of rugby defined the risks which Mr Worsley consented to be exposed to. For many activities, the inherent danger is part of the attraction. To impose a duty of care in this case would limit the freedom of all those who wish, for whatever reason, to engage in a dangerous pastime.

This case is important for maintaining the status quo. If the plaintiff had succeeded it would have been serious consequences for all those associated with the administration of sport.

The real importance of these proceedings, however, probably lies in the future. The players' claims against the other defendants are still before the courts and are likely to result in many further judgments, by courts at different levels, exploring ideas such as the scope of the duty of care and the importance of a plaintiff consenting to the risk of injury.

Restricting claims for psychiatric injury

Case name:

Morgan v Tame

Citation:

New South Wales Court of Appeal [2000] NSWCA 121 per Spigelman CJ, Mason P and Handley JA

Date of judgment:

12 May 2000

Issues:

- in what circumstances a plaintiff can recover damages for psychiatric illness
- when a duty of care is owed in relation to psychiatric illness

The New South Wales Court of Appeal has confirmed existing limitations on claims for psychiatric illness.

The facts

The essential facts are as follows:

(a) In January 1991 the plaintiff was injured in a road accident. There was never any real dispute that the other driver was at fault as he was driving on the wrong side of the road with a high blood-alcohol reading. He didn't help his case by fleeing the scene and assaulting the police who arrested him.

(b) In June 1992, long after liability had been admitted, the plaintiff learned that a police form showed both her and the other driver with the same high blood-alcohol reading. She immediately rang the police, who confirmed it was a mistake and that there was no issue that her own reading was zero.

(c) The plaintiff alleged that, in time, her musings over this mistake led to her suffering major psychotic depression.

(d) The evidence revealed:

  (i) she never mentioned this mistake in her personal diary and did not speak about it to her doctor for 3 years;

  (ii) she was already having crisis counselling before she knew of the mistake;

  (iii) at about the same time as the mistake was made her father died;

  (iv) 6 months after the mistake her husband attempted suicide.

  The trial judge held that the mistake caused her depression and that the police authority was liable for the mistake of its employee.

Decision of the NSW Court of Appeal

The defendant appealed against both the factual finding of causation and on various legal issues. It is very difficult to overturn a factual finding and this part of the appeal was unsuccessful.

There were a number of related legal issues before the Court of Appeal. In particular, the court considered:

- what types of psychiatric injury will be recognised by the courts; and
- the interaction between "reasonable foreseeability" and liability for psychiatric illness.

(a) Psychiatric Injury

At present, a claim for psychiatric injury can only be made if it results from a sudden "shock" to the senses. The plaintiff argued unsuccessfully that this limitation should be removed.

The Court of Appeal held that the plaintiff's illness did not result from the shock of being told about the mistake, but from her subsequent ruminations. This was one of 2 grounds on which the Court upheld the appeal.

(b) Reasonable foreseeability

"Reasonable foreseeability" is relevant, but not decisive, in determining whether a defendant owed the plaintiff a duty of care (i.e. whether the defendant should be liable to the plaintiff for the consequences of its negligence).

The officer who made a mistake when completing the form was negligent. Was it reasonably foreseeable, however, that the mistake might lead to psychiatric illness? The plaintiff appears to have taken 2 approaches.

- It was reasonably foreseeable that the plaintiff might suffer economic loss. The defendant therefore owed a duty of care to the plaintiff. This was sufficient to impose a duty of care to avoid any sort of harm, including psychiatric illness, even if that type of harm was not foreseeable.
- It would suffice to show that it was reasonably foreseeable that a person who was unusually susceptible to psychiatric illness might be harmed.

The Court of Appeal rejected both these arguments. It held that, in determining whether a defendant owed a duty of care to a plaintiff in relation to psychiatric illness, one should consider whether it was reasonably foreseeable that a person of ordinary fortitude might suffer psychiatric harm.

In the present case it was not reasonably foreseeable that a person of ordinary fortitude would suffer psychiatric illness due to a mistake filling out the form, so no duty of care was owed to the plaintiff. The appeal was therefore allowed on this ground as well.

This decision is important for containing claims for psychiatric illness. The decision of the trial judge illustrates that, no matter how weak a plaintiff's case might appear, there is always a possibility they will succeed.

Two bites of the cherry: settlements in multi-party litigation

Case name:

Baxter v Obacelo Pty Limited

Citation:

(2000) 48 NSWLR 522 New South Court of Appeal per Mason P, Sheller and Giles JJA

Date of judgment:

31 March 2000

Issues:

- partial settlement
- claim pursued against remaining defendant
- assessment of damages

This decision highlights the need to be wary of settlements involving only some of the parties in multi-party litigation. The plaintiff may be able to pocket the settlement and then continue its claim against the other defendants for the balance even if they are being sued over the same subject matter.

The facts

Baxter was a solicitor employed by Whitehead, a sole practitioner. Obacelo Pty Limited retained Whitehead to act in relation to a conveyancing transaction. Baxter performed the conveyancing work on behalf of Whitehead.

The transaction went awry and Obacelo sued both Whitehead and Baxter for negligence. Obacelo subsequently settled the claim against Whitehead on payment by him of $250,000 and Whitehead consented to judgment in that amount. The claim against Baxter, however, remained on foot.

Several years later, Baxter sought to have the proceedings against him dismissed on the basis that they were futile. According to Baxter, they were futile because any claim against him had been satisfied by Whitehead's $250,000 payment. Baxter's application was dismissed and he appealed.

The appeal

It was common ground between the parties that Baxter and Whitehead were joint tortfeasors. Joint tortfeasors are persons who are responsible for the same wrongful act and, as a result, are jointly and severally liable for the whole of the victim's loss. The old common law position was that there was only one indivisible cause of action against joint tortfeasors. As a result, settlement with one joint tortfeasor released all the others. This rule was changed by the *Law Reform (Miscellaneous Provisions) 1946* (NSW) which relevantly provides:

> *5(1) Where damage is suffered by any person as a result of a tort (whether a crime or not):*
>
> *(a) judgment recovered against any tort feasors liable in respect of that damage shall not be a bar to an action against any other person who would, if sued, have been liable as a joint tort feasor in respect of the same damage;*
>
> *(b) if more than one action is brought in respect of that damage by or on behalf of the person by whom it was suffered…against tort feasors liable in respect of the damage (whether as joint tort feasors or otherwise) the sums recoverable under the judgment given in those actions by way of damages shall not in the aggregate exceed the amount of the damages awarded by the judgment first given; and in*

> *any of those actions, other than that in which judgment is first given, the plaintiff shall not be entitled to costs unless the court is of opinion that there was reasonable ground for bringing the action…*

Baxter argued that s5(1)(b) applied not only where two or more proceedings were commenced, but also where two or more judgments were given in the *same* proceedings. The Court of Appeal rejected this agreement. The Court was of the view that s5(1)(b) was not intended to limit recovery in the one set of proceedings. Rather, it was intended to prevent multiple or successive proceedings made possible by the abolition of the old common law rules about joint tortfeasors.

Baxter next invoked the rule against double satisfaction. This is the rule that the plaintiff cannot recover greater than his or her actual loss. Baxter's argument was that the plaintiff's claim had been satisfied by the $250,000 payment made by Whitehead and Obacelo was not entitled to any more compensation.

The Court of Appeal acknowledged the existence of the rule against double satisfaction but was of the opinion that it did not necessarily operate where proceedings had been brought to an end by way of settlement rather than judgment. One could not assume that a settlement payment was made in full satisfaction of the plaintiff's claim. Indeed, the settlement payment may not bear any real relation to the loss actually suffered by the plaintiff. This is in contrast to a damages award which represented a judge's assessment of what the plaintiff had suffered. Furthermore, the Court considered that to conclude otherwise would discourage settlements as plaintiffs would be inhibited by fear of the negative effect settling with one defendant may have on their claim against the others.

This decision is a reminder that defendants in multi party proceedings who take an unreasonable approach to settlement negotiations may find that a settlement with other defendants is reached while the plaintiff continues its claim against the less compromising defendants for the balance of its loss. In such circumstances, provided the plaintiff can demonstrate that the settlement was reasonable (as to which see the High Court decision in *Unity Insurance Brokers v Rocco Pezzano* reported in our 1998 Annual Review) then the remaining defendants will be exposed for the full balance of the claim, together with costs. The case also illustrates the importance of obtaining appropriate indemnities where there is only a partial settlement. In this case, if Baxter was liable he would have a claim in contribution against Whitehead. Generally, an employee has a right to complete indemnity in respect of liability for negligent conduct in the course of employment. The relevant New South Wales legislation is the Employees Liability Act 1991.

Duty of care owed by public authorities

Case name:

Graham Barclay Oysters Pty Limited & Ors v Ryan

Citation:

[2000] FCA 1099 Federal Court of Australia per Lee J, Lindgren J and Kiefel J

Date of judgment:

9 August 2000

Issues:

- duty of care
- whether the local council and/or the NSW government owed a duty of care to consumers of oysters

The scope of the duty of care owed by public authorities remains uncertain following a recent decision of the Full Court of the Federal Court

The facts

In early 1997 many people were affected by an outbreak of hepatitis A from eating contaminated oysters grown in Wallis Lake. 185 people brought actions against the Local Council and the NSW government seeking compensation for their injuries. Many of these people also claimed against particular growers or distributors of oysters.

The contamination of the oysters was caused by pollution - in particular from untreated sewage – in Wallis Lake. The claims against the Local Council and NSW government were primarily based on allegations that they should have taken further steps to minimise pollution in the lake and, in the case of the NSW government, order a temporary cessation of harvesting following the heavy rain in November 1996. There were also actions against the growers and distributors under the Trade Practises Act and in negligence. However, the case is of most interest for its consideration of the circumstances in which a public authority owes a duty of care.

When do public authorities owe a duty of care?

If a Court decides that a defendant's negligence caused the plaintiff to suffer a loss it must then ask itself: should the defendant be liable to compensate the plaintiff for that loss? This question is generally re-phrased as: did the defendant owe the plaintiff a duty of care? If the Court decides that the defendant did not owe a duty of care to the plaintiff, then it will not be liable for the loss.

The courts have made many different attempts to formulate a principle to determine when one person owes a duty of care to another. Concepts such as "reasonable foreseeability", "proximity" and "reliance" have all been tried, but none have gained general acceptance.

Determining the existence of a duty of care is even more difficult when public authorities are involved, as the courts do not wish to be seen to be interfering with policy decisions of public bodies.

The main issues in this case were whether the Local Council and NSW government owed a duty of care to those people who contracted hepatitis A as a result of eating contaminated oysters.

The decision

Lindgren J considered this issue in most detail. Of the three judges he held that a duty of care arose in the most limited circumstances. He held that the following factors favoured the imposition of a duty of care on the Local Council.

(a) Parliament would have envisaged that the powers delegated to the Local Council would be exercised, to an extent, to protect consumers of oysters.

(b) The power to control faecal contamination of the lake was ceded by the legislature to (in part) the Local Council.

(c) The plaintiffs were "vulnerable" in the sense that they could not take steps themselves to ensure that the oysters were not contaminated.

(d) The powers which the Local Council failed to exercise (keeping the lake clean) were neither core policy-making powers nor quasi-legislative.

(e) The Local Council was aware of the problems caused by the discharge of faecal matter into the lake, but these problems were generally not known to consumers.

Lindgren J held that the following factors suggested that a duty of care should not be imposed.

(i) The relevant duty would be owed to the public at large, rather than to an identified individual or group of individuals.

(ii) One should be particularly hesitant to impose a duty of care towards the public at large where that duty requires positive action by the Local Council.

(iii) The Local Council would not be required to exercise this power in relation to a particular site or sites, but rather the faecal contamination occurred from many sites known and unknown along the lengthy shoreline of the lake.

(iv) The Local Council could never prevent faecal contamination. At best it could minimise it.

(v) By imposing a duty of care the Court would be interfering with the Local Council's discretion as to the allocation of its resources. The Local Council had many powers which it could exercise for the benefit of the public health and it was for the Local Council to determine which of these it should give priority to.

(vi) If a duty of care were imposed it would raise difficult causation issues as one could never know whether or not reasonable steps by the Local Council would have prevented the contamination that in fact occurred.

(vii) The cost of monitoring all sources of pollution might be too onerous financially for the Local Council.

On balance, Lindgren J held that the Local Council did not owe a duty of care to consumers of oysters.

Lindgren J also held that the NSW Government did not owe a duty of care to consumers of oysters. His reasoning was similar to that for the Local Council, but he held that the following additional factors were also relevant.

♦ The NSW government had no reason to believe that an outbreak of hepatitis A was imminent or that there was particular danger in consuming oysters from Wallis Lake. Any duty would be owed to the public at large in respect of all oyster – growing estuaries. The duty would not be in relation to an identified group or an identified risk.

♦ The NSW government had taken a policy decision to favour a system of industry–based control through 2 committees, and the Court should not interfere with that decision.

Kiefel J held that a public authority could owe a duty of care in wider circumstances than those suggested by Lindgren J. He held that in determining the scope of a duty of care one needed, most importantly, to ascertain the nature of the powers given to the authority and what they were directed to.

The Local Council was given powers, inter alia, to prevent environmental damage. This included the power to mitigate the pollution of water. There was no power, however, which had as its apparent purpose the

prevention of contamination of oysters, the protection of water in which oysters were grown or the protection of consumers. He therefore held that the Local Council did not owe a duty of care to oyster consumers.

Kiefel J held that, in contrast to the Local Council, the powers of the NSW government were directed at consumers of oysters. Furthermore, the NSW government was aware of the risk of viral contamination of oysters and it was foreseeable that its negligence might cause injury to consumers of oysters. Kiefel J concluded that the NSW government owed a duty of care to consumers of oysters.

According to Kiefel J the heavy rainfall in November 1996 created a "*known and significant risk of faecal contamination of oysters, and with it a risk of viral infection including (hepatitis A)*". He therefore held that the NSW Government should have banned the harvesting of oysters following this rainfall until satisfied that the danger had passed. Its failure to do so meant that it was liable for the resulting injuries.

Lee J held that a public authority owed a duty of care in even broader circumstances, and these included the Council in this case. In contrast to Kiefel J, Lee J held that the powers of the Local Council to prevent contamination of water were directed towards consumers of oysters. Other relevant factors, to Lee J, were:

- the Council was aware of the danger of contamination from faecal waste;
- it was reasonably foreseeable that if a Local Council did not ensure the cleanliness of the water there might be an outbreak of hepatitis A;
- consumers of oysters were "vulnerable" in the sense that they themselves could not ensure that the oysters were free from contamination; and
- imposing a duty of care would not affect the council's core policy-making or quasi-legislative functions.

For similar reasons Lee J also held that the NSW Government owed a duty of care to consumers of oysters. He further held that a decision of the NSW Government to favour a system of industry-based control was not a policy decision but "*a course undertaken as a consequence of a failure to appreciate the nature of the risk to public health represented by continuing the production of oysters from the waters of the lake without the imposition of further control*".

Lee J concluded that, given the negligence of the Local Council and the NSW Government, *"the events that occurred were not merely foreseeable, they were inevitable"*. He therefore found both bodies liable to the injured consumers.

The result (by majority) was that the claims against the Council failed but they succeeded against the NSW government.

In this case Lee and Kiefel JJ showed little of the traditional reluctance of the courts to impose a duty of care on statutory authorities. Although there is no clear ratio to the case, the following factors appeared to be most important in determining whether a duty of care is owed:

(a) the "vulnerability" of the plaintiff, ie the extent to which the plaintiff was dependent on the public authority;

(b) the purpose for which the public authority was given a power; and

(c) whether the resulting loss was reasonably foreseeable.

The cogent reasoning of Lindgren J, however, suggests that the judgments of Lee and Kiefel JJ may be inconsistent with the most recent judgments of the High Court. This case therefore does little to clarify what is currently one of the most uncertain areas of tort law.

Things speaking for themselves

Case name:

Schellenberg v Tunnel Holdings

Citation:

High Court of Australia [2000] 170 ALR 594 per Gleeson CJ, Gaudron J, McHugh J, Kirby J and Hayne J

Date of judgment:

3 May 2000

Issues:

- when negligence can be presumed
- the scope of res ipsa loquitur

The High Court has once again considered the doctrine of res ipsa loquitur – the thing speaks for itself – and once again confined it to merely a "mode of inferential reasoning".

The origin of res ipsa loquitur

On 18 July 1863 a man was "*thrown down, wounded, lamed and permanently injured*" when a barrel of flour fell upon him. He brought an action against the owner of the premises. None of the witnesses on the street saw how the barrel came to be falling from the defendant's premises. The owner did not call his employees to give evidence as to how the barrel came to fall from the window. In the absence of any evidence, the Assessor found that the injured man could not prove negligence.

On appeal, the defendant's counsel stated that there was *"not a scintilla of evidence, unless the occurrence is of itself evidence of negligence".* In reply, Pollock CB stated that *"There are certain cases of which it may be said res ipsa loquitur, and this seems one of them".*

Since that time the meaning of res ipsa loquitur has been considered frequently by the highest courts throughout the english speaking world. It serves a useful role in enabling a plaintiff to succeed where common sense suggests that the defendant was negligent. What it actually means, however, is less clear.

The decision of the High Court

Mr Schellenberg was injured when a hose carrying compressed air detached from a coupling and whipped him. The main issues before the court were whether the principle of res ipsa loquitur applied in this case and, if so, what did the principle mean.

The Court held, in line with its earlier decisions, that res ipsa loquitur was not a rule of law, but merely a mode of reasoning. Its importance is that, where the requirements of res ipsa loquitur are made out, a court might infer that the defendant was responsible in the absence of any direct evidence to that effect. The plaintiff is still required, however, to satisfy its burden of proof.

The court held that res ipsa loquitur applies where:

(a) there is no explanation for the relevant occurrence;

(b) the occurrence would not ordinarily happen without there being negligence; and

(c) the cause of the occurrence was under the control of the defendant.

These 3 factors were clearly present in the example, referred to above, of the falling barrel of flour. In the present case, however:

- there was an explanation of the relevant occurrence: the hose whipped the plaintiff because it detached from the coupling;
- the factual background was quite complicated and the court did not feel confident in saying that, as a matter of common experience, hoses of this type do not detach without there being negligence; and
- the hose was as much (or more) under the control of the plaintiff as under the control of the defendant.

The trial judge considered the detaching of the hose to be the relevant occurrence. As this could not be explained, he applied res ipsa loquitur to infer that it was due to the defendant's negligence.

The High Court held that the "occurrence" was the plaintiff being whipped by the hose. In this case there was an explanation of the occurrence – it occurred because the hose detached from the coupling. There was therefore no room for the application of res ipsa loquitur.

As the plaintiff could not show that the hose detached due to the defendant's negligence, the Court found for the defendant.

Res ipsa loquitur cannot be used to shift the burden of proof to the defendant. It only operates where common sense dictates that the immediate cause of the plaintiff's injury was, in the absence of evidence, a negligent act of the defendant. In these circumstances the absence of evidence will not be decisive against the plaintiff, but the plaintiff must still satisfy the burden of proof.

Accountant's statement of net worth unable to be relied on as a valuation

Case Name:

HIT Finance Limited v Cohen Arnold & Company (a firm)

Citation:

English Court of Appeal – Queen's Bench Division per Gibson, Clarke & Hirst LLJ

Date of judgment:

14 October 1999

Issues:

- professional liability
- duty of care
- accountant's statement of net worth

This appeal arose from one of a flood of cases which followed the UK property market collapse in the early 1990s and in which lenders sought to recover their losses from persons other than the borrower and the guarantor of the borrower.

The facts

The plaintiff, HIT, was a joint venture vehicle established to provide short term secured lending. In 1989, HIT provided a 12 month facility of £3 million to Hatchford Ltd which was incorporated to acquire and develop a parcel of land in South East London. One of the controlling interests in Hatchford was a Mr Schreiber.

As a pre-condition to the grant of the facility HIT required that a net worth statement in relation to Schreiber be provided by Schrieber's accountants. For that purpose, Schrieber's long standing accountants, Cohen Arnold & Company (***Cohen Arnold***) provided a letter to HIT stating that, according to the information provided to it, the net asset worth of Mr Schrieber, including properties at valuation, was in excess of £3.3 million.

The loan was drawn down and Hatchford subsequently defaulted. The total loss which HIT claimed to have incurred as a result of entering into the transaction was in excess of £2.7 million. Schrieber was made bankrupt on his own petition. HIT looked to recover its loss from Cohen Arnold.

The proceedings at first instance

HIT's case at trial was that it had entered in to a loan agreement with Hatchford in reliance upon a negligent representation made by Cohen Arnold. The Judge accepted the case advanced by HIT that Cohen Arnold had acted negligently in asserting in the letter provided to HIT that Schrieber's net asset worth was in excess of £3.3 million – it was in fact just a fraction of that amount. The judge awarded HIT damages in the region of £2.6 million. Cohen Arnold appealed the decision.

The Court of Appeal

The Court of Appeal in a majority 2:1 judgment allowed Cohen Arnold's appeal and set the judgment for HIT aside.

The Court of Appeal accepted that Cohen Arnold owed a duty of care to HIT. Whether that duty was breached depended upon the meaning of the letter. The court considered in detail the true construction of the Cohen Arnold representation letter and the actual circumstances surrounding the provision of the letter. HIT's submission was that it accepted the

letter as an unqualified statement of Schrieber's net worth and that the statement was a crucial factor in HIT's evaluation of the transaction and its decision to lend to Hatchford.

Cohen Arnold asserted that the letter said no more than that according to the information provided to it, Schrieber's net worth was in excess of £3.3 million. Clarke LJ accepted that it was important in the terms of the letter that Cohen Arnold had taken such steps as a reasonable accountant would take before writing the letter, and were not simply passing on information. However, he also considered that the letter was not a statement or warranty as to net worth. He considered the duty Cohen Arnold owed was limited to a duty to take such care as a reasonable accountant would before writing such a letter. Since HIT had not pleaded breach of such a duty, but had argued that the letter was a warranty as to net worth, they were precluded from raising that issue and their claim failed. In any event, Clarke LJ considered that such evidence as there was was not sufficient to demonstrate that Cohen Arnold had failed to make reasonable care before sending the letter. This duty did not extend much further than checking that the information was consistent with other information provided and ensuring that the information was accurately passed on to HIT.

Gibson LJ concurred with Clarke LJ. Hirst LJ took the view that the letter did constitute a statement confirming Schrieber's net worth and he upheld the first instance decision on liability.

The judgment illustrates how professionals, whether lawyers, accountants or valuers, can usefully limit the scope of their duties, where appropriate, by identifying the extent and scope of the instructions which they are given and when providing advices or opinions, setting out the basis upon which that advice/opinion is given.

The case also illustrates the importance for claimants of getting the pleading right. In this case the assumption that the letter was a net worth statement and the failure to assert at trial the alternative argument that the accountant's had failed to make reasonable enquiries precluded them from raising that issue on appeal.

Advocates' immunity from suit removed by House of Lords

Case Name:

Arthur JS Hall v Simons

Citation:

[2000] 3 All ER 673 United Kingdom House of Lords per Lord Browne-Wilkinson, Lord Steyn, Lord Hoffmann, Lord Hope, Lord Hobhouse, Lord Millett and Lord Hutton

Date of Judgment:

20 July 2000

Issues:

- advocates immunity from suit
- public policy issues

In this decision, the House of Lords unanimously dismissed appeals of three solicitor advocates, removing the advocates' immunity from suit, at least in respect of the conduct of civil proceedings. Advocates have enjoyed this immunity since *Rondel v Worsley* in 1969.

The facts

This dealt with 3 separate claims based on negligence alleged against 3 separate solicitors. The essential question before the House of Lords was whether the Court of Appeal had correctly ruled in all 3 cases that the claims against the solicitors had wrongly been struck out at first instance, opening the way for actions in negligence against the solicitors to proceed. This depended upon whether the solicitors could rely on advocates immunity from suit.

Lord Steyn considered the various reasons for the immunity (as it traditionally applied to barristers) including: the dignity of the Bar, the "cab rank" principle, the assumption that barristers may not sue for their fees, the undesirability of re-litigating cases decided or settled, and the duty of barristers to the Court. He concluded that maintenance of the immunity could not be justified on any of those bases, nor on other grounds enunciated by Lord Diplock in *Rondel v Worsley* [1969]1 A.C. 191 – such as the public interest in not permitting decisions to be challenged by collateral proceedings.

The majority asserted that immunity from suit should still be maintained in respect of conduct of criminal (as opposed to civil) proceedings. Lord Steyn drew on his own experience of the criminal justice system as a previous member of the Court of Appeal (Criminal Division). He expressed the view that in civil cases the principles of res judicata, issue estoppel and abuse of process should be adequate to cope with the risk of collateral challenges to civil decisions. Thus, the public interest is satisfactorily protected by independent principles and powers of the Court. A collateral civil challenge to a subsisting criminal conviction would ordinarily be struck out as an abuse of process, but the public policy against such a challenge would no longer bar an action in negligence by a client who had succeeded in having his conviction set aside.

Lord Steyn emphasised that it would not be easy to establish negligence against a barrister. The courts will differentiate between errors of judgment and negligence.

Lord Steyn gave the following additional reasons in favour of ending the immunity:

(a) one of the functions of tort law is to set external standards of behaviour for the benefit of the public. Despite generally high standards at the Bar there is always room for improvement. The

exposure of isolated acts of incompetence would strengthen rather than weaken the legal system; and

(b) most importantly, public confidence in the legal system is not enhanced by the existence of the immunity. In a more commercialised system of legal practice and more consumerist society with greater awareness of rights, people expect to have redress if they suffer a wrong as a result of negligent provision of professional services.

Lord Millett acknowledged that the case for its abolition was stronger in the context of civil litigation. However, he pointed to the difficulty in justifying its retention in criminal cases. First, there are a wide variety of cases before magistrates and in tribunal disciplinary proceedings which may be classed as both civil and criminal or quasi-criminal in character. Further, if a party would have a remedy where the incompetence of his counsel deprived him of compensation for breach of contract or unfair dismissal, but not where that incompetence led to his imprisonment for a crime he did not commit (and the consequent and uncompensated loss of his job), the public would at best regard such a result as incomprehensible and at worst greet it with derision.

A further reason which convinced several of the judges that the immunity should no longer be retained - at least in civil proceedings - arose from the difficulty in drawing a distinction between that part of the work of an advocate which attracted the immunity and that part of his or her work which did not. This was an issue that fell to be considered by the High Court in *Boland & Webster v Yates Property Corporation Pty Limited* (1999) 74 ALJR 209. In that case, the majority upheld the maintenance of the immunity provided the claim related to a matter which was "*intimately connected with the work ultimately done at Court*". Kirby J delivered a dissenting judgment which was quoted and approved by Lord Hutton in this case. It remains to be seen whether a future High Court may be persuaded by the reasoning of the House of Lords in this case. However, as the law currently stands (by reason of this decision) the position in Australia is now different to that in England, where the immunity has been abolished in civil proceedings.

Whilst the decision has formally abolished the immunity of advocates from suits in negligence only in the context of civil proceedings it seems only a matter of time before what remains of the immunity will be abolished altogether - both in the UK and, based on the High Court's recent pronouncements in *Boland v Yates Property Corporation Pty Ltd*, in Australia as well.

Causation requires more than an increase in risk

Case name:

Seltsam Pty Limited v McGuinness

Citation:

(2000) 49 NSWLR 262
Supreme Court of New South Wales Court of Appeal per Spigelman CJ, Stein JA and Davies AJA

Date of judgment:

7 March 2000

Issues:

- causation
- use of epidemiological evidence

The facts

Mr McGuinness worked from 1950 to 1991 in factories in which he was exposed to crocidolite (blue asbestos) and chrysotile (white asbestos).

In 1997, Mr McGuinness was diagnosed as suffering from renal cell carcinoma of the left kidney (***RCC***). The issue both at trial and on appeal was whether Mr McGuinness' exposure to asbestos at the appellants' factories caused his RCC.

In the hearing at first instance before the Dust Diseases Tribunal, Maguire J found in favour of McGuinness on the basis of the epidemiological evidence which was put before the Tribunal.

Medical and epidemiological evidence

Although asbestos is acknowledged as a causal agent of mesothelioma, asbestosis and lung cancer, there appeared from the evidence before the Court that there was no scientific consensus that asbestos was causally linked to other cancers, such as RCC. The cause of most cases of RCC is unknown. A biopsy of Mr McGuinness' kidney did not disclose the presence of asbestos fibre in the kidney, although the sample taken was only small.

Epidemiology is the study of the distribution and determinants of disease in human populations. In the absence of conclusive medical evidence, both the Tribunal and the Court reviewed epidemiological studies on the links between asbestos and RCC.

Most of the epidemiological studies presented before the Tribunal had found no association between asbestos and RCC. However, a small number of studies, including the Mandel study on which the Tribunal placed particular reliance, had concluded that it was possible that exposure to asbestos increased the risk of RCC, although further research needed to be done before a causal association could be established.

Evaluation of epidemiological evidence by a court

In evaluating the epidemiological evidence before the Tribunal at first instance, the majority of the appellate judges considered that Maguire J treated the evaluation as a contest between the evidence of Dr McCredie (who was of the opinion that the epidemiological studies showed that asbestos exposure materially contributed to Mr McGuinness' RCC) and Prof McLaughlin (who thought that the epidemiological studies showed that a causal relationship between asbestos and RCC did not exist). Maguire J took the view that, as a judge and not an epidemiologist, he had to choose between the views of Dr McCredie and Prof McLaughlin and that it was not open to him to form his own view on conclusiveness or otherwise of the epidemiological evidence.

On appeal, the Court held that Maguire J had erred in taking this approach. Spigelman CJ and Davies AJA (Stein JA dissenting) held that a court is bound to look at the studies on which the expert opinions were based and that Maguire J therefore ought to have considered the strength and quality all of the epidemiological evidence, rather than just the opinions of Dr McCredie and Prof McLaughlin. In particular, he ought not to have excluded the possibility of a finding that the epidemiological studies were inconclusive.

Causation

The Court then turned to the issue of causation. Legal causation may be established if both of the "general" and the "specific" causation questions are answered in the affirmative, namely:

- whether the agent (in this case asbestos) is capable of causing the disease (general); and
- whether the agent caused the disease in the specific case.

Causation will not be established where the evidence presented establishes only a possibility of a nexus between the agent and the disease. This includes any evidence which shows an "increase in risk". However, such evidence may still be admissible. This evidence will then be weighed in the balance with any other evidence available to determine whether causation has been established. Where the whole of the evidence taken cumulatively does not rise above the level of possibility, causation will not be established.

On the basis of these principles, the Court (by majority) upheld the appeal, finding that few of the epidemiological studies before the Court supported an increased risk of RCC in persons exposed to asbestos and that even those studies showed a very low increase in risk. Balanced against the studies showing no relationship between asbestos and RCC and in the absence of other compelling evidence, the Court found that causation was not established in Mr McGuinness' case.

Stein J delivered a dissenting judgment. He considered that it was open for the trial judge to find as he did on the evidence. He also considered that the trial judge had turned his mind to the strength and quality of the epidemiological evidence, and he was not bound to consider every aspect of it.

This case is a useful authority on the use of expert evidence to establish a causal link between negligent acts/omissions (in this case exposure to asbestosis) and injury (in this case kidney cancer). Wherever experts rely on external studies or data, the Court must take care to consider the strength and quality of those studies/data in considering whether, on the balance or probabilities, causation is established.

Privilege and purpose: defining the parameters of the doctrine

Case name:

Esso Australia Resources Limited v The Commissioner of Taxation

Citation:

(1999) 168 ALR 123

Date of judgment:

December 1999

Issues:

- ♦ client legal privilege
- ♦ dominant purpose test
- ♦ implications for insurers

This appeal gave the High Court opportunity to reconsider its decision in Grant v Downs, and to clarify the position relating to the test for privilege at common law.

Esso commenced proceedings in 1996 in the Federal Court of Australia, appealing against assessments of income tax. After general orders for discovery were made, disagreement arose concerning which documents attracted legal professional privilege. The evidence showed that many of the documents were brought into existence for the dominant purpose of providing legal advice.

The issue that came before the High Court for determination was whether a *sole* purpose test, or a *dominant* purpose test should apply in relation to assertions of privilege in the production of discovered documents. The Court was invited to reconsider the well known decision of *Grant v Downs* (1976) 135 CLR 674.

The High Court by majority (McHugh and Kirby JJ dissenting) upheld the appeal. The Court noted that in *Grant v Downs* the dominant purpose test had not been considered as a possible test and therefore had never been expressly rejected. The Court considered that the *dominant* purpose test should now be regarded as being the appropriate test for privilege at common law throughout Australia.

The Court gave the following reasons for favouring the dominant purpose test:

- ♦ the sole purpose test is unduly restrictive; it means that documents which are meant to be confidential may fail to attract privilege merely because, although produced primarily for a privileged purpose they are also used for some incidental purpose such as reporting to management;
- ♦ while the *sole* purpose test might appear to be *'a bright-line test, easily understood and capable of ready application'*, in practice it has not been so easy to apply;
- ♦ the *dominant* purpose test '*strikes a just balance'* between the competing rights of the client entitled to privileged communications with legal counsel, and broader rights associated with the disclosure of information in the interests of justice;
- ♦ the overruling of *Grant v Downs* and the resulting imposition of a *dominant* purpose test would bring Australia into conformity with other common law jurisdictions including New Zealand, England and Canada.

This widening of the test for privilege at common law is a step that will generally assist insurers. It will reduce the exposure of insurers to the disclosure of documents such as accident reports, internal reports, loss assessors' reports or other documents created in investigating a claim made so long as they were produced for the *dominant* purpose of use in litigation or obtaining legal advice. However, insurers should be mindful that in practice the dominant purpose test can be difficult to apply. The High Court left open the question whether only documents which would not have been produced at all but for the purpose of legal advice or use in pending or anticipated litigation can satisfy the dominant purpose test. The test is probably not so restrictive, but each case will turn on its facts. In ascertaining purpose, the intention of the maker of the document is not necessarily determinative. Factors which the courts take into account include:

- **whether the document was produced as part of an established policy/procedure;**
- **if so, the purpose underlying that policy or procedure;**
- **the job descriptions of the author and recipient of the relevant document; and**
- **in the case of documents produced by internal legal advisers, the competency of those advisors and the degree to which they are able to function independently of management.**

Legislation overrides Astley

The purpose of the Tortfeasors and Contributory Negligence Amendment Act (Tas) 2000 (No 39 of 2000) (the ***Act***) is to amend the Tortfeasors and Contributory Negligence Act (Tas) 1954 (now called the *Wrongs Act*) so that the provisions of the act relating to the apportionment of liability in cases of contributory negligence apply to actions for damages arising from a breach of a contractual duty of care. Section 4 of the Act provides for the apportionment of liability in cases of contributory negligence where a person suffers damages as a result of negligence or breach of statutory duty. Although this legislation applies to Tasmania only, the various other state and territory Attorneys' General have agreed to adopt it as the model legislation.

In 1999, the High Court decision in *Astley v Austrust Ltd* [1999] HCA 6 (reported in our 1999 Annual Review) held that where there was a concurrent liability in contract and law, the provisions of section 4 (in the identical South Australian apportionment legislation) did not operate to reduce the plaintiff's damages for breach of contract even though it did reduce the damages in tort for the plaintiff's contributory negligence.

Until the decision in *Astley v Austrust*, the apportionment provisions of the Act were held to apply in both contract and negligence. However, following that decision and until the enactment of the Act there was considerable confusion surrounding the operation of the principles of apportionment and contribution. As a result of the *Astley* decision, whilst the plaintiff may have contributed to his or her loss, there could be no reduction in damages if the action for damages was also pleaded as breach of contract. This would have had a significant impact on quantum in those cases where a plaintiff sued in negligence and breach of contract, as there would be no reduction in damages awarded for contributory negligence, however negligent the plaintiff may have been. The commercial effect of increased damages as a result of this decision would ultimately have been reflected in increased insurance premiums in business, commercial and professional insurance categories.

The Standing Committee of Attorneys-General therefore agreed that the apportionment legislation in the various jurisdictions was to be amended to apply the contributory negligence provisions to actions for a breach of contractual duty of care.

The Act provides that the changes to the law will apply retrospectively in all causes of action with the exception of:

- a cause of action in respect of which a court has given judgment; and
- a cause of action in respect of which the parties have entered into an agreement to settle claims arising from that cause of action, including an agreement as to liability only.

The exceptions do not extend to a cause of action in respect of which, at the time at which the Act comes into effect, there has been a trial, judgment has been reserved and judgment has not yet been delivered.

In summary, the Act returns the law to what it was previously thought to be. The effect of the Act will be to enable damages to be reduced by the amount of the plaintiff's contributory negligence irrespective of whether a cause of action is pleaded in contract or negligence.

Summary: Draft Goods and Services Tax Ruling GSTR 2000/D23: GST consequences of court orders and out of court settlements

The draft ruling states that the act of settling a dispute (either out of court or as a consequence of a court order) will not itself constitute a taxable supply. Rather, whether or not there is a GST impact depends on the underlying supply or claim (i.e. the earlier supply of goods or services or the claim for loss due to a wrongful act). Settling a dispute is merely an inherent part of the legal machinery to add finality to a dispute which does not give rise to additional payment in its own right. This draft ruling is relevant to insurers as any GST imposed on policy holders under a settlement may affect the amount claimed under a policy.

Although the Draft Ruling specifically states that it does not deal with the settlement of insurance claims, it is still relevant to insurers as the GST resulting from policy holders' out of court settlements or from court orders may affect the amount claimed under the policy.

According to the draft ruling, the act of settling a dispute does not itself constitute a taxable supply. However, the settlement will give rise to a taxable supply (and therefore a GST liability) if the settlement can be linked to an underlying supply which would be considered a taxable supply under normal principles. The two categories of underlying supplies to which settlements which can be linked are "earlier supplies" and "current supplies".

An example of an earlier supply is where the settlement is in favour of a plaintiff who earlier supplied the defendant an order of widgets. In this case, the settlement would be viewed as consideration for the supply of widgets and would include GST (if all the other tests for GST are satisfied, such as the supplier being GST registered for example).

An example of a current supply is where the settlement is in favour of a plaintiff who sued the defendant for using its trading name without consent. Where the parties settle out of court and agree that the defendant may use the trade name in the future for a fee, then that fee is in respect of a current supply (the right to use the name) and is subject to GST as long as the other requirements (such as the plaintiff being GST registered) are satisfied.

A settlement or court order for damages (such as negligence causing loss of profits or personal injury) will not, by itself, give rise to a GST liability. This is because the subject of the claim itself does not constitute a "supply" under the GST Act.

The draft ruling also permits apportionment of settlements and court orders where the settlement is in respect of more than one supply. Under the draft ruling, if the settlement is expressly itemised as to what portion applies for each supply, then that dissection will govern the GST apportionment. Where no express dissection is done, then the parties will need to apportion the settlement on a reasonable and objective basis.

Finally, the draft ruling deals with transitional issues, where the underlying supply was made prior to the introduction of GST (1 July 2000) but settlement was completed after 1 July 2000. In such cases, as long as there is a sufficient nexus between the settlement and the pre-1 July 2000 supply, then there will be no GST consequences, as the earlier supply was not a taxable supply.

Insurers should take note of these principles when its policy holders enter settlements or are subject to a court order. The question whether or not the policyholder is liable for GST may impact on the amount claimed under the policy.

Allen Allen & Hemsley

APRA proposed reforms to the prudential supervisory requirements for general insurers

The Policy Discussion Paper

The Australian Prudential Regulation Authority (***APRA***) released a Policy Discussion Paper in April 2000 in which it outlined its proposed reforms to the prudential supervisory requirements for general insurers.[1] (the ***Paper***).

The Paper is part of APRA's broad approach to policy reform which includes the harmonisation of prudential standards for Authorised Deposit-taking Institutions, the development of a comprehensive framework for the prudential supervision of conglomerates and the development of policies to address emerging developments in the financial system, including the trend towards *e-commerce*.

The Paper follows on from discussion papers issued by APRA in September 1999 and sets out APRA's vision for the structure of the proposed new supervisory regime. The proposals contained in the Paper have received support from the Federal Government.[2]

The proposals

The proposals are intended to modernise the prudential supervisory regime for companies authorised to conduct general insurance business in Australia. The objectives are to further enhance the protection afforded to general insurance policy holders; to promote a more risk responsive solvency and capital regime; to enhance transparency in the general insurance industry; and to move towards APRA's stated aim of harmonising prudential supervisory requirements for different types of financial industries.

New regulatory framework: remodelled Insurance Act 1973

The proposed new regulatory framework will involve a three tier hierarchy with the remodelled Insurance Act 1973 (the ***Act***) at the top of the structure with the stated objective of the Act being to protect policy holders. The primary responsibility for this will rest with the board of directors and chief executive officer of the insurer.

The Act will set out high level prudential supervisory principles including that an insurer authorised under the Act must:

- meet a Capital Adequacy Standard at all times;
- make provision in its accounts for liabilities in accordance with a Liability Valuation Standard;
- have reinsurance arrangements in place at all times in accordance with a Reinsurance Arrangements Standard; and
- comply with any other Prudential Standards set by APRA from time to time under the Act.

The proposals, if adopted, would require amendments to the Act.

New regulatory framework: Prudential Standards

The second layer in the proposed regulatory hierarchy will consist of a series of Prudential Standards issued from time to time by APRA. The Prudential Standards will reflect and embellish the high level principles set out in the Act. They will be issued following consultative processes with the insurance industry. It is presently contemplated by APRA that the consultative process will be mandated in the revised Act.

New regulatory framework: Guidance Notes

The third and final layer of the proposed hierarchy will consist of a set of Guidance Notes for each Prudential Standard. The notes will be issued by APRA and will set out the details of how APRA expects the Prudential Standards to be interpreted.

Draft prudential standards

APRA currently proposes to make Prudential Standards in respect of:

- Capital Adequacy;
- Liability Valuation;
- Qualitative Requirements for Reinsurance Arrangements; and
- Operational Risk.

Draft Standards were released by APRA for industry comment progressively during the course of 2000. The Standards are proposed to be finalised by July 2001 with a start up date of July 2002. A transition period is to be provided, and in the case of regulatory capital, insurers will have up to five years from the commencement of the new requirements to comply.

Following reform to the Act it is anticipated that APRA will implement the four Prudential Standards.

The ***Capital Adequacy Standard*** will replace the current *blunt* solvency test under the Act and is stated to be a more risk responsive regime which better aligns capital requirements with each insurer's individual risk profile. The minimum level of capitalisation for general insurers will be increased from $2 million to $5 million. The stated intention behind the increase is to ensure all insurers have sufficient resources to put in place appropriate systems to control levels of risk.

The ***Liability Valuation Standard*** is designed to improve the consistency of valuation of insurance liabilities across insurance companies. The Standard is intended to improve the ability of the market to adequately assess the risk adjusted strength and ranking of each insurer. It will also require most general insurers to consult with an actuary in determining the value of their provisions for insurance liabilities. This is intended to improve the objectivity and reliability of provisioning.

The ***Reinsurance Arrangements Standard*** is intended to make general insurers more accountable for their own reinsurance arrangements. It will require insurers to have in place a reinsurance management strategy tailored to the size, complexity and mix of their business.

The ***Risk Management Standard*** will contain new measures to improve the internal governance of general insurance companies and to encourage best practice.

In addition, a draft stand-alone Guidance Note setting out proposed minimum requirements for obtaining an authority under Section 23 of the Act has been issued. APRA has proposed that the following conditions will apply to an insurance authority:

- the insurer must comply with prudential requirements;
- the insurer must consult APRA on prudential matters; and
- the insurer must provide any information necessary to APRA.

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[1] APRA Policy Discussion Paper dated April 2000 entitled *Proposed Reforms to the Prudential Supervision of General Insurance Companies in Australia.*

[2] Minister for Financial Services and Regulation – Press Release No FSR 1071 – dated 2 November 2000.

CLERP 6 overview

1. Draft Financial Services Reform Bill

Perhaps the most significant legislative development for the insurance industry this year has been the unveiling by the Government of the Draft Financial Services Reform Bill. Known colloquially as CLERP 6 the draft legislation proposes nothing less than an overhaul of the way in which financial products including most types of life and general insurance are regulated and sold in Australia.

The proposals have been subject to extensive industry review and comment. The progress of the draft legislation towards introduction has been stalled partly because of the sheer scope of the proposals and also because of the present uncertainty surrounding the Commonwealth's ability to validly legislate in the field of Corporations Law. The legislation is intended to form part of the Corporations Law. Because of the constitutional uncertainties, the proposed start date of the legislation has been pushed back progressively and in a written statement from Joe Hockey the Minister for Financial Services & Regulation dated 29 November 2000 the Government has put CLERP 6 on hold indefinitely. The Minister stated that further work on the bill cannot be undertaken until there is a clear way forward to resolve the problems with the Corporations Law.

Nevertheless, there is an inevitability that CLERP 6 will proceed in one form or another at some stage in the not too distant future.

For full details on CLERP 6 and how it affects the insurance industry please visit our dedicated CLERP 6 website at www.allens.com.au/clerp6

Below is a broad summary of the proposed new regime as contained in the draft bill which was released by the Government for public comment in March 2000.

2. Uniform regulation of comparable products

Definition of financial product

This definition is central to the CLERP 6 legislation which aims to establish an integrated regulatory framework for financial products which will provide consistent regulation of functionally similar markets and products.

Generally speaking, if a person performs a defined function in relation to a financial product, they will be required to comply with the relevant parts of the new Chapter 7 of the Corporations Law – Financial Services and Markets - unless they are specifically excluded.

Accordingly, if they fall within this definition, they will then need to comply with the licensing, disclosure and general conduct requirements contained in Part 7.

The definition of a financial product is very broad.

What is covered?

1. Products which fall within the catch-all definition contained in section 763A, which is based on 3 perceived functions of financial products:
   - making a financial investment (section 763B);

- managing a financial risk (section 763C); and
- making non-cash payments (section 763D, but this has specific exclusions such as credit cards).

2. Products specifically listed in section 764A, such as:
   - shares and debentures;
   - managed investment scheme products;
   - general and life insurance (with specific exclusions);
   - superannuation interests; and
   - deposit taking facilities made available by a bank or similar financial institution.
3. There are also products which might fall within definitions but which are specifically excluded by section 765A, such as:
   - various types of insurance – including health insurance, marine insurance and insurance provided by the Commonwealth, a State or the Northern Territory;
   - interests in unregistered managed investment schemes; and
   - contracts for future services.

3. Single licensing regime for financial intermediaries

A single licensing regime will apply to all persons carrying on a financial services business, replacing the existing multiplicity of licences for securities dealers, investment advisers, futures advisers and brokers, general and life insurance brokers and foreign exchange dealers.

It is important to note that for insurers the licensing requirements will be in addition to, and will not replace, the APRA authorisation requirements under the Insurance Act 1973 or the Life Insurance Act 1995.

This approach is designed to ensure that investors are provided with the same consumer protection, irrespective of the source of the financial services.

Generally, those providing financial services will require a licence whether they are dealing with retail or wholesale clients. In any event, the definition of 'retail client' is very broad.

What are financial services

There are 5 defined categories of financial services:

- providing financial product advice;
- dealing in a financial product;
- making a market in a financial product;
- operating a managed investment scheme; and
- providing a custodial or depository service.

Regulation

ASIC will use the financial service providers licence to ensure that licensees are appropriately skilled and have adequate financial resources and compliance systems.

There will be:

- stringent pre-vetting by means of a comprehensive licence application process; and
- imposition of appropriate licence conditions to ensure continuing compliance.

Licensees will have extensive obligations, imposed either through licence conditions or specific legislative provisions, particularly if they deal with retail clients. They cover such areas as dispute resolution, professional indemnity insurance and the training and supervision of authorised representatives. In particular, in relation to training of authorised representatives ASIC updated its Interim Policy Statement 146 – Training of Authorised Representatives - on 4 October 2000. The Interim Policy Statement sets out detailed and stringent requirements which must be met by financial services licensees to ensure the adequate training of their authorised representatives.

Information about licensees will be consolidated and ASIC will maintain a register of licensees, authorised representatives and exempted professional bodies. This will reduce the amount of information currently required to be kept by licensees themselves.

Liability for authorised representatives

The legislation proposes significant changes to the liability of licensees for their representatives, particularly in relation to joint and several liability for those who represent more than one licensee.

Modelled on the regime currently contained in the Insurance (Agents and Brokers) 1984 Act, which is proposed to be repealed with the introduction of the new legislation, with modifications, joint and several liability is imposed where a representative acts for more than one licensee. The Bill covers a number of scenarios which outline how liability will arise in these circumstances.

The legislation specifically states that these responsibilities imposed on a licensee do not affect a representative's liability to his or her client and do not prohibit a representative or licensee indemnifying the other affected licensees for the action of a representative.

4. Uniform product disclosure standards

Applies to financial services providers (FSPs) who provide services to retail clients. They replace current heterogeneous, product-based disclosure requirements.

Financial services guide – to be supplied to all retail clients

- generally at the time of first contact, but before financial services are provided;
- designed to ensure that clients receive sufficient information to make an informed decision whether to acquire the offered financial services from the FSP; and
- information to be covered includes the financial services available, details of the FSP's remuneration, details of any relationship between the FSP and the issuer of the financial products offered and dispute resolution procedures.

Statement of advice – to be supplied when personal investment advice is provided to a retail client

- the FSP must have a reasonable basis for the advice provided, based on detailed client information;

- must be given to the client before any further service arising from the advice is provided, such as selling the client a recommended financial product; and
- general advice may be given, for example where the client has declined to disclose the necessary personal information, provided that it is accompanied by a warning that the advice has been prepared without taking the client's specific requirements into account.

Financial product disclosure – point of sale, and ongoing disclosure and periodic reporting to retail clients

- This is designed to:
  - harmonise disclosure requirements for managed investments, public offer superannuation and the investment component of life insurance products; and
  - promote flexibility with sufficient similarity in disclosure to permit comparison of quite different products.
- This takes the middle ground between the Key Features Statement currently required for superannuation products and the general disclosure approach of the Corporations Law – in other words, a directed disclosure approach, supplemented by known information which might materially influence a retail client's decision to acquire the product.
- There is no time limit on the currency of a Product Disclosure Statement (PDS), but it must be either replaced or supplemented when it becomes false or misleading in a way that is materially adverse from the perspective of a retail client.
- A PDS relating to managed investments, superannuation and investment life insurance products must be lodged with ASIC. It will not be registered but will be subject to a 7 – 14 day exposure period.
- There are ongoing disclosure requirements which relate to material changes and significant events affecting the content of the PDS. These will not apply to managed investment products which will remain subject to s1001A – D of the Corporations Law.
- There are also requirements relating to periodic reporting, transaction confirmations, alternative dispute resolution, advertising and cooling off periods.

5. Implications for the insurance industry

Despite the present uncertainty which surrounds CLERP 6, the fundamental changes to licensing requirements, the vicarious liability provisions, and the detailed product disclosure standards which apply to retail clients and which are included in the draft Bill will change significantly insurers' distribution methods, particularly as regards retail clients.

That will have far reaching consequences for insurers, their agents and for insurance brokers. The Insurance (Agents & Brokers) Act 1984 is to be repealed and the Insurance Contracts Act 1984, the Insurance Act 1973 and the Life Insurance Act 1995 are all proposed to be amended to deal with the changes which are to be made by CLERP 6.

Our dedicated CLERP 6 website at www.allens.com.au/Clerp6 contains further detailed information about how we see the draft legislation impacting on the Australian insurance industry.

Workers Compensation Legislation Amendment Bill 2000

The draft Workers Compensation Legislation Amendment Bill 2000 (the ***Draft Bill***) was tabled in the NSW Legislative Council on 10 October 2000. The Draft Bill proposes amendments to the *Workers Compensation Act* 1987 (the ***1987 Act***) and the Workplace Injury Management and Workers Compensation Act 1998 (the ***1998 Act***). The significant proposed changes are summarised below in the same order as they appear in the Draft Bill.

- **Abolition of the Advisory Council**

  Schedule 1 of the Draft Bill will abolish the Workers Compensation Advisory Council of NSW (the ***Advisory Council***) and redistribute its functions between the WorkCover Authority of NSW (the ***Authority***) and the new Workers Compensation and Workplace Occupational Health and Safety Council of NSW (the ***Council***).

- **The Rating Bureau's Constitution**

  The Rating Bureau (the ***Bureau***) will no longer be exempt from the control and direction of the Minister in relation to the contents of any advice, report or recommendation given to the Minister or the Authority (by removing section 24(3)(b) of the 1998 Act).

- **Removal of Functions of the Rating Bureau**

  It will no longer be a function of the Bureau to provide advice and statistical information on the scheme performance and costings or to provide costing estimates in relation to any proposed changes. The Explanatory Note to this states that this is consequential on the abolition of the Advisory Council and the redistribution of functions between the Authority and the Council.

- **Abolition of the OHS Council**

  The Draft Bill abolishes the Occupational Health and Safety Council of NSW (the ***OHS Council***) and replaces its functions with the Council. The Council will have a wider membership than the OHS Council (including five persons appointed by the Minister as employer representatives from a panel of at least six persons nominated by approved employer organisations).

- **Functions of the Council**

  The Council's functions include advising the Minister on matters relating to occupational health and safety, injury management and workers compensation that are:

  1. referred to it by the Minister;
  2. emerging issues and trends; and
  3. of concern to scheme participants (including employers and employees).

  The Draft Bill inserts new provisions in Schedule 2 of the 1998 Act relating to the membership and procedures of the Council to replace those dealing with the Advisory Council. There are no substantive differences other than the removal of the provisions relating to the disclosure of pecuniary interests.

- **Premium Discount Schemes**

  The Draft Bill introduces a new section 230A in the 1998 Act that will allow the Authority to establish a Premium Discount Scheme to "*encourage employers to improve occupational health and safety and injury management performance so as to minimise the financial and social costs of*

workplace injury." The Authority is given wide scope to determine the conditions and requirements of the scheme, which may provide for the awarding of discounts on workers compensation insurance premiums to employers who participate in the scheme. The scheme may also authorise different accredited persons to award different levels of premium discounts, depending on such factors as the Authority determines. If the Authority so directs, the calculation of risk premiums is to include provision to give effect to any premium discount awarded to an employer under a Premium Discount Scheme.

♦ **Injury Management Pilot Projects**

The Draft Bill introduces a new Schedule 5A in the 1998 Act that authorises the Authority to establish pilot projects under which the Authority will appoint an injury manager for the employees in a particular area or in a particular business or industry to act as agent for the employers and their insurers in respect of the following functions:

4. any function arising relating to Workplace injury management in Chapter 3 of the 1998 Act;
5. any function connected with dealing with a claim against which the employer is indemnified under an insurance policy; and
6. any other functions prescribed by the regulations.

♦ **Claims Procedures**

Section 66 of the 1998 Act is amended by the Draft Bill to change the manner in which a claim for compensation is made, distinguishing between an initial claim, and claims that are not initial claims. Briefly, an initial claim must be served on the employer. However, in certain circumstances an initial claim may be served on the insurer. A claim that is not an initial claim may be served on either the employer or the insurer.

The Draft Bill introduces the new section 66 (2A), (2B) that will allow an injured worker (who has made an initial claim for compensation through his or her employer) to make a later claim for further payments in respect of the same injury (eg payment for permanent disability) directly to the employer's insurer.

♦ **Common Law Elections**

Section 151 of the 1987 Act is amended to provide that the commencement of proceedings in the Compensation Court to recover permanent loss compensation under the Act is an election to claim that compensation which prevents the claimant from claiming damages from the employer at common law.

The new provision section 151A (3A) provides that for the purposes of the above, the amendment of a claim before the Compensation Court to include a claim for permanent loss compensation constitutes the commencement of proceedings to recover that compensation.

The new clause 12 of Part 14 of Schedule 6 contains transitional provision to deal with injuries received prior to the commencement of the amendments. Generally, the amendments apply to injuries received before or after the amendments commence. However, the commencement of proceedings to recover permanent loss compensation before the amendments commence is not to constitute an election to claim permanent loss compensation unless the proceedings are pending on the commencement of the amendments and are not withdrawn within 12 months after the introduction of the Bill or result within that 12 month period in an award by the Compensation Court.

- **Contributory Negligence in Contract Actions**

The new section 151N(1A) of the 1987 Act is a response to the High Court's decision in *Astley v Austrust Limited* and extends the contributory negligence provisions of the Law Reform (Miscellaneous Provisions) Act 1965 to an action to recover damages in a work injury case when the action is an action for breach of contract founded on a breach of a contractual duty of care. Those provisions provide that contributory negligence is not a defence in an action and that the damages to be awarded are to be reduced having regard to the claimant's share in the responsibility for the damage.

- **Information Exchange**

The new section 79A in the 1998 Act will require the parties to the conciliation of a dispute about compensation to provide a list of evidence on which they propose to rely when the dispute is referred for conciliation.

Amendments to section 80 will allow a conciliation officer to order a party to provide documents or information to the other party to the dispute and prohibit the admission of evidence before the Compensation Court if a party has failed to produce evidence when required to do so by a conciliation officer.

The new section 81A will require a party to a conciliation to provide the other party with a copy of the documentary evidence which the party proposes to rely on at least seven days prior to hearing.

- **Recovery from Directors of Uninsured Corporations**

New sections 146A, 171A and 156B in the 1998 Act allow the Authority to recover from a director double the insurance premiums evaded where the employer cannot pay and:

1. the employer does not obtain and maintain insurance;
2. the employer has provided false or misleading information used to calculate a premium; or
3. the employer does not pay the correct premiums.

Other amendments to the 1998 Act allow the Authority to estimate the premium, and will allow a Court to order a person to pay the Authority the amount that the Authority would be entitled to recover if the person is convicted of an offence in connection with evading the premium.

- **Certificates of Currency with Respect to Insurance**

The proposed sections 155A of the 1998 Act and 163A of the 1987 Act provide for the issue by insurers of certificates of currency to employers, as evidence that an employer has a policy of insurance in respect of the employer's workers. Certain persons (such as WorkCover inspectors, principals, and authorised union representatives) will be able to demand to see these certificates.

- **Fraud Against the WorkCover Scheme**

The proposed section 169A of the 1998 Act and section 173A of the 1987 Act introduce an offence for giving false information to an insurer to be used for premium calculation.

The proposed section 235A of the 1998 Act introduces a general fraud offence with respect to a person who obtains a financial advantage by deception from the scheme. The offence would not be limited to injured workers.

Proposed section 235B of the 1998 Act provides for the recovery from a fraudulent claimant and others of a fraudulently obtained financial advantage.

- **Increased Penalties**

There are a number of amendments to the 1998 and 1987 Acts that increase the penalties for various offences (such as an employer's failure to take out insurance).

- **Insurer Penalties**

The proposed section 183A of the 1998 Act provides for the imposition of a civil penalty of up to $50,000 or the issue of a letter of censure for a contravention by an insurer of its licence, the Act, the regulations or an insurer agreement under section 9 of the Act.

A similar provision is to be drafted with respect to the 1987 Act.

- **Specialised Insurers and Self-Insurers**

Amendments to sections 177 of the 1987 Act and 175 of the 1998 Act provide that achieving specialised insurer status requires an application for a licence with a specialised insurer endorsement.

The proposed sections 177A of the 1987 Act and 175A of the 1998 Act provide for certain requirements to be satisfied before a specialised insurer endorsement can be granted and provide for the cancellation of the endorsement if those requirements do not continue to be met.

The proposed section 208AA of the 1987 Act provides for the levying of contributions to the Premiums Adjustment Fund against self-insurers and specialised insurers in respect of employers who become self-insurers or become insured by specialised insurers on or after 1 July 1998. The provision provides, as an alternative to the making of a contribution to the Premiums Adjustment Fund, for the self-insurer or specialised insurer to enter into an agreement with the Authority to assume responsibility for outstanding claims against the employer that would otherwise be payable by the managed fund insurer who previously insured the employer.

ASIC Interim Policy 161: registered insurance brokers and their representatives

ASIC's Interim Policy 161 explains the requirements of broker representatives under the Insurance (Agents & Brokers) Act 1984 (the *IABA*). The aim of the Policy is to ease the transition from the IABA to the new CLERP 6 licensing rules. The Policy (taking into account the IABA and the draft of CLERP 6 as at the time of the Policy's issue) specifies what factors ASIC will take into account when deciding whether a representative is required to register as a broker.

Life and general insurance brokers are required to be registered under the IABA and those who act as their representatives (i.e. agents) must also comply with the broker's obligations under the IABA. As long as a representative does not carry on a broking business on its own account but merely as a representative, then the representative will not need to register as a broker. In determining whether a representative is carrying on its own broking business, ASIC will look at the following factors:

(a) The extent of cover for the representative's conduct under the registered broker's professional indemnity policy.

The IABA requires a registered broker to have a current professional indemnity insurance policy. Such policies should specify whether anyone is acting as a representative of the broker. ASIC considers that any direct or indirect exclusion of liability in the policy for a representative's conduct indicates that the person is not a representative of the broker.

(b) Disclosure of the principal's identity

The IABA prohibits a person from claiming to be a registered insurance broker unless that person is registered as such. Accordingly, a representative must clearly indicate to clients that it is providing services on behalf of a registered broker. This can usually be done by disclosing the identity of the broker in any business documentation given to the client.

(c) Handling of clients' funds

Registered brokers are subject to specific requirements under IABA when handling clients' funds. Any representative receiving client funds must have internal procedures to ensure that those funds are immediately deposited in the broker's account. ASIC considers that if the representative is able to retain such funds for a period of time before depositing the funds into the broker's account, then this may indicate that the representative is actually carrying on a broking business on its own account.

(d) Monitoring and Supervising

A broker must monitor and supervise the conduct of its representatives. If the broker allows other persons to provide broking services on its behalf with minimal monitoring and supervision under a franchise or other contract, ASIC considers that this strongly suggests those persons are not the broker's representatives.

(e) Ownership of Client Information

Even though a representative may be providing brokering services to a client, that client remains at all times the broker's client. Accordingly, all client information belongs to the broker, not the representative.

Enforcement of the IABA

ASIC states in the Policy that if it becomes aware that a registered broker has a representative which is conducting insurance broking business on its own account, the *broker's* licence may be revoked or not renewed on the basis that the broker has failed to discharge its obligations when acting through representatives.

As against the offending representative, ASIC states that it may initiate an enforcement action against that representative for breach of the IABA and also of the Trade Practices Act for misleading and deceptive conduct.

Impact of CLERP 6

According to the Policy, the current draft of CLERP 6 (see "CLERP 6 Overview" above) will impose a single licensing regime requiring brokers, as persons dealing in or providing advice on financial products (which are defined to include insurance contracts), to operate under an Australian Finance Services licence. However, like the Policy, CLERP 6 only requires persons principally providing financial services as principals to be licensed. In addition, CLERP 6 has monitoring and supervision requirements similar to those in the Policy. ASIC states in the Policy that by adopting the guidelines in the Policy, brokers and their representatives will have an easier transition into CLERP 6 when that is implemented (assuming it is implemented in the same form as the draft when the Policy was released).

Conclusions

Regardless of when CLERP 6 is implemented, brokers and representatives must comply with the IABA. A bonus of following the guidelines in the Policy is that it may ease the transition from the IABA when CLERP 6 is finally implemented.

ACCC authorises life insurance bar on genetic testing

The Australian Competition and Consumer Commission (***ACCC***) issued a Media Release on 22 November 2000 addressing a significant issue for the life industry.

The ACCC has granted authorisation for 2 years to a proposed agreement by life companies that they will not require applicants for life insurance to undergo genetic testing. ACCC clearance was sought in view of the fact that the proposed agreement could have constituted anti-competitive business arrangements or have breached the Trade Practices Act.

The two year authorisation is intended to provide the life industry and government with a breathing space during which the issues surrounding genetic testing can be properly debated and government policy developed.

The Media Release was issued against a background of vigorous debate between industry and consumer groups in relation to the issue. On 9 August 2000 the government announced that the Australian Law Reform Commission and the National Health and Medical Research Council are to inquire jointly into human genetic information privacy and discrimination issues.

The ACCC has stated that it sees public benefit in avoiding coercion of applicants for life insurance to undergo genetic testing.

The proposed agreement between life insurers provides that they will not require applicants for life insurance to undergo genetic tests. Neither will life insurers induce applicants to undergo such testing by offering discounts off standard premium rates based on favourable test results.

However, the issue of requiring applicants for life insurance to disclose results of any genetic testing already undertaken is contentious. The ACCC was not invited to authorise the conduct of that practice, which life insurers contend is a requirement of the law under the Insurance Contracts Act 1984.

Clearly this is just one of the many complex issues which impact on life insurance and which the proposed government inquiry into human genetic information privacy and discrimination issues will hopefully address. A further issue will include the question of whether or not life industry self regulation in respect of genetic testing and the practice surrounding it is appropriate.

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