2022

KWM INSURANCE POCKETBOOK

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Artwork by Lin Zhao

FOREWORD

Welcome to the second edition of the *Insurance Pocketbook.*

To be frank – the time between now and when we published the inaugural addition has been a bit of a blur (especially for readers in Sydney and Melbourne). 2021 was a difficult year to be an insurer (not least because of a wave of new law which came into effect) and a challenging year to be a policyholder, but was also a year marked by significant insurance-related disputes in court and high-profile transactions involving life insurance companies.

Inside this second edition of the *Insurance Pocketbook* you will find editorials from our team, short papers on legislative reform and industry trends, and consumable summaries of significant cases. This year, we have profiled some significant decisions from the past 12 months, but also brought back into focus some classic Australian insurance cases.

The inspiration behind the *Insurance Pocketbook* is that we wanted to find a better way of sharing our insight and experience with our clients, and industry stakeholders. The insurance team at King & Wood Mallesons has broad experience and deep market insight. We understand the current drivers in the sector. Our experience acting for both policyholders, and insurers, has allowed our team to develop an in-depth knowledge of the industry and understand key risks associated with in the financial services sector.

If anything in this publication captures your interest – please feel free to contact a member of our team to discuss it further. We are only a (virtual) call away.

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CAUGHT BETWEEN A ROCK AND A HARD PLACE: OPTIONS FOR INSUREDS IN THE HARDENED D&O MARKET IN AUSTRALIA

In recent years, the D&O insurance market has undoubtedly hardened for insureds. Indeed, the market was described in early 2021 as *"the most volatile and restrictive…in the history of the segment"*.[1]

In this hardened market, not only has the scope of available cover narrowed, but retentions and premiums have significantly increased. By way of example, Marsh reported that as at Q3 2021, there had been 21 consecutive quarters of double-digit increases to financial and professional lines premiums. [2]

At the same time, the D&O market in Australia has grown dramatically and the premium pool is currently estimated to be well over $800 million and possibly as high as $1 billion,[3] compared to $250 million in 2017.[4]

While the steep increases in premiums that have been observed in recent years have somewhat moderated, with a downward trend being observed in recent quarters, that downward trend is still resulting in double-digit premium increases each quarter, which continues to place increased pressure on insureds (especially those who take out Side C cover). Even though it is half the 51% increase experienced in Q4 2020,[5] a 25% premium increase in Q3 2021 is hardly a cause for celebration.

As a result, companies have been actively considering alternative solutions for managing their risk and reducing the cost of D&O cover, especially in respect of Side C cover.

[1] Marsh, "Under Pressure – D&O insurance in a hard market", (September 2020), p. 2. Available at https://www.marsh.com/nz/services/financial-professional-liability/insights/do-under-pressure.html

[2] Marsh, "Global Insurance Markets: Pricing increases 15% in third quarter" (October 2021), p. 15. Available at https://www.marsh.com/uk/services/international-placement-services/insights/pacific-gimi-q3-2021.html

[3] Aon Insights, "Directors' & Officers' Insurance Market Insights Q3 2021", (2021), p. 1. Available at https://aoninsights.com.au/wp-content/uploads/Directors-and-Officers-Q3-Market-Update-Final-1.pdf

[4] Aon, "Insurance Market Update Directors & Officers", (2017), p. 1. Available at https://www.aon.com.au/australia/insights/insurance-market-updates/2017/files/directors-and-officers-insurance-market-updates-brochure.pdf

[5] Marsh, "Global Insurance Markets: Pricing increases 15% in third quarter", (October 2021). Available at https://www.marsh.com/uk/services/international-placement-services/insights/pacific-gimi-q3-2021.html

OBSERVATIONS IN THE HARDENED MARKET

While the market has recently shown signs of stabilisation, we have nonetheless observed in the past several years that:

1. **Premiums have continued to significantly increase.** Premium increases of 200% - 600% were experienced in 2020.[6] As a dollar amount, in June 2020, Marsh reported that premiums for $100 million - $200 million of cover had risen from $500,000 - $800,000 in previous years to now $5 million - $10 million (or more).[7] Marsh has recently suggested that the sustained increases in premiums is starting to level out after 21 consecutive quarters of double-digit increases in financial and professional lines premiums in the Pacific region as a result of more competition in the excess layers.[8] This observation was made after the increases in the first three quarters of 2021 were 48%, 37% and 25%, respectively, having been immediately preceded by an increase of 51% in Q4 2020. Despite this, the costs remain very high and, in our experience, premiums are undeniably front of mind for companies considering taking out, or renewing, D&O policies. Although future increases may not be as steep as in recent years, they are not likely to reduce significantly in the short-term.

2. **Retentions are also on the rise.** In recent years insurers have required a minimum retention for Side C Cover of between $10 million and $50 million where the relevant company is an ASX-listed entity, with extreme examples reaching up to around $225 million.[9]

3. **Insureds are reducing the limits of their cover.** Aon reported that, in 2020, limits of liability across its portfolio reduced by an average of around 30%.[10]

4. **Increased scope of exclusions (beyond the well-publicised "Royal Commission exclusions") as well as reduced heads of loss covered.**[11] We are also aware of insurers flagging further reductions to the scope of cover, in particular, exclusions in respect of cyber and insolvent trading.

5. **Fewer insurers are providing D&O cover,** with a resulting reduction in competition. While new entrants and capacity have emerged, Aon has reported that there continue to be capacity challenges.[12]

[6] Willis Towers Watson, "Directors' & Officers' Market Update", (April 2021), p. 2. Available at https://www.willistowerswatson.com/-/media/WTW/Insights/2020/09/wtw-au-d-and-o-market-update-april-2021.pdf?modified=20210414105746

[7] Marsh Pty Ltd, Public Submission to the Parliamentary Joint Committee on Corporations and Financial Services, "Litigation Funding and the Regulation of the Class Action Industry", (11 June 2020), p. 2. Available at https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Litigationfunding/Submissions

[8] Marsh, "Pacific Pricing: Rate of Increase Slows for Third Consecutive Quarter", (2021). Available at https://www.marsh.com/uk/services/international-placement-services/insights/pacific-gimi-q3-2021.html

[9] Marsh Pty Ltd, Public Submission to the Parliamentary Joint Committee on Corporations and Financial Services, "Litigation Funding and the Regulation of the Class Action Industry", (11 June 2020), p. 3. Available at https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Litigationfunding/Submissions

[10] Aon Insights, "Directors' & Officers' Insurance Market Insights Q1 2021", (2021), p. 4. Available at https://aoninsights.com.au/wp-content/uploads/Directors-Officers-Insurance-Market-Insights-Q1-2021-Final-1.pdf

[11] Ibid p. 3.

[12] Aon, "Aon Global Market Insights Q3 2021", (2021), p. 35. Available at https://assets.foleon.com/eu-west-2/uploads-7e3kk3/48136/aon_q3_global_market_insights_report.54905ff06a2f.pdf

NAVIGATING THE HARDENED MARKET

The prevailing market conditions (in particular, the significant premiums), coupled with the perception that holding Side C cover makes a company a target for securities claims,[13] has led many companies to question whether there is value or benefit in obtaining Side C cover and, if it is obtained, what limit and scope of cover is appropriate and necessary for them.

The other difficulty that Side C cover presents is that D&O policies are often structured with an aggregate limit of liability. The risk this poses for policyholders is that a significant securities claim could erode the entire limit and leave directors and officers, as well as any other insured persons under the policy, uninsured or with reduced amounts of cover.

There are a range of options open to companies pondering the utility of Side C cover and the nature and extent of cover required. While one option is to simply "sit tight" and hope the market does indeed stabilise in the next year or two, companies seeking alternative solutions from a cost and/or risk perspective in the short-term may wish to consider one or more of the following options:

1. **Not taking out any Side C Cover:** There has been an increase in companies choosing not to take out any Side C Cover and instead bear this risk on their balance sheet. Aon recently observed that, based on its ASX100 client portfolio, approximately 25% of clients no longer (or never did) purchase Side C cover.[14] In determining whether to take out Side C cover, a company and its directors need to balance the benefits which may be provided by this cover and the premium payable, with the company's need for such cover. In our experience, however, the removal of Side C cover does not necessarily equate to an equivalent reduction in the premium payable for the policy. Further, once removed, it can be difficult for companies to re-obtain Side C cover in the future.

2. **Setting up an overseas captive:**[15] We have observed that corporate groups are increasingly choosing to utilise captives as a means to effectively self-insure against certain risks as an alternative to engaging with commercial insurers. This cover can be utilised as a primary layer of cover, in particular, as "fill in cover" if your existing Side C cover has a high retention. Unlike traditional self-insurance, a captive insurance arrangement does not necessarily require a company to set aside capital up-front.

[13] Aon Insights, "Directors' & Officers' Insurance Market Insights Q1 2021", (2021), p. 2. Available at https://aoninsights.com.au/wp-content/uploads/Directors-Officers-Insurance-Market-Insights-Q1-2021-Final-1.pdf

[14] Aon Insights, "Directors' & Officers' Insurance Market Insights Q3 2021", (2021), p. 4. Available at https://aoninsights.com.au/wp-content/uploads/Directors-and-Officers-Q3-Market-Update-Final-1.pdf

[15] King & Wood Mallesons, "Insurance Insights – Are Captives Right For You?", (30 March 2021). Available at https://www.kwm.com/en/au/knowledge/insights/insurance-insights-are-captives-right-for-you-20210330

While captives are on the rise across hardened insurance markets (especially D&O and professional indemnity), they can only be used in a limited context in respect of D&O insurance due to the prohibition on companies and related bodies corporate from indemnifying their directors and officers. Side C Cover is not, however, caught by this prohibition.

While captive arrangements can impose additional regulatory and administrative requirements on a company, the benefits of such an arrangement can include greater financial flexibility and increased liquidity, direct access to the reinsurance market, and improved and customised coverage terms. Captive insurance arrangements are typically structured in one of two ways:

- by establishing a captive insurer which is wholly-owned (either directly or indirectly) by its insured corporate group; or
- by participating in a sponsored (or "rental") captive arrangement which is already established and is conducted through a third-party captive insurer.

3. **Negotiating a higher excess or retention:** If the primary concern is having cover for only the most significant claims you might face, it may be worth considering negotiating a higher excess in exchange for a reduced premium (whether or not also combined with a captive arrangement). Marsh has observed companies signing up for excess payments of between $100 million and $200 million per claim.[16] This may not, however, have an equivalent or otherwise significant impact on premium. According to Aon, insurers have reportedly been unwilling to reduce premiums even where companies sought to increase their deductible to amounts as high as $50 million.[17]

4. **Order of payment clauses:** If included in a policy, these clauses provide payment first to insured persons before the company and are a helpful means to mitigate the risk that a significant securities claim could erode the aggregate limit of liability under the D&O policy in its entirety.

5. **Otherwise structuring your D&O programme so that dedicated cover is available only to insured persons:** Using side A Difference-in-Conditions (DIC) /Difference-in-Limits (DIL) policies is a commonly seen approach.

6. **Considering and negotiating limits and insuring clauses:** As an additional option, companies can consider whether to reduce policy limits or sub-limits, or reduce the number of insuring clauses.

We continue to observe the market closely and actively discuss these options with our clients. It will be interesting to see whether the market does indeed stabilise and the extent to which changes to the corporate landscape (in particular, the recent amendments to Australia's continuous disclosure laws) might also have an impact on premiums.

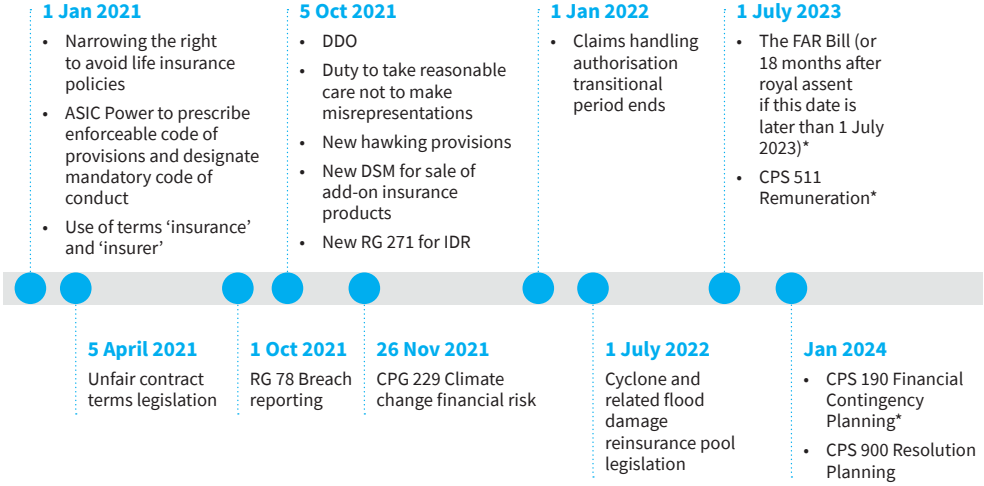
[16] Roddan, Michael, and Walsh, Liam, "Directors' liability insurance rises 200pc", (25 June 2021). Available at https://www.afr.com/companies/financial-services/directors-liability-insurance-rises-200pc-20210625-p584c2

[17] Aon Insights, "Directors' & Officers' Insurance Market Insights Q1 2021", (2021), p. 3. Available at https://aoninsights.com.au/wp-content/uploads/Directors-Officers-Insurance-Market-Insights-Q1-2021-Final-1.pdf

NO REST IN SIGHT FOR REGULATORY REFORMS IN THE INSURANCE INDUSTRY

2021 saw the implementation of a number of regulatory reforms. It was a busy year for the industry with system and process reviews in readiness for compliance with the new regulatory requirements. These changes impacted all stages of an insurance product's life, from its design and distribution to claims handling and complaints handling.

2021 Overview



* The effective date applicable to the insurance industry. Note that a different effective date may apply to banking and superannuation industries.

Extension of unfair contract terms regime to insurance contracts

The amendments to the Australian Securities and *Investments Commission Act 2001 (Cth)* (**ASIC Act**) and the *Insurance Contracts Act 1984 (Cth)* (**ICA**) to apply the unfair contract terms regime to insurance contracts generally started applying to insurance contracts entered into on and after 5 April 2021.

ASIC has conducted a targeted review of insurance contracts to identify potential unfair terms.[18] Insurers have noted ASIC's expectations in relation to contract reviews and proactively made important changes to insurance policies in light of the new regime. Insurers have either removed, reworded or qualified any identified terms to make it fairer for consumers.[19]

Enforceable code of provisions and mandatory codes of conduct

On 1 January 2021, the *Corporations Act 2001 (Cth)* (**Corporations Act**) and the *National Consumer Credit Protection Act 2009 (Cth)* were amended to give ASIC the power to make certain provisions of industry codes of conduct approved by ASIC (such as the General Insurance Code of Practice) "enforceable code provisions". The amendments also introduced a framework for the establishment of mandatory codes of conduct for the financial services industry (which may include civil penalty provisions). As at March 2022, ASIC has not yet designated any enforceable code provisions or prescribed any mandatory codes of conduct for the insurance industry.[20]

The new General Insurance Code of Practice came into effect on 1 July 2021 and was updated on 5 October 2021 to align with ASIC's Regulatory Guide on internal dispute resolution. Updates included a reduction from 45 to 30 days to resolve a complaint, as well as an updated definition of a complaint. Changes also included a new commitment to improve customer awareness through information on Code subscriber websites about the availability of financial hardship support.

The National Insurance Brokers Association has launched the 2022 Insurance Brokers Code of Practice on 1 March 2022, which will come into effect and replace the current 2014 Insurance Brokers Code of Practice on and from 1 November 2022.[21]

The 2017 Life Insurance Code of Practice is currently in review. The Financial Services Council has suggested that the final Life Insurance Code of Practice will be submitted for registration under ASIC's new enforceable code regime.

Internal dispute resolution

The new Regulatory Guide 271 'Internal dispute resolution' (**RG 271**) began applying to complaints received by financial firms on or after 5 October 2021. Some of the key changes implemented by RG 271 and the legislative instrument accompanying it include a broadened definition of complaint, reduced timeframes for responding to internal dispute resolution (**IDR**) complaints, prescribed content requirements of IDR responses and guidance on the identification and management of systemic issues.

Product design and distribution obligations

The product design and distribution obligations (**DDO**) regime came into force on 5 October 2021. This new regime had significant impact on insurers' retail product design, distribution, operations, IT and governance processes. It includes obligations to:

- assess the target market of a product and design and publish an appropriate target market determination (**TMD**);

- monitor and review consumer outcomes produced by the design and distribution of the product and consider changes required to the product or the TMD;

[18] ASIC, 'Are you ready? Laws on unfair contract terms apply to insurance from 5 April 2021' (News Release, 22 March 2021). Available at https://asic.gov.au/about-asic/news-centre/news-items/are-you-ready-laws-on-unfair-contract-terms-apply-to-insurance-from-5-april-2021

[19] Insurance Council of Australia, 'Insurers ready for regulatory changes' (News Release, 30 September 2021). Available at https://insurancecouncil.com.au/resource/insurers-ready-for-regulatory-changes/

[20] ASIC, *Insurance* (Web Page) <https://asic.gov.au/for-consumers/insurance/>

[21] National Insurance Brokers Association, I*nsurance Brokers Code of Practice* (Web Page) <https://www.niba.com.au/insurance-brokers-code-of-practice/>

- distribute in accordance with the TMD conditions; and

- comply with record keeping and reporting obligations.

Deferred sales model for add-on insurance products

An industry-wide deferred sales model (**DSM**) for the sale of add-on insurance products started to apply to commitments to acquire principal products and services which are entered into on or after 5 October 2021. The DSM imposes a range of restrictions on the offer or sale of "add-on insurance products" (and communications in respect of such products) during certain prescribed periods. The restrictions replace the anti-hawking obligations for add-on insurance products during those periods.

We have found that these changes led not only to wholesale amendments in the sale processes for add on insurance products but in some cases a re-evaluation of the commercial feasibility such a sale model.

Hawking provisions

The previous hawking provisions came into force on and from 5 October 2021. The single general prohibition stipulates that a person must not issue, sell, request or invite the purchase of a financial product if the consumer is a retail client and this is made in the course of, or because of, an unsolicited contact with the consumer. On 23 September 2021, ASIC reissued the Regulatory Guide 38 'The hawking prohibition' to reflect this change and explain how to comply with the consolidated hawking prohibition provisions.

Breach reporting

ASIC Regulatory Guide 78 'Breach reporting' by AFS licensees and credit licensees (and their representatives) commenced on and from 1 October 2021.

Well designed internal information gathering, reporting and record keeping systems are key for compliance with these requirements. In addition, it is important to note that the breach reporting requirements are intertwined with the above mentioned DDO and IDR obligations. Breach reporting procedures should also be designed for reporting of significant dealings that are inconsistent with the TMD and reportable incidents or breaches of IDR procedures.

Climate change and financial risk

On 26 November 2021, APRA released the final CPG 229 Climate Change Financial Risks (**CPG 229**). It is designed to assist banks, insurers and superannuation entities with managing climate-related risks and opportunities within their existing risk management and governance practices. CPG 229 does not create any new regulatory requirements or obligations for institutions but rather, points towards existing prudential guidance.

2022 Onwards

Regulatory activities continue to be a focus in 2022. Below are some key regulatory changes to be considered.

Claims handling as a financial service

Claims handling AFSL exemption is now, officially, history. The financial service licensing regime in relation to claims handling has come into full force on 1 January 2022.

Crisis preparedness and resolution planning

On 2 December 2021, APRA released its Discussion Paper "Strengthening Crisis Preparedness" with two draft prudential standards accompanying it, draft CPS 190 Financial Contingency Planning and draft CPS 900 Resolution Planning.[22] The Financial Contingency Planning standard will require an institution to have a plan in place which is acceptable to APRA detailing how it would respond to a stress that threatens its viability.[23]

[22] Max Allan et al, '*Planning to Resolve a Crisis: APRA Assists Regulated Entities in Strengthening Crisis Preparedness*' (Insight Post, 21 December 2021) <https://www.kwm.com/au/en/insights/latest-thinking/apra-consults-on-strengthening-crisis-preparedness-.html>.

[23] Further detail on this reform can be found at www.kwm.com/au/en/insights/latest-thinking/apra-consults-on-strengthening-crisis-preparedness-.html

The Resolution Planning standard contemplates APRA having a plan for how to resolve the institution if it is not viable. While the plan is APRA's, the institution is obliged to organise its affairs to ensure it is resolvable and assist APRA to prepare the plan.

Financial Accountability Regime

On 28 October 2021, the Federal government introduced and read the Financial Accountability Regime Bill 2021 (**FAR Bill**) to the House of Representatives. The FAR Bill was later referred to the Senate Economics Legislation Committee for inquiry and report. The Senate Economics Legislation Committee published its report on the FAR Bill in February 2022, which reported overall support for the FAR Bill. The regime in the FAR Bill will extend the Banking Executive Accountability Regime to all entities that are regulated by APRA, as well as introducing further obligations for affected entities. Please refer to our separate article in the *Insurance Pocketbook* on this topic.

Reinsurance pool for cyclone and cyclone-related flood insurance policies

On 3 December 2021, the Government released an exposure draft legislation for the establishment of a reinsurance pool for cyclones and related flood damage for privately-owned homes, strata corporations and small business insurance policies. The draft legislation, if passed, is expected to commence from 1 July 2022 and be backed by a $10 billion Government guarantee.

CPS 511 and CPG 511 Remuneration

On 27 August 2021, APRA released the final version of *Prudential Standard CPS 511 Remuneration* (**CPS 511**). It sets out the requirements for regulated entities to design and maintain prudent remuneration arrangements that promote effective risk management, sustainable performance, and long term soundness. It will operate alongside the FAR regime. The final version of the *Prudential Practice Guide CPG 511 Remuneration* was released on 18 October 2021 by APRA to provide principles and examples of better practice to assist entities in meeting their new requirements under CPS 511.

Other regulatory focuses

APRA anticipates finalising the non-operating holding company authorisation guidelines and envisages the following consultation process in 2022:[24]

- stress testing PPG;
- CPS 510 Governance;
- CPS 220 Risk management; and
- CPS 520 Fit and proper.

On 13 December 2021, APRA launched the third round of consultation on reforms to the Life and General Insurance Capital Standards (**LAGIC Standards**) framework and released the updated draft standards which reflect changes in the accounting standard AASB 17 Insurance Contracts for the recognition, measurement, presentation and disclosure of insurance contracts, which has a commencement date of 1 January 2023 (with early adoption permitted).

On the same date, APRA also released the detailed proposals of a new capital framework for private health insurers (**PHI**) which aims to provide more robust standards of financial resilience for the protection of policy holders.

APRA has deferred the finalisation of the revised Prudential Standard LPS 117 Capital Adequacy: Asset Concentration Risk Charge to 2022 with a planned commencement date of 1 July 2023.[25]

It will no doubt be a busy year for insurers and other insurance service providers in responding to these changes.

[24] Renee Roberts, APRA, 'APRA policy priorities: Interim Update' (Letters, 24 September 2021). Available at https://www.apra.gov.au/apra-policy-priorities-interim-update
[25] Ibid.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FAR IS NEAR!

The proposed Financial Accountability Regime (**FAR**) legislation – which will impose obligations on insurers – could be passed as soon as Autumn 2022. In this article, we explore the scope and implications of the draft legislation (as drafted at the time of publication).

Background

FAR is the Federal Government's response to recommendations 3.9, 4.12, 6.6, 6.7 and 6.8 in the Financial Services Royal Commission's Final Report - a proposed extension of the existing Banking Executive Accountability Regime (**BEAR**) to cover all APRA-regulated entities (which includes insurers), as well as the introduction of further obligations for affected entities.

FAR has taken a long and winding path through 2020 and 2021 to reach where it is at today.

After deferrals in issuing the consultation draft legislation on account of the COVID-19 pandemic, the Federal Senate finally referred the FAR Bill 2021 to the Economics Legislation Committee for inquiry and report. The Committee published its report on the FAR Bill in February 2022, indicating its overall support for the Bill. On this basis, it may be passed in the Autumn 2022 sitting of Federal Parliament (subject, of course, to the timing of the federal election).

When and Who?

Subject to a ministerial declaration, FAR will apply to insurers (and the insurers' non-operating holding companies) from 18 months after the legislation has commenced.

An accountable entity must comply with its obligations under FAR and also ensure that its "significant related entities" comply with certain obligations. This can extend the impact of FAR to non-APRA-regulated entities within a corporate group, resulting in increased compliance obligations for organisations. For most accountable entities, this will mean subsidiaries with business activities that are material or substantial to the accountable entity.

Accountable persons and accountability obligations

Accountable persons in the insurance industry (including those holding prescribed responsibilities and positions) will be required to fulfil their responsibilities with honesty, integrity, due skill, care and diligence and deal with the regulators in an open, constructive and cooperative way.

Importantly, they will also be required to take reasonable steps in fulfilling and conducting their responsibilities to:

- prevent adverse impact on their entity's prudential standing; and
- prevent matters from arising that would (or would be likely to) result in a material contravention of applicable laws and regulatory regimes including any financial services law, the *Insurance Act 1973* (Cth), *Life Insurance Act 1995* (Cth) and *Private Health Insurance (Prudential Supervision) Act 2015* (Cth).

The requirement to deal with regulators in an open, constructive and cooperative way is a fairly undefined and broad requirement in the regulators' arsenal alongside the duty of an AFSL holder to provide financial services honestly, efficiently and fairly. The impact on clients will largely depend on how the regulators choose to use this.

The explanatory materials state that, in practice, Treasury expects that only CEOs and their direct reports will be accountable persons under FAR – which will likely have the practical effect that those same accountable people would need to have multiple prescribed responsibilities.

Each entity must register its accountable persons for each of the prescribed responsibilities that are relevant to it. The FAR Bill allows APRA to make the register of Accountable Persons available on the internet.

The "prescribed responsibilities and positions" will be determined by the Minister, rather than being legislated as is currently the case under BEAR.

We recommend allowing a significant amount of time for the scope of accountable persons' responsibilities to be discussed, agreed, mapped and documented, noting that accountable persons will have joint and several liability when

multiple people are accountable for a responsibility. This is likely to be the case for the persons with end-to-end product responsibility (see below).

The FAR Bill has provided some relief to accountable persons who were, under the consultation draft legislation, required to adhere to a higher standard of ensuring compliance with applicable laws, however, now they must take "reasonable steps" to prevent matters that are (or are likely to result in) a contravention of the law. Much ink will be spilt over what this requires as the definition contains broad and obvious statements about what those steps must include. Insurers should allow a significant amount of time to allow for the development and implementation of policies and procedures to facilitate "reasonable steps" being taken by accountable persons.

End-to-end product responsibility

FAR requires that there is an accountable person with end-to-end product responsibility. This responsibility seems to impose obligations upon the accountable person which are already imposed on the entity under the design and distribution obligations legislation and, in some cases, appears to go further.

The aim of this responsibility is to ensure holistic management of the value chain, including when the function is outsourced, rather than disaggregation by stages. It is not necessary for the relevant accountable person to have technical expertise on every stage of the product chain.

With adjacent marketing, product and digital innovation being a focus for many insurers as they look to new markets and digital channels, as well as vertical and conglomerate mergers on the rise, insurers venturing forward should be mindful of this new responsibility.

It is important to note that end-to-end product responsibility is broad, with the only exclusion being road-side assistance. It will accordingly be important to have someone with the requisite skillset to meet this new prescribed responsibility, which will likely depend on a range of matters including the nature of the product, the distribution channel and the intended consumer.

The responsible person will likely be the CEO of a small accountable entity or, for a larger and more complex entity, a head of a business division (APRA recognises that there may be more than one person with this responsibility – e.g. in each core division).

Deferred remuneration obligations

Where an accountable person breaches their accountability obligations, FAR will require a minimum of 40% of an accountable person's variable remuneration to be deferred for a period of 4 years (or longer where an accountable entity considers an accountable person is likely to have breached their accountability obligations). The deferral requirements do not apply to an accountable person performing a temporary vacancy for no more than 90 days, for small amounts of variable remuneration (where the amount to be deferred is less than $50,000), or in other circumstances determined by APRA. The FAR remuneration rules will need to be considered alongside the requirements of APRA Prudential Standard CPS 511 Remuneration and Prudential Practice Guide CPG 511 Remuneration.

Importantly, ASIC or APRA (as applicable) may have a role in determining how equity-based variable remuneration is to be calculated for deferral purposes. If ASIC and APRA choose not to specify a calculation methodology, then the deferral proportion is to be calculated based on the equity's value at the time of the grant and assuming maximum opportunity.

Notification obligations

Core obligations: All accountable entities must notify ASIC and APRA of certain events concerning the entity and its accountable persons (such as the appointment or cessation of accountable persons, or a reduction in variable remuneration) as well as of certain breaches of FAR.

Enhanced obligations: In addition, general and private health insurers with total assets over 2 billion dollars and life insurers with total assets over 4 billion dollars will be subject to enhanced notification obligations. These obligations will require accountability statements for each accountable person and an accountability map for the organisation to be lodged. Insurers should be prepared to share multiple drafts of these documents with the regulators before final documents are submitted. We consider it would be prudent for insurers plan to submit their draft accountability statements and accountability maps to APRA one year prior to the commencement of FAR as this will give APRA time to have completed its work in relation to ADIs (that will be subject to FAR a year earlier than insurers), while leaving time for APRA to be provided with a number of drafts.

Insurance cover

Given the wide range of penalties and regulatory action available to APRA and ASIC under FAR, accountable entities should consider whether their insurance policies (such as professional indemnity, statutory liability and D&O policies) adequately cover them and their accountable persons. Consideration should be given to whether new types of claims should be covered, such as contesting a disqualification order and other reviewable decisions under FAR or responding to other regulatory investigations.

APRA regulated entities should bear in mind that, under FAR, a related body corporate of an accountable entity cannot indemnify nor pay premiums for an insurance contract that would insure the accountable entity against the consequence

of breaching an obligation under FAR (albeit excluding insurance coverage or indemnification for legal costs). As under BEAR, the scope of this prohibition and what is within the scope of "consequence" of breaching a FAR obligation is unclear.

Accordingly, entities should ensure that their policies, deeds of indemnity and constitutions are drafted or amended in a way that does not breach this prohibition, or they risk a situation where a policy, otherwise validly negotiated and incepted, is voided. This is a delicate exercise to preserve as much coverage as possible whilst staying within the boundaries of the prohibition. Interestingly, unlike the position in BEAR, the prohibition above does not extend to indemnifying or paying premiums for accountable persons or insurance policies covering these individuals.

As indicated above, accountable persons are expected to be members of the Board and various senior executives. These persons should ordinarily be covered under a D&O policy but, if there is any doubt as to whether any holders of the office of the accountable person are covered, entities should consider expressly adding them as insured persons.

Enforcement

FAR contemplates civil penalties for breaches by an accountable entity, being the highest of:

- $11.1 million dollars (current equivalent to the prescribed 50,000 penalty units);
- three times the benefit derived and detriment avoided; or
- 10% of the annual turnover of the body corporate, capped at $555 million dollars (current equivalent to 2.5 million penalty units).

Should an accountable person breach their obligations, the regulators are empowered to direct that their remuneration be readjusted, their responsibilities reallocated or to disqualify them for a period of time. Accessorial liability explicitly arises where a person, among other things, aids, abets, counsels or procures a contravention (section 81 of the FAR Bill).

Interestingly, the range of regulatory powers exercisable by APRA and ASIC differ from their powers under other legislation such as the *Insurance Act 1973* (Cth). For example, under section 52 of that Act, there is a two-step process for APRA to investigate the insurer. In contrast under section 45 of the FAR Bill, the regulator may investigate an accountable entity or significant related entity if it has reasonable grounds to believe that the accountable entity, the significant related entity or accountable person may have contravened a provision of FAR.

All this highlights the "triple" jeopardy that the FAR regime introduces. Regulators will have a greater range of provisions from which to select in bringing actions relating to a particular act or omission: breach of the relevant law for the underlying conduct, using a "stepping stones" argument to allege a breach of directors' duties and, once FAR begins, alleging a breach of the FAR obligation to take reasonable steps to prevent a breach of the law.

BEYOND COVID-19 – THREE FINDINGS FROM THE SECOND COVID-19 INSURANCE TEST CASES RELEVANT TO GENERAL INSURANCE LAW

Swiss Re International Se v LCA Marrickville Pty Limited (AFCA 2 Test Case) [2021] FCA 1206

On 8 October 2021, Jagot J delivered judgment in the second set of COVID-19 insurance test cases authorised by the Australian Financial Complaints Authority. The proceedings considered whether ten business interruption insurance policies responded to losses claimed to have been suffered by various businesses as a result of the effects of the COVID-19 pandemic in 2020.

On 21 February 2022, the Full Court of the Federal Court (Moshinsky, Derrington and Colvin JJ) delivered their judgment on appeal from Jagot J's decision.

Whilst Jagot J's judgment and that of the Full Court are very significant to industrial special risks policies, and specifically the possibility of cover for COVID-19, their reasons also contain important findings and developments relevant to insurance law generally.

In this article, we examine the implications of Jagot J's judgment and that of the Full Court on the following matters that are relevant to all insurance practitioners and market participants:

- independent, concurrent causes of loss;
- interest under s 57 of the *Insurance Contracts Act 1984* (Cth) (**ICA**); and
- the meaning of *"some other person"* under s 54 of the ICA.

1. INDEPENDENT CONCURRENT CAUSES OF LOSS

QUESTION CONSIDERED

- What is the proximate cause of loss where there are two independent, concurrent causes of an insured's loss, both of which cause total loss but one commencing earlier in time?

OVERVIEW

- Where there are two independent, concurrent causes of loss, the first in time may be the only proximate cause of the loss if it leaves no room for another cause to operate.

The issue of independent, concurrent causes of loss has attracted much controversy in the decade since the decision in *Orient-Express Hotels Ltd v Assicurazioni Generali SpA* [2010] EWHC 1186 (*Comm*) (**Orient-Express**) where Justice Hamblen (then a judge of the England and Wales High Court) held that the insured was not entitled to cover where there were two independent, concurrent causes of loss and only one was an insured peril. Orient-Express attracted some subsequent criticism and, in *FCA v Arch Insurance (UK) Ltd & Ors* [2021] UKSC 1 (the UK's COVID-19 insurance test case), the UK Supreme Court overturned Orient-Express on the basis that the parties to an insurance policy will generally intend that cover is available for other consequences of the same underlying fortuity as an insured peril.

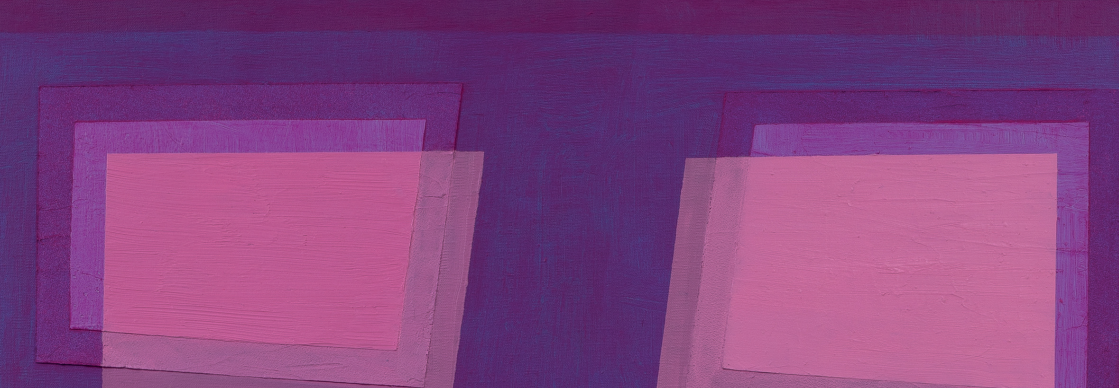
Jagot J's decision offers a further development in this debate. While her Honour adopted the finding of the UK Supreme Court regarding causes that share the same underlying fortuity, her Honour's reasoning suggests that the timing of those causes may be critical. Namely, if the cause of loss that was first in time resulted in total loss, it may be the only proximate cause, notwithstanding that a later cause of loss would have independently caused the same loss. In doing so, her Honour moved away from "but for" causation.

Background

In the case of *QBE v Coyne (EWT)* (considered by Jagot J as part of the test case), the relevant policy provided cover for interruption or interference with the insured's business in consequence of closure or evacuation of the premises by order of a competent government, public or statutory authority as a result of a human infectious or contagious disease.[26]

The insured in that case operated a travel agency which primarily arranged outbound tours for Australian secondary school students to international destinations.[27] From mid-March 2020, the insured experienced changed trading conditions, including uncertainty as to its ability to offer future tours to international destinations and an unprecedented number of cancellations and requests for refunds.[28]

On 25 March 2020, the Overseas Travel Ban (**Ban**) prohibited an Australian citizen or permanent resident from leaving Australia without an exemption.[29] The Ban did not require closure of the insured's premises. On or around 31 March 2020, the insured closed the business premises because the changed trading conditions meant that staff had insufficient tasks to occupy them or require their attendance on the premises, amongst other reasons.[30]



Around four months later, on 5 August 2020, and during the period in which the Ban was in force and the premises remained closed, the Victorian Workplace Closure Directions (**Directions**) commenced and required that the premises be closed until 9 November 2020.

Decision

Jagot J held that the Directions (which were an insured peril) were not a proximate cause, or any other cause, of the closure of the insured's premises. Rather, the Ban (which was not a covered peril) was the proximate cause of the closure.[31]

Her Honour considered that the issue of the liminal period, or the period in which there are two independent concurrent causes of loss, should be resolved as a matter of fact. Firstly, she considered that the "but for" test is indicative, but not determinative, of the proper characterisation of the essential causes of the closure. In this case, the Directions would not satisfy the "but for" test because the premises would have remained closed but for the Directions.[32]

Her Honour found that the Ban was the proximate cause of the closure because it effectively destroyed the business and remained in force at the time of, and after, the Directions came into effect. In contrast, the Directions were not a proximate or any other cause of the closure because the premises were already closed when the Directions came into effect and whilst the Ban remained in force. In other words, *"there was no scope for any other cause to operate".*[33] There was also no evidence that the premises, but for the Directions, could or would have re-opened. The analogy adapted by her Honour was that of two hunters who simultaneously shoot and kill a hiker, each of whom were sufficient but not necessary to cause the death. Her Honour reasoned that, in this case, the analogy departed in that the Ban (hunter 1) shot and killed the business and the Directions (hunter 2) shot the dead body.

Jagot J's decision suggests that where there are independent, concurrent causes of loss, the cause of the loss that was first in time may be a proximate cause of the loss and the second cause of the loss may not be a proximate or other cause of the loss, provided the first cause of the loss remains effective and sufficient at the time the second cause of loss begins.

Her Honour's reasoning on this issue was upheld on appeal.[34]

[26] *Swiss Re International SE v LCA Marrickville Pty Limited* (AFCA 2 Test Case) [2021] FCA 1206, [1077], [1084] ('AFCA 2 Test Case').
[27] *AFCA 2 Test Case* [1068], [1079], [1104].
[28] *AFCA 2 Test Case* [1104].
[29] *AFCA 2 Test Case* [1086(1)].
[30] *AFCA 2 Test Case* [1105].
[31] *AFCA 2 Test Case* [1086(4)], [1096], [1109].
[32] *AFCA 2 Test Case* [1119].
[33] *AFCA 2 Test Case* [1120].
[34] *LCA Marrickville Pty Limited v Swiss Re International SE (AFCA 2 Test Case)* [2022] FCAFC 17 [44], [769]-[771].

2. INTEREST UNDER SECTION 57 OF THE ICA

QUESTION CONSIDERED

- If the insureds were successful, was interest under s 57 of the ICA payable in circumstances where the claims were sufficiently complex to be the subject of test cases?

OVERVIEW

- The fact that the insured's claim is sufficiently complex to be the subject of test cases does not mean it is reasonable, under s 57, for an insurer to withhold payment until final resolution of the claim.
- On the other hand, interest under s 57 may not be payable where the insured fails to provide necessary information to the insurer or changes the essential nature of their claim.

Insureds often seek interest under Section 57 of the ICA in litigated claims. Section 57 relevantly provides that an insurer may be required to pay interest where it was unreasonable to have withheld payment of an insured's claim.[35]

The key issue is when does it become "unreasonable" for insurers not to have paid a claim. This is often a contested area of dispute between the parties who identify, invariably, requests for information or provision of information and briefings as justifying their position.

In the AFCA 2 Test Case, Jagot J found that if, contrary to her findings, the insurers were liable to pay an amount to the insureds, it was not unreasonable for the insurers to withhold payment until the final judicial resolution of the claims (including any final determination on appeal), given the circumstances of the claims.

Namely, her Honour concluded it was not unreasonable for the insurers to have withheld payment as:

- the circumstances of the claims were sufficiently complex to become the subject of the test cases (her Honour did not provide any guidance as to the 'threshold' for such complexity);
- the insureds' claims were part of a test case with the insurers', AFCA's and other regulators' cooperation;
- AFCA agreed to the insureds' claims being part of a test case;
- the insureds provided material to supplement their claim as part of the proceedings; and
- the insureds had changed, in part, the basis for their claims as part of the proceedings.[36]

On appeal, the Full Court disagreed with Jagot J on the first three points above and found that the fact the insureds' claims were part of a test case, with the cooperation of the insureds and other third parties, did not mean that it was reasonable for the insurers to have withheld payment.[37]

On the other hand, the Full Court confirmed that it is reasonable for insurers to withhold payment where an insured:

- fails to provide necessary information to the insurer, that is, information that a reasonable insurer would require to consider the insured's claim; or
- changes the whole or essential nature of their claim.[38]

The Full Court was unable to determine, on the basis of submissions before it, whether an insured in the test case failed to provide the necessary information to the insurer, or whether the nature of the claims advanced at the hearing essentially differed from the claim initially rejected by the insurer.[39]

An area of law we anticipate will develop in the coming years is the intersection of how the concept of "unreasonable" is Section 57 of the ICA is assessed, and the requirements on insurers to provide claims handling services "efficiently" (as part of the requirement for financial services to be provided *"efficiently, honestly and fairly"* by AFLS holders). It will remain an area of significant contest on complex claims.

35 *AFCA 2 Test Case* [415], [516], [631]-[632], [696], [785], [842], [969], [1016], [1063], [1142].
36 *AFCA 2 Test Case* [415].
37 *LCA Marrickville Pty Limited v Swiss Re International SE (AFCA 2 Test Case)* [2022] FCAFC 17 [1], [252].
38 *LCA Marrickville Pty Limited v Swiss Re International SE (AFCA 2 Test Case)* [2022] FCAFC 17 [1], [254], [255].
39 *LCA Marrickville Pty Limited v Swiss Re International SE* (AFCA 2 Test Case) [2022] FCAFC 17 [1], [256].

3. THIRD PARTIES UNDER SECTION 54 OF THE ICA

QUESTION CONSIDERED

- Who qualifies as *"some other person"* within the meaning of s 54 of the ICA?

OVERVIEW

- The acts or omissions of *"some other person"* may be those of a person with a relevant connection to the insured or the policy, whether as a beneficiary under the policy or having some function in the performance of the insured's obligations under it.

Section 54 of the ICA is a remedial provision that may prevent an insurer from refusing to pay an insured's claim because of the insured's act or the act of *"some other person"*. Her Honour's decision provides further commentary as to who is considered *"some other person"* within the meaning of s 54(1) of the ICA. Her Honour's reasoning suggests that the test of who is *"some other person"* remains orthodox and that novel or creative arguments to extend s 54 to the acts or omissions of strangers to the policy will be unsuccessful.

In the case of *Swiss Re International v LCA Marrickville* (considered by Jagot J as part of the test case), clause 9.1.2.1 of the relevant policy provided cover for certain losses but excluding *"losses arising from or in connection with… any disease(s) declared to be a listed human disease pursuant to subsection 42(1) of the Biosecurity Act 2015".*[40]

Jagot J held that s 54 did not apply to the exclusion in clause 9.1.2.1 because the making of the Biosecurity (*Listed Human Diseases*) *Amendment Determination 2020* (Cth) under s 42 of the *Biosecurity Act 2015* (Cth) by the Director of Human Biosecurity is not an act of *"some other person"* by reason of which the insurer may refuse to pay insured's claim within the meaning of s 54.[41]

Her Honour noted that *"some other person"* within the meaning of s 54 must be a person with a relevant connection to the insured or the policy, whether as a beneficiary under the policy or having some function in the performance of the insured's obligations under it. The Director of Human Biosecurity was not "some other person" as he was a stranger to the policy, with no connection to the insured nor to any obligation under the policy.[42]

This reasoning suggests that there must be a relevant connection between the third party and the insured or the policy in order for s 54 to apply. It also suggests that the act of a Minister or other government official in making a legislative instrument will likely be insufficient to engage s 54 on the basis that they would likely be a stranger to the relevant policy.

Her Honour's reasoning on this issue was not the subject of appeal but, in any event, the Full Court agreed with Her Honour's reasoning.[43]

KWM Note – In February 2022, the Full Court of the Federal Court delivered judgment on the appeal from Jagot J's decision. At the time of printing, it was known that three parties had applied for special leave to appeal to the High Court of Australia.

[40] *AFCA 2 Test Case* [197].
[41] *AFCA 2 Test Case* [232].
[42] *AFCA 2 Test Case* [223].
[43] *LCA Marrickville Pty Limited v Swiss Re International SE (AFCA 2 Test Case)* [2022] FCAFC 17 [1], [286].

W&I INSURANCE: TRENDS IN 2021 AND BEYOND

2021 was an incredibly busy year of recovery for the warranty and indemnity (W&I) insurance market. The demand for W&I insurance grew—or rather, exploded—with the resumption of cross-border deals, availability of surplus capital and auditors regaining access to target sites after difficulties caused by COVID-19 in 2020.

COVID-19 remained a topic for conversation with insurers, in part due to the emergence of the new variants and the reintroduction of restrictions by government halfway through the year. The W&I insurance market continued to evolve to meet these new challenges.

KWM saw unprecedented levels of M&A activity involving W&I insurance throughout 2021. In fact, 54% of the deals on which we advised obtained W&I insurance (an impressive increase of 10% compared to FY2020 and an even bigger jump of 24% from the start of the pandemic in March 2020). Overall, this accounted for 80% of all competitive sale processes, 73% of all deals with a value of $100 million or more, 61% of cross-border deals and 72% of deals involving private equity firms.

In this article, we set out key W&I insurance trends in 2021 and discuss what we expect to see in the medium term going forward into 2022.

COVID-19: two years on

Consistent with the trend that developed in the latter part of 2020, the first half of 2021 saw insurers take a commercial approach to areas of underwriting involving COVID-19, in that most insurers were open to narrowing or removing the relevant exclusions as long as they had the assurance of adequate due diligence. This trend took a slight turn with the emergence of the Delta variant in June and then the Omicron variant in early

December 2021, with insurers once again requiring COVID-19 exclusions in most deals coupled with more extensive diligence around the impacts of the coronavirus pandemic.

Separately, and in recognition of the practical difficulties arising from the new restrictions, insurers continued to seek to accommodate insureds in different ways by, for example, modifying the deadlines and the method of delivery of any post-completion deliverables. New breach cover also continues to be intermittently offered by insurers.

Other trends and areas of underwriting focus

In our 2021 Insurance Pocketbook, we identified COVID-19, business continuity and disaster recovery plans, financial performance and stability, material contracts and supply chains, cyber, privacy and data protection, tax, compliance with laws and employment as areas in which W&I insurers were focusing their underwriting efforts in 2020. Each of those areas remained an area of interest for underwriters throughout 2021. We also saw the following additional trends:

Area of interest	Comment
Cyber risks	Insurers were hesitant to cover cyber risks and required adequate due diligence before providing (mostly limited) cover. This was in part due to the increasing frequency and severity of ransomware attacks, data breaches, regulatory penalties for non-compliance with data protection laws, and the emergence of data risks in more industries.[44]
Compliance with laws, including the ABCs	Insurers continued to be interested in the deal parties' compliance processes. In 2021, the return of cross-border deals also saw renewed attention to compliance with anti-money laundering, bribery and corruption regulations (**ABCs**) particularly in East Asian and South-East Asian countries and the UAE, with insurers showing limited appetite for those risks.
Employment	In Australia, JobKeeper was an area of concern. Insurers were also cautious in both domestic and foreign jurisdictions with employment-related risks, such as accounting for overtime and severance payments.
Limit of liability	Where the valuation of the target was based on a multiple of EBITDA or revenue, some insurers sought to limit their liability at 15x EBITDA or 4x revenue if the valuation went beyond these figures. Whilst this was previously customary in the IT sector, such limits are now emerging in all industries.

[44] See, e.g., Liberty, 2021 claims briefing: Exclusive insights guiding global decision-making (Report, September 2021) 22.

W&I insurance pricing

In 2021, the W&I insurance market did not only recover from its lowest point on record in the preceding year,[45] but it saw average premium rates rising above their pre-pandemic levels altogether. One broker, Marsh, reported close to a 25% increase to the average premium rates, with average premium increasing to 1.26% of policy limit purchased, in the first half of 2021 when compared with the previous year,[46] and by mid-November 2021, Willis Towers Watson had seen premium rates almost doubling across 6 months.[47] By the end of the year, due to unrelenting demand and market strain particularly in the third and fourth quarters, the premium rate had reached 1.51%.[48] KWM advised on deals where rates ranged from 1.7–1.8% of policy limits for medium size deals and 2.5–3% for larger deals. We saw even higher pricing in some other deals, particularly in the final weeks of 2021.

Limited insurer capacity and W&I insurance as a condition precedent

Demand for W&I insurance exploded in the APAC region in 2021 and Australia and New Zealand alone saw record levels of activity. With Marsh reporting a 549% increase in aggregate purchase price in the span of a year to the end of June 2021,[49] it was no surprise that by December, many W&I insurers had limited capacity to underwrite new policies.[50] Further, whilst time estimates for obtaining a fully underwritten policy was 5 business days for the most part of 2021, in the final few months of the year, the process was taking at least 10 business days.

In response, especially for competitive deals in which delay was not palatable towards the end of 2021, parties to some deals opted to make W&I insurance a condition precedent to deal completion, giving rise to some interesting questions about risk allocation and risk appetite. In these instances, parties negotiated as to which was to bear the risks of unknown and known gaps in coverage where the policy is incepted post-signing.

Concluding remarks: trends for 2022 and beyond

If COVID-19 continues to affect businesses (and in particular, supply chains) throughout Australia, we expect to see continued underwriting focus on material contracts, supply chain and other areas impacted by COVID-19.

COVID-19 is also impacting claim trends, with major W&I insurers expecting an uptick in regulatory activity on tax compliance and financial statements due to challenges caused by the pandemic.[51]

We expect W&I insurance to continue to be a key aspect of M&A transactions. The increase in demand will also likely lead to new insurers entering the market, potentially bringing new and different industry focuses with them.

[45] Marsh, Pacific Mergers & Acquisitions (M&A) Insurance Trends Report 2021 (Report, September 2021) 2–3.
[46] Ibid 3.
[47] Daniel Wood, 'M&A insurance rates double in six months', Insurance Business Australia (online, 17 November 2021) <https://www.insurancebusinessmag.com/au/news/breaking-news/manda-insurance-rates-double-in-six-months-316788.aspx>.
[48] Marsh, Transactional risk insurance 2021: Year in review (Report, February 2022) 13.
[49] Marsh, Pacific Mergers & Acquisitions (M&A) Insurance Trends Report 2021 (Report, September 2021) 2.
[50] Anthony Macdonald, Yolanda Redrup and Kanika Sood, 'Deal delays as M&A insurance policies soar', Australian Financial Review (online, 30 November 2021) < https://www.afr.com/street-talk/deal-delays-as-m-and-a-insurance-policies-soar-20211130-p59diw>.
[51] Liberty, 2021 claims briefing: Exclusive insights guiding global decision-making (Report, September 2021) 8.

A REFRESHER ON THIRD PARTY CLAIMS AGAINST INSURERS IN NSW - THREE ELEMENTS AND THREE CASES

- The *Third Party Claims Against Insurers) Act 2017 (NSW)* ("**the TPCAI Act**") came into force on 1 June 2017. Its primary function is to enable claimants to recover directly from an insurer where there is a real possibility that an insured would be unable to meet a claim against it.
- Section 5 of the TPCAI Act provides that proceedings cannot be commenced without leave of the court. Leave can be sought either before or after proceedings against the insurer have been commenced.
- Three critical elements must be met before leave to proceed against an insurer will be granted. Leave must be refused if the insurer can establish that it is entitled to disclaim liability under the contract of insurance or otherwise.
- This article sets out the three critical elements required for leave to be granted and summarises four recent cases that considered section 5 of the TPCAI Act and its territorial scope.

ELEMENT 1

The plaintiff must have an arguable case of liability against the insured

The threshold for existence of an 'arguable case' of liability will be satisfied where it is arguable that certain facts exist, and equally arguable that those facts would entitle the plaintiff to legal relief against the defendant

ELEMENT 2

There must be an arguable case that the policy (which must be in place at the time of the incident, provided by the insurer and covering the insured) responds to the plaintiff's claim

There is a lack of judicial guidance on what is meant by an "arguable" case. Courts appear to have had reference to the usual meaning of the word, in that to satisfy this element, the plaintiff must demonstrate it is at least "arguable" that the holder of the policy would, if found liable to the plaintiff, be entitled to indemnity under the policy

ELEMENT 3

There must be a real possibility that if judgment is obtained, the insured would not be able to meet it.

The 'real possibility' test is met where there is doubt about a defendant's capacity to pay. For example, this element has been satisfied where the defendant was self-represented, or where multiple proceedings against a defendant may have resulted in the value of their assets being reduced substantially

In the event that the three said criteria are satisfied, the onus then falls on the Insurer to prove beyond argument that there is a relevant exclusion in the Policy which excludes liability. 'Beyond argument' is a high threshold and authorities suggest that it will only be satisfied where the effect of the exclusion clause renders the plaintiff's claim under the Policy so clearly untenable that it cannot possibly succeed.

Even if the three elements are satisfied, and no relevant exclusion in the policy applies beyond argument, the court retains a residual discretion to refuse leave under the TPCAI Act. This residual discretion has been consistently attributed to the need to ensure that insurers are not unnecessarily exposed to unwarranted claims against them.

CASE 1: COUNT FINANCIAL LIMITED V PILLAY [2021] NSWSC 99

Facts: the plaintiff applied for leave to proceed against the professional indemnity insurer of the defendant accountant in circumstances where the defendant had allegedly breached his duty to exercise reasonable care and skill in conducting his accounting business.

Outcome:

Leave refused (Stevenson J)

Elements considered:

Element 2 (policy responds), residual discretion.

Analysis:

- The relevant policy contained an exclusion for claims arising from the insured giving advice "in respect of any investment". Stevenson J observed that the plaintiff's own List Statement replicated the words of the exclusion by claiming the dispute arose out of services provided by the defendant "in respect of" certain products. Counsel for the insurers submitted that this exclusion was clearly engaged.
- Stevenson J considered that he was compelled to refuse leave on the basis that Element 2 was not satisfied as the insurers had established an 'entitlement to disclaim liability'. Put differently, Stevenson J considered that the insurers' submissions on applicability of the exclusion were correct and therefore the insured's claim for indemnity was untenable. It followed that the Court was compelled to refuse leave to join the insurers.
- Alternatively, Stevenson J was found that the insurers' argument as to the applicability of the exclusion were so strong that, as a matter of discretion, leave should be refused.

CASE 2: AVANT INSURANCE LTD V BURNIE [2021] NSWCA 272

Facts: Avant Insurance Ltd (**Avant**) sought leave to appeal from a decision of the District Court granting leave under the TPCAI Act to join Avant to proceedings between Ms Burnie and the insured. In those proceedings, Ms Burnie sought damages for personal injury suffered as a result of the insured's alleged medical negligence. At the time of the claimed negligence, the insured held a Practitioner Indemnity Insurance policy issued by Avant (**the Policy**). Relevantly, the Insured had not notified Avant of a claim.

Outcome:

Avant's appeal was granted. Emmett AJA (with McCallum JA and Simpson AJA agreeing) held that Ms Burnie did not have an arguable case as there was no insured liability under the Policy.

Elements considered:

Element 2 (policy responds)

Analysis:

- Ms Burnie submitted that the Policy could respond despite the failure to notify. She did so by arguing, first, that the Policy contained a near-verbatim extract of section 40(3) of the *Insurance Contracts Act* 1984 (Cth) (**ICA**) which gave rise to a contractual obligation to give notice and, second, that section 54 of the ICA could then be relied upon cure the failure to notify. It was held (consistent with other authorities) that the Policy did not create a contractual obligation to give notice of facts that might give rise to a claim. In replicating s 40 of the ICA in the Policy, Avant had simply observed the statutory obligation imposed by section 40(2) of the ICA to explain the effect of section 40(3). Section 54 therefore had no role to play and, in the absence of any notification to Avant, the Insured had no entitlement to indemnity for any liability to Ms Burnie. The court held that there was therefore no arguable case that the Policy would have responded to any claim by the Insured.

CASE 3: GENTLE DENTAL CARE GROUP PTY LTD V AL-MOZANY [2021] NSWSC 1234

Facts: The plaintiff was an incorporated dental practice that claimed damages from the defendant, a dental practitioner, for breaches of the duty to take reasonable care and skill. The practitioner formerly carried on practice in association with the plaintiff. The plaintiff sought to join the defendant's professional indemnity insurer to the proceedings.

Outcome:

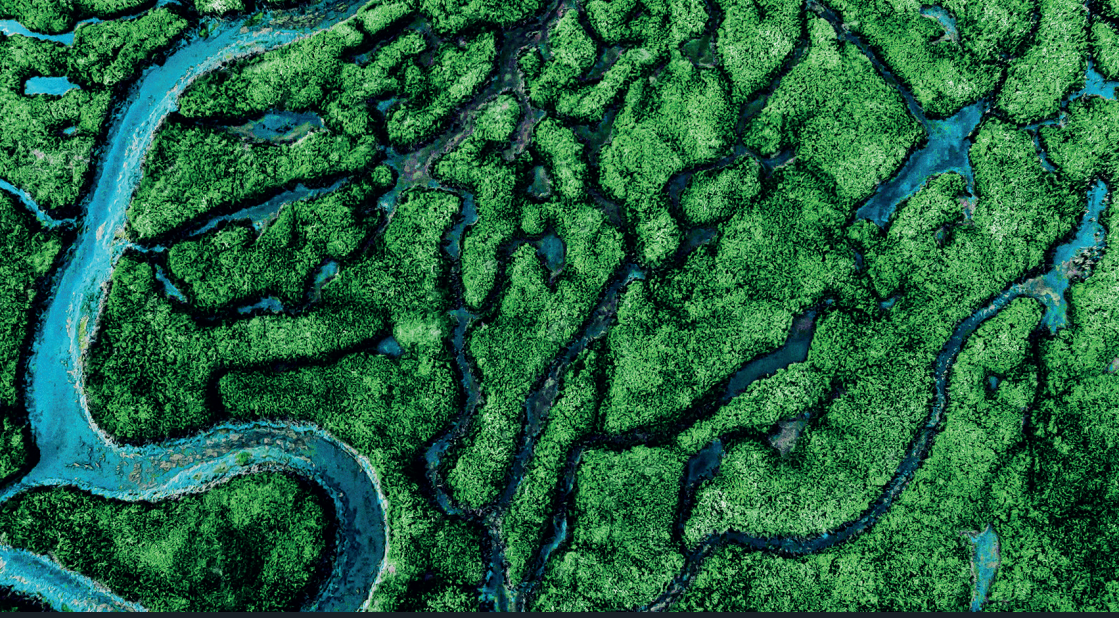
Campbell J granted leave to the plaintiff to sue the insurer directly pursuant to the TPCAI Act.

Elements considered:

Element 1 (arguable case against defendant), Element 3 (ability of defendant to meet judgment), residual discretion

Analysis:

- Campbell J was satisfied that the plaintiff had an arguable claim against the defendant both in contract and tort arising from the alleged breach of the duty to render services with reasonable care and skill, despite the contestability of some of the resulting losses. Campbell J considered the question of whether the defendant could meet a judgment against him. Campbell J considered evidence of the defendant's assets, which included shares and proceeds of a home sold for $4.4M in 2018. Nonetheless, Campbell J was satisfied there was a real possibility that the defendant could not satisfy the judgment obtained by the plaintiff, largely due to the defendant's self-represented status. The court was not prepared to exercise its residual discretion to deny leave in circumstances where the three criteria were satisfied



(VIRTUAL) COFFEE WITH KELLY BUTLER

Kelly Butler is the Cyber Practice Leader – Pacific at Marsh (a member of Marsh & McLennan Companies, Inc).

Kelly Butler has been working in insurance for more than 20 years, but it wasn't until 8 or 9 years ago that cyber insurance really piqued her interest. KWM chatted with Kelly in early 2022 about cyber insurance trends, what impact COVID-19 had, and how the world of cyber insurance is evolving.

Did you always think you'd end up in cyber insurance and broking? How did you get to where you are now?

No, not at all! Like most people in the insurance industry, I just fell into it out of school. I started in the administrative side: that's what young people did to enter the industry and then I worked my way to where I am today. I really haven't looked back since I joined. I've also been lucky enough to travel around and live and work in London, Singapore, New Zealand and Australia. My journey has certainly been interesting: I've been both sidewards and upwards.

Following my admin role, I started in liability claims then curved my way into crisis management. There were a couple of major events in Australia that were supported by Government at the time; a fuel contamination issue in small aircrafts was one, and I was involved in those from an insurance perspective.

I then moved into the complex D&O & PI litigation space which eventually led to me being approached by a broking firm. Initially I thought there was no way I would move to what I thought was the "dark side" but getting to work with clients really intrigued me: that really is my passion now. I was broking financial lines for a while and then when the topic of cyber started to pop up more regularly with clients, I took a real interest in it. I asked my firm at the time if I could sink my teeth into cyber. They were supportive but said cyber insurance probably wasn't going anywhere!

7 years later, here I am at Marsh after setting up their cyber practice which is now a team of 11 specialist brokers and supported by 3 cyber security experts.

Cyber insurance has no doubt changed a lot since you've been in the insurance industry. What key changes stand out for you?

When I first got into it, cyber as a topic just kept arising in small ways. While cyber insurance has been around for about 20 years or so, for a long time it was more about privacy breaches and resulting third party liability.

In the early days it was a lot of discussions with clients to help them identify what the cyber risks were for their businesses and how insurance could help from a risk transfer prospective. I found that part really interesting: sitting with an organisation and explaining what cyber risk meant to them. Organisations didn't have the large security teams in place then, but they knew they needed to do something to deal with the increasing threat.

Cyber risk and insurance has obviously continued to evolve now to cover network incidents, ransomware, business interruption expenses and in some instances system failure. We have all become more and more reliant on systems and networks, so the industry and product has had to evolve to match that.

The tactics and sophistication of the hackers continues to grow and they are very successful at what they do. One example is ransomware. Until a few years ago, it was all about malware and a denial of service to individual computers. This involved duping an individual for small amounts, say $25. Then ransomware burst onto the scene with large ransoms demanded and cyber products have broadened around that increased risk exposure.

The other fundamental part of cyber insurance and the way it's changed is that it needs to be customised around a particular client. The types of risks to an organisation will differ depending on the industry and size.

How did 2021 shape up in the cyber insurance world?

It was a year to remember, that's for sure. I think I aged about 20 years!

It was absolutely a turbulent period for the cyber risk landscape. There were increased risks and widespread security challenges: it is an ever-changing market.

2021 was dominated by ransomware attacks. They increased in frequency and severity. The severity of the costs associated with ransomware attacks was not anticipated nor were there accurate models to show how much they would cost an organisation. The ransom demand itself is just one element however the costs associated with the triage, negotiations and then rectification post-event really caught clients and insurers off guard.

What impacts have the COVID-19 pandemic had on the impact the cyber insurance space? Are they continuing?

COVID-19 has no doubt had an impact. Overnight, whole organisations were working from home. Thankfully a lot of corporate Australia had already done a big body of work in the lead up on digital transformation projects therefore a lot of businesses were in a better position than they could have been.

We did see an increase in malicious attacks, and attackers trying to exploit network vulnerability from remote working. That had an impact from the underwriting perspective. Multi-factorial authentication became important. Underwriters wanted you to secure your network and a lot of work had to be done by Australian businesses.

All in all, businesses have stood up really well from a cyber perspective and we didn't get the huge flood of claims some were predicting.

There has been a noticeable increase in cyber incidents and losses over the past couple of years. What are some of the trends you are seeing?

Ransomware attacks are top of the list. Those attacks have changed pretty significantly over the years. They used to be focused on network shutdowns where the demand was for payment in exchange for accessing your network, which resulted in businesses investing more time and effort into how they backed up their systems. They implemented strong mandates for back-ups and testing and focused on business continuity plans.

Unfortunately, hackers are very good at what they do and are getting more sophisticated. They adapted too, and data exploitation has become a significant problem. Rather than an attack resulting in denial of service, they're getting access to valuable and sensitive information and are using that to extort the organisation with the threat of releasing the data. That's the biggest issue we've seen recently.

Is it just the uptick in cyber incidents and losses that is driving an increase in procurement of cyber insurance policies and an increase in premiums, or are there other factors at play?

Increase in claims has absolutely played a key role. Risk exposure in the cyber insurance market in general also continues to grow and therefore premiums will grow. Clients have become more reliant on their network, which increases the risk of an attack and then a loss.

Insurers have already turned their focus to the aggregation of risk and the systemic nature of cyber. Insurers are grappling with how to underwrite whole supply chains with third party providers where multiple parties experience, for example, a data breach and where those multiple parties are all insureds. That is being modelled by insurers and that places a load on premium.

Do you have any top tips for businesses? What can they do to avoid or prepare for a cyber event?

It's really all about preparedness now. We like to say: it's not if, it's when.

Strong governance from the Board down is key, and managing cyber risk shouldn't be the job of the security team only, it's a whole business risk.

You also need to look holistically around the organisation. Training is key because human error is still the major cause of cyber incidents. Businesses should try to cultivate a culture of awareness, look at their security perimeters, and test their incident response processes.

What are you expecting in the cyber space for 2022?

I think there's still some pain to come. It will likely remain challenging over these 12 months, but at Marsh we enter 2022 with cautious optimism that the market corrections are working and creating a sustainable market place going forward!

I think premiums will grow and retentions will be scrutinised. Capacity reductions will continue: gone are the days where insurers will put big chunks of capacity on risk.

In terms of coverage, that'll be interesting. Insurers might look to pull back on additional coverage but that will temper and be less severe with time.

Top cybersecurity controls are the key to risk mitigation, resilience and insurability.

Most importantly, where can we find you when you're not at the office (whether physical or virtual!)?

Definitely outdoors, that's where I like to be. And anywhere with sun (which is sometimes difficult being based in Melbourne).

I like to explore places and watch live sport. My highlight for 2022 so far was being at Rod Laver Arena when Rafa won the Australian Open. It went for so long that I got home at 3am but it was so worth it!

(VIRTUAL) COFFEE WITH CATHY MANOLIOS

Cathy Manolios is Zurich Financial Services' General Counsel and Head of Governance and is responsible for leading Zurich's legal, compliance, regulatory affairs and company secretarial functions in Australia.

Cathy Manolios has been a lawyer in the insurance industry for almost 35 years. KWM "sat down" (by videoconference) with Cathy to better understand her multi-faceted role and obtain Cathy's wisdom and insights.

How did you get into the insurance industry?

I accepted a job as an in-house lawyer at AMP straight out of university, as a result of which I necessarily specialised in insurance.

After several years at AMP I moved into private practice as an insurance and superannuation lawyer, before later returning in-house at another insurer. I have worked in-house ever since.

The insurance industry has seen huge change over the course of your career. What are some of the biggest changes you have observed or experienced – especially in the regulatory and corporate governance spaces?

By far and away, the biggest change has been the increase in the volume and breadth of the laws that insurers are now subject to (especially from a corporate governance and regulatory perspective), or that are otherwise relevant to their operations or the lines they insure. As a consequence of this, in-house lawyers now also need to be across so many more areas of the law than in previous years.

I have also observed increased engagement from regulators, with insurance being a major focus for regulators within the last decade, especially in relation to corporate, risk and governance culture.

More recently, there has also been increased focus and change around executive remuneration.

In the wake of the Financial Services Royal Commission, there has been a wave of legislative and regulatory changes. What are some of the challenges faced when adapting to new laws?

There was a period of about 12 months where we had to grapple with significant reform. It was and continues to be a challenge because, even once you have made the necessary changes to implement and comply with new laws internally, you still need to make sure those changes are operationalised and well embedded so that compliance continues in the future. You also then need to be continually testing the implementation and compliance internally. You can't just rest on your laurels once the initial changes have been made.

Outside of that context, I've also observed in recent years the convergence and evolution of different laws that are relevant to our business. We also need to be aware of the application of and interaction between the laws of different jurisdictions, both within Australia and overseas. It is quite challenging as there is a lot that we need to be across, especially in terms of legislative changes and international developments.

What does a working day in your life look like?

My main "working day" is from about 8am to 6pm. During these hours, I usually find myself in back to-back meetings. The internal meetings I attend range from multiple executive team meetings (including as a member of the executive teams for life insurance and general insurance), Board meetings, SteerCo meetings, one-on-one meetings with my direct reports, to team meetings attended by all my direct reports.

Outside those meetings and hours, I am responding to emails and actioning all of my other substantive work.

There is a lot to juggle!

How have you observed the role of an in-house lawyer for an insurer develop over the course of your career?

Earlier in my career, in-house legal departments were often treated like a discrete section of the business. They would be approached as needed by the business to provide legal advice and were usually otherwise kept on the sidelines of the organisation. While not every in-house legal department operated this way – and I didn't run my departments that way – it was fairly commonplace.

These days, I have observed that in-house lawyers are actively involved across all aspects of the business. Their insight is sought out and valued when offered, and they are also used as a sounding board and included in decision making, particularly where there is some risk (even if not strictly a legal risk). They have a "seat at the table". This change is perhaps at least partially a product of the increased regulatory environment insurers face, as well as general counsel (such as myself) having dual legal and corporate governance functions.

I have always encouraged my team to be proactive and "stick their noses" in the business. This applies across all topics including raising issues, and I do it myself. I remember years ago I was raising issues related to climate change. In more recent years, I've been raising matters related to First Nations Australians.

Do you foresee any further transformation of the role of in-house lawyer and general counsel in the future?

I think in-house lawyers will continue to be actively involved across all aspects of the business and there will be further entrenchment of that type of role.

There will also continue to be "new" issues that in-house lawyers will need to get across because

they inform the risks insured by the business and/or affect the business's operations. The most recent and significant example is cyber and artificial intelligence. As in-house lawyers, we need to understand what it is, the risks it may pose, how it may assist the business, and new or foreshadowed laws in relation to it. We then need to assist the business to adapt accordingly.

What is the greatest value an in-house lawyer can add to the business?

First and foremost, I think in-house lawyers – particularly those who are more junior – should recognise that they are bright people. More often than not, they are also more across the detail of a particular topic being discussed and aware of things that are going wrong or the reason why a solution won't work. I encourage everyone I work with to raise (in a polite and constructive way) the issues that they see emerging out of a matter they are working on or anything else.

For example, I made a decision a few months ago in a forum with a number of people present and I thought it was a sensible decision. Someone then called me after that meeting and asked me if I had considered "X, Y and Z". It was incredibly important and caused me to change my view. I am sure that person was probably apprehensive about calling me, but it was important that they made the call.

In-house lawyers also shouldn't feel confined to only providing input to legal matters. It is perfectly open to them to make contributions outside the four walls of the legal function. That could range from commenting on a product design feature or wanting to get involved in a diversity and inclusion project. There is no doubt that younger people bring new perspective to things.

It's important, however, that that culture and environment is cultivated from the top and that there is a corporate structure that allows the in-house team to raise those issues.

Are there any major challenges you've had to overcome in your career?

The biggest challenge for me was trying to balance a busy work and home life when my twin boys (who are now 25 years old) were born. It was hard and stressful. I only took 3 months' maternity leave and I then worked from home for 3 months. At that time, technology was also far less sophisticated, which made it especially challenging. All I had at home was a telephone. It would have been great to have been able to work from home with a laptop and just jump on a Teams call like we are doing right now.

I also feel it was much harder back then to speak up and say you needed to step out to do something with your kids (such as an appointment or an awards session). It might have been fine, but at the very least it felt like you had to make a big excuse for not being in the office. I feel like workplaces are much more understanding when family-related things pop up these days.

Is there a piece of advice you give now that you wish you had received yourself?

The best piece of advice is to not be self-limiting. That is, don't assume limits or barriers exist. Know your self-worth, push on, and assume you can achieve what you want to (in a healthy and realistic way). Similar to the "lean in" concept.

The other piece of advice I give is around CVs. I tell people to make sure they don't just set out their job history and what they've done. I always recommend that people also set out the skills they have derived from those experiences and how those skills transfer into other industries or areas. For example, if you have a job in financial services, the analytical skills you've learned are applicable and transferable to other industries.

Are there any key lessons you've learned in your career?

Apart from the advice just mentioned, it's crucial to make time for important things. As in-house lawyers, so much of our job involves multi-tasking and being able to respond quickly to things as they happen (especially the more senior you get), but it's absolutely essential to recognise when a task requires your full attention and to carve out the time for those "meaty" tasks and give them the attention they deserve.

How have you adapted to working from home? What are your top tips and recommendations?

My top advice is to (as best as you can) make the area where you work at home a "working environment" by creating a deliberate and proper workspace for yourself.

Beyond that, I've found it helpful to try to get into a routine for each working day. One thing I do each day is put on my makeup and earrings as that helps me get into "work mode".

I also think it would help me to have less chocolate in the house and more fruit instead!

What is your favourite thing to do on a weekend?

Before COVID-19, I would go to pilates every Saturday and Sunday.

Now, every weekend, my twin boys and I watch a Poirot film while we eat chocolate. I also make a large batch of spaghetti bolognese for Monday and Wednesday night dinners. I'm lucky that my boys cook on all the other nights!

I also love taking the opportunity to sleep in and catch up on life admin when I can.

CASE NOTE

NON-DISCLOSURE STILL TOP OF THE CLASS

All Class Insurance Brokers Pty Ltd (in liquidation) v Chubb Insurance Australia Limited (No 2) [2021] FCA 782

SNAPSHOT

- A person is not a third-party beneficiary to a policy (and, as a result, not required to comply with the statutory duty of disclosure per *ABN Amro Bank NV v Bathurst Regional Council* [2014] FCAFC 65 (**ABN Amro**) simply because someone else arranged the policy on their behalf. Courts will closely consider the circumstances of the entry into the insurance contract when considering whether a person is a third party.
- Where such an arranger acts as agent, an insurer will comply with its disclosure obligations under section 22 of the *Insurance Contracts Act 1984* (Cth) where the relevant notifications are given to the arranger.
- Knowledge of a director for the purposes of section 21 may be attributed to the company in circumstances where the director is the "directing mind and will" of the company.
- Fraudulent conduct of a director may be attributed to the company where it is carried out for the benefit of the company and not just for the personal benefit of the director.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether the insured was a third-party beneficiary, such that it did not have a duty to disclose in accordance with *ABN Amro.*
- Whether the insured complied with its disclosure obligations under the ICA.
- When a director's knowledge will be attributable to an insured.

The administrator of All Class Insurance Brokers Pty Ltd (in liquidation) (**All Class**), sought indemnity under a clause of an insurance policy issued by Chubb Insurance Australia Limited (**Chubb**) which provided cover for direct loss resulting from theft, fraud, or dishonesty committed by an employee and discovered during the policy period (**Theft Clause**).[52]

- All Class alleged that its sole (and managing) director, shareholder and company secretary, Mr Bowmaker, had misappropriated client trust moneys, having improperly transferred up to $8 million out of the insured's trust account between 2008 and 2013, resulting in an alleged trust account imbalance of approximately $2 million.[53] A significant proportion of the misappropriations were paid into All Class's office accounts for the benefit of "keeping it afloat".[54] All Class claimed that Mr Bowmaker was relevantly an "Employee" under the Policy and that the Theft Clause was therefore triggered.[55]
- Mr Bowmaker, on renewing the policy on an annual basis, declared that there were no facts he knew of which may give rise to a claim,[56] and no cause for suspicion of fraud or dishonesty on the part of Principals or Employees.[57] Such declarations were made in the insured's application for cover for the relevant policy period (2012/13). This disclosure was, however, made to Steadfast Group Limited (**Steadfast**), a company that relevantly arranged insurance for its shareholder brokers (including All Class) by obtaining a single policy. Steadfast then made disclosures to Chubb on the basis of information submitted to it.

52 *All Class Insurance Brokers Pty Ltd (in liquidation) v Chubb Insurance Australia Limited (No 2)* [2021] FCA 782 [1] ('*All Class*').
53 *All Class* [82].
54 *All Class* [175].
55 *All Class* [10].
56 *All Class* [31].
57 *All Class* [32].

- Chubb denied liability for two main bases:
    - All Class failed (either fraudulently or innocently) to comply with its duty to disclose the misappropriation under sections 21, 21A and 22 of the ICA, as a result of which Chubb was entitled to either avoid the insurance contract or reduce its liability to nil in accordance with section 28 of the ICA.
    - The Theft Clause was not triggered because Mr Bowmaker was not an employee and no direct loss was sustained.
- This case note focuses on the first basis. In circumstances where it was not in dispute that All Class had not disclosed the employee theft prior to entry into the policy, the case focused on whether All Class was required to comply with the duty, whether compliance had been waived, whether the theft was "known" to All Class, and whether the non-disclosure was fraudulent.

Analysis by the Court

Duty to disclose - third party beneficiaries

- All Class submitted that it did not owe Chubb a duty of disclosure, because:
    - It was not a party to the insurance contract, but rather, a third party beneficiary under section 48 of the ICA, because the Policy was arranged on its behalf. [58]
    - The Court's finding in ABN *Amro* that a subsidiary of the policyholder (who was by definition an "Insured") was not a party to the insurance contract and, accordingly, had not duty to disclose, applies to All Class.
- Allsop CJ found that All Class was a party to the Policy and did not derive its entitlement to cover from section 48 of the ICA. All Class was not a subsidiary of Steadfast, but rather, Steadfast acted on behalf of its members to obtain insurance as their agent. [59]
- In reaching this conclusion, Allsop CJ made several important factual distinctions between this case and *ABN Amro*:
    - Unlike this case, the evidence in *ABN Amro* did not support a finding that the policyholder had acted in negotiation for, and entry into, the policy as an agent of its subsidiary. [60]
    - Steadfast was not a parent with subsidiaries, as was the case in A*BN Amro*. Rather, Steadfast was acting for and on behalf of its members to obtain insurance for them, and each of them, if they wanted the cover. [61]

[58] *All Class* [116], [128].
[59] *All Class* [130] – [131].
[60] *All Class* [128].
[61] *All Class* [131].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Duty to disclose – Alleged waiver of the duty

- All Class also argued that it was not required to comply with the statutory duty to disclose because Chubb had waived the duty on four distinct bases:[62]

    - First, the Policy was an eligible contract of insurance for the purpose of section 21A of the ICA and Chubb failed to carry out its notification obligations under that provision, amounting to a waiver of the duty to disclose. Allsop CJ rejected this and found the Policy was not a class of contract declared under the regulations nor was it a contract of new business.[63]

    - Second, Chubb otherwise waived the duty of disclosure by failing to inform All Class in writing of the general nature and effect of its duty of disclosure, in accordance with section 22(1). Allsop CJ rejected this, finding such notification was only required to be given – and was given – to Steadfast, which Chubb did.[64] Such notice was effective notice to All Class in accordance with section 71 of the ICA, since Steadfast was All Class's agent.[65]

    - Third, Chubb had waived the duty to disclose by reason of section 21(3) of the ICA, which operates where a person fails to answer or gives an obviously incomplete or irrelevant answer to a question in a proposal form. This was also rejected, with Allsop CJ finding that there was no relevant failure merely because All Class did not submit a disclosure directly to Chubb.[66]

    - Fourth, that the requirement that the employee theft be "discovered" in the policy period constituted waiver of the duty of disclosure in accordance with section 21(2)(d) of the ICA. Allsop CJ rejected this argument, finding that the definition of "discovered" did not constitute waiver.[67] His Honour noted its terms were not directed to waiver and compared the wording used to other express waivers in the policy. In addition, while Chubb had also argued that the terms of the policy itself cannot constitute a waiver under section 21(2)(d) since the duty applies while the policy is being negotiated, Allsop CJ was not persuaded this would always be the case and observed that the form and content would not always be irrelevant to the duty, as the risks covered will bear upon the matters relevant to the decision of the insurer and in turn what needs to be disclosed.[68]

62 *All Class* [141].
63 *All Class* [144].
64 *All Class* [144].
65 *All Class* [149]-[150].
66 *All Class* [153].
67 *All Class* [157].
68 *All Class* [156].

Duty to disclose – was the employee theft "known" to the insured?

- An insured's duty of disclosure under section 21 of the ICA is limited to matters that are actually "known" to the insured.[69]
- Having found that All Class was required to comply with the duty to disclose, a central question was whether the misappropriation of trust funds was "known" to it, in circumstances where the fraud was only known to Mr Bowmaker prior to entry into the policy.[70]
- Allsop CJ observed that whether or not the knowledge of a particular officer or employee of a company should be attributed to the company depends upon the context in which the question of attribution arises.[71]
- Allsop CJ found that Mr Bowmaker's knowledge was attributable to All Class, in reliance on the following matters:
    - As Mr Bowmaker was the sole director, shareholder and company secretary of All Class, he was undoubtedly the "directing mind and will" of the company, such that his knowledge could be attributed to All Class.[72]
    - Although there exists a "fraud exception" (such that knowledge may not be attributed where it concerns that person's fraud against the company), and the policy protected All Class against the very risk of fraud, the funds were also misappropriated for the benefit of All Class (not just Mr Bowmaker personally). It was just and appropriate to attribute Mr Bowmaker's knowledge that he was dishonestly misappropriating funds held on trust for clients – in significant part for the purpose of assisting the company – to All Class.[73]

Duty to disclose – was the non-disclosure fraudulent?

- Allsop CJ found that All Class had fraudulently failed to disclose the misappropriation of trust funds.
- His Honour observed that Mr Bowmaker was an insurance broker and so must have been aware that his non-disclosure was fraudulent and that, had he disclosed his dishonest treatment of the trust account, the insurer would decline cover.[74]

Result

- All Class was required to comply with the statutory duty to disclose and it fraudulently failed to do so. As a result of All Class's fraudulent non-disclosure, Chubb was entitled to avoid the Policy or, in the alternative, reduce its liability to nil.
- The proceeding was dismissed with costs.[75]

69 *All Class* [159].
70 *All Class* [160].
71 *All Class* [179].
72 *All Class* [178]-[179].
73 *All Class* [176].
74 *All Class* [182].
75 *All Class* [216].

CASE NOTE

JUST ADD WATER: THE DUTIES OWED BY INSURANCE BROKERS

***Adelaide (SA) Pools & Spa Manufacturing and Installation Pty Ltd & Ors v Westcourt General Insurance Brokers Pty Ltd (No 2)* [2021] SASC 123**

SNAPSHOT

- An insurance broker owes a general duty to the insured to exercise reasonable care and skill in the performance of their duties. This requires the insurance broker to take reasonable steps to understand their client's needs and business in order to obtain a suitable policy.
- An insurance broker must ensure that their clients understand the insurance coverage being obtained and are satisfied that all necessary items are adequately covered under that policy.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether an insurance broker's advice breached its contractual or general duty of care owed to an insured.

Facts

- The first to fifth applicants were a group of entities involved in pool manufacture, sale, fencing and related products (**ASA**). The sixth applicant, Mr Timothy Elliot, was a former director, controller and shareholder of each of the ASA entities.
- The respondent, Westcourt General Insurance Brokers Pty Ltd (**Westcourt**), was an insurance broker. OBI Services Pty Ltd and its principal Mr Gary Olbrich were authorised representatives of the respondent.
- In 2009, Mr Olbrich took out an 'Industrial Special Risks Policy' (**Policy**) for ASA. In January 2010, a fire erupted at the ASA factory which caused extensive damage to the factory and its operations. Mr Elliot made a claim on the Policy, however, the Policy did not cover a significant amount of the factory's stock and contents. As a result, ASA were underinsured.
- Mr Elliot was unable to rebuild the factory or resume manufacturing. Mr Elliot made attempts to continue the business after the fire, which involved sourcing pools from interstate at a greater cost. Notwithstanding these attempts, in 2012 some ASA entities were placed into voluntary administration, others ceased trading and the remaining entities became insolvent.
- ASA alleged that the respondent acted in breach of contract to the named insureds and in breach of its duty to exercise the skill and care of a reasonably competent insurance broker. Specifically, they argued that Mr Olbrich failed to provide them with adequate advice in respect of various limits and declared values under the Policy, with the result that they ended up with an inadequate level of cover under both the material damage and business interruption sections of the Policy.

[76] *Adelaide (SA) Pools & Spa Manufacturing and Installation Pty Ltd & Ors v Westcourt General Insurance Brokers Pty Ltd (No 2)* [2021] SASC 123 [626] ('*Adelaide Pools*'); *PC Case Gear Pty Ltd v Instrat Insurance Brokers Pty Ltd (in liq)* [2020] FCA 137 [100]-[110].
[77] *Adelaide Pools* [630].
[78] *Adelaide Pools* [652], [662].
[79] *Adelaide Pools* [696].
[80] *Adelaide Pools* [857].
[81] *Adelaide Pools* [735].
[82] *Adelaide Pools* [733].
[83] *Adelaide Pools* [740].
[84] *Adelaide Pools* [802].
[85] *Adelaide Pools* [808].
[86] *Adelaide Pools* [822] - [823].
[87] *Adelaide Pools* [825].
[88] *Adelaide Pools* [835] - [837].

Analysis by the Court

- As a general statement of principle, the Court applied Anderson J's summary of an insurance broker's general duty of care owed to the insured in *PC Case Gear Pty Ltd v Instrat Insurance Brokers Pty Ltd (in liq)* [2020] FCA 137. [76]

- The Court reiterated that a broker must take reasonable care to ascertain the client's needs, which ordinarily requires an understanding of the client's business.[77] To understand the precise content of the duty depends on the circumstances of the particular case and instructions given by the client to the broker.

- The Court found that the broker had breached its general duty to exercise the 'skill and care of a reasonably competent insurance broker',[78] in several respects.

    - First, the respondent failed to properly advise Mr Elliot in relation to the replacement value of the factory. The court considered that had the respondent provided Mr Elliot with proper advice, then Mr Elliot would have sought and purchased cover for the value of at least $900,000.[79]

    - Second, the respondent failed to advise ASA to nominate an indemnity period of at least 24 months, rather than 6 months.[80] This was particularly relevant where there was an obvious risk of having inadequate cover.[81] It was held that a competent insurance broker would have recommended, or at least given advice or questioned, an extension of indemnity period to 24 months given the complications and delays associated with rebuilding the factory, obtaining interstate products and then resuming production to pre-occurrence levels.[82]

    - Third, the policy taken out in 2006 had a declared value for gross profit of $500,000 per annum. This amount was increased to $2 million in the 2007 policy, and stayed at this amount in the 2008 and 2009 policies.[83] In respect of the declared value, the court held that the respondent's advice fell short of what was required of a competent insurance broker. The court held that if the respondent had given appropriate advice, asked Mr Elliot appropriate questions to ascertain the relevant information to make informed recommendations, or put Mr Elliot in the position to make an informed estimate, the declared value would have been significantly in excess of $2 million.[84]

    - Fourth, the 2009 policy has a sub-limit of $100,000 for the additional increase in cost of working (**AICW**).[85] The court held that the respondent did not undertake or cause Mr Elliot to undertake the requisite inquiries and analysis to ascertain the appropriate sub-limit for the AICW. Had these inquiries been made, the court considered that it would have been made clear to the parties that a $100,000 sub-limit was inadequate.[86] The court considered that competent advice would have resulted in a sub-limit of at least $500,000.[87]

    - Finally, the sub-limit for claims preparation was for $15,000 in the 2009 policy. The court held, in line with expert evidence, that a competent insurance broker would have recommended a sub-limit for claims preparation fees of at least $100,000.[88]

- These extensions of cover under the Policy would have increased the premium payable, but Doyle J accepted that, had ASA been advised differently, they would have been prepared to pay the premiums necessary to obtain cover with a declared value for the factory of at least $900,000, a 24 month indemnity period with a declared value throughout that period of at least $6 million, a sub-limit of at least $500,000 for AICW and a sub-limit of at least $100,000 for claims preparation costs.[89]

- ASA also contended that Westcourt breached its contractual duty to exercise reasonable care and skill, and breached a specific term to ensure that ASA was 'fully insured'.[90]

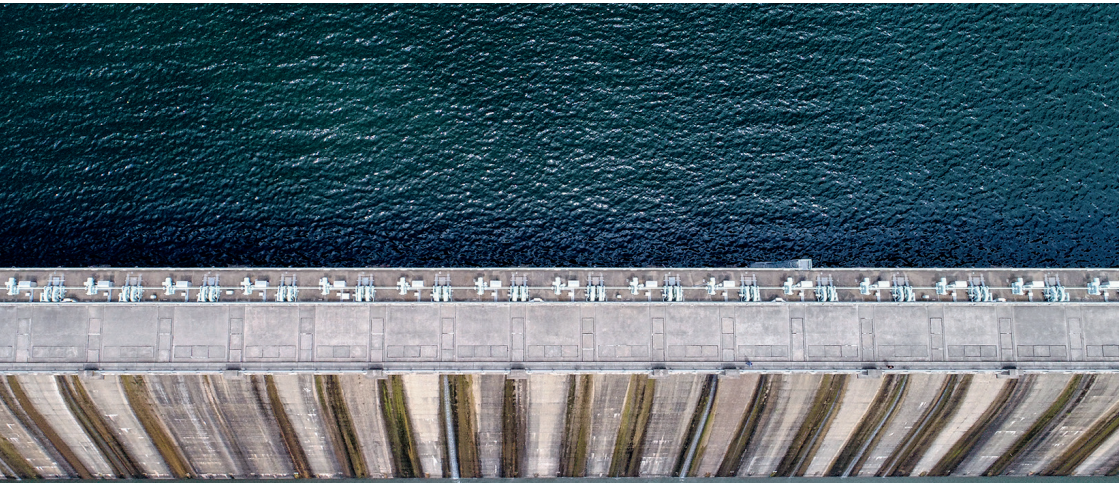
- Given the contractual duty had the same content as the general duty of care, his Honour upheld the claim in contract as in negligence.

- However, his Honour rejected any higher contractual duty to obtain "full insurance". It was argued that Mr Elliot verbally instructed Mr Olbrich on several occasions to the effect that ASA wanted their companies to be 'fully insured against any and all potential risks and losses'.[91] Doyle J held that the oral evidence may have expressed a desire to be 'fully insured' in the sense of adequate and appropriate cover under the Policy but that such a statement was 'exaggeration'.[92] His Honour's view was that such statements would have merely reinforced and informed the content of the general duty to ensure adequate and appropriate cover, rather than establish a higher contractual duty of full insurance.[93]

Result

ASA was entitled to recover damages in the amount of $3.2 million, being the additional amount of insurance proceeds ASA would have received had the Respondent not breached their duty owed to the insureds.[94]

89 *Adelaide Pools* [695], [807], [825]-[826], [836]-[837], [857].
90 *Adelaide Pools* [597].
91 *Adelaide Pools* [663].
92 *Adelaide Pools* [666].
93 *Adelaide Pools* [667].
94 *Adelaide Pools* [1136].



CASE NOTE

AN ELECTED VUE ON NON-DISCLOSURE

***Allianz Australia Insurance Limited v Delor Vue Apartments CTS 39788* [2021] FCAFC 121**

SNAPSHOT

- An insurer who seeks to rely on section 28(3) of the Insurance Contracts Act 1984 (Cth) (**ICA**), after having promised not to do so, may have elected against exercising their rights under section 28, or waived their right to rely on the section, or be estopped from relying on the section.
- An insurer who resiles from an earlier promise not to rely on section 28(3) of the ICA may have breached the statutory duty of utmost good faith contained in section 13 of the ICA.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The operation of the common law doctrine of election in relation to insurance contracts.
- The interaction of the right to avoid a claim for non-disclosure contained in section 28(3) of the ICA and the general law doctrines of election, estoppel, and waiver.
- The content of the statutory duty of utmost good faith contained in section 13 of the ICA.

Facts

- Delor Vue Apartments CTS 39788 (**Delor**) is the body corporate for a complex of apartment buildings in far north Queensland. On 28 March 2017, the roof of the apartment buildings suffered significant damage during a cyclone. At the time of the cyclone, Delor had taken out a public liability and property damage insurance policy (the **Policy**) with Allianz Australia Insurance Ltd (**Allianz**). Shortly after the cyclone, Delor notified a claim under the Policy.
- On 9 May 2017, Allianz sent an email to Delor stating that, prior to the Policy being effected, Allianz was not informed of defects to the property despite these being clearly known to Delor. Nevertheless, the email confirmed that Allianz would indemnify Delor "despite the non-disclosure" (**May 2017 Email**).
- In the following 12 months, Allianz took steps to hold third parties responsible for building defects and undertook an assessment of the damage according to the terms of the Policy. This assessment required the cooperation of Delor and Allianz's unfettered access to the property.
- In May 2018, Allianz sought to resile from the representations it made in the May 2017 Email. Instead, it offered Delor a lump-sum settlement offer (**May 2018 Offer**). If the offer was not accepted within 21 days, Allianz stated that the offer would lapse and that Allianz's liability would be reduced to nil pursuant to section 28 of the ICA.
- Pursuant to section 28(3) of the ICA, if an insured fails to comply with a duty of disclosure, the liability of the insurer in respect of a claim is reduced to the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred.

Analysis by the Court

At first instance in the Federal Court, Allsop CJ found that Allianz was unable to rely on section 28 of ICA to reduce its liability to nil. His Honour held that Allianz:

- was estopped from resiling from its representation in the May 2017 Email that indemnity would be provided;
- had waived its right to rely on section 28(3) by confirming to Delor in the May 2017 Email that it would be indemnified under the policy; and
- had failed to comply with its duty under section 13 of the ICA to act with the utmost good faith by attempting to resile from the representation in the May 2017 Email and by seeking to rely on Delor's non-disclosure.[95]

Allianz appealed against all three findings.

The Full Court of the Federal Court was split on the issues of election, estoppel, waiver, and good faith. By majority, McKerracher and Colvin JJ dismissed the appeal based on their treatment of these issues. In dissent, Derrington J would have allowed the appeal.

As to election

- At first instance, Delor argued that Allianz made a binding election by the May 2017 Email which prevented it from relying on section 28(3) of the ICA. Allsop CJ rejected this contention.[96] On appeal, however, the majority found that Allianz had, in fact, made a binding election not to rely on section 28(3).
- The majority took the view that the common law doctrine of election applies whenever a party is required by law to make a binding choice between two alternatives.[97] In relation to insurance contracts, the majority held that insurers are required by law to elect between disclaiming any liability under the policy and seeking to rely upon the rights conferred by the policy.[98] The obligation to make this choice arises when the insurer becomes aware of the relevant facts.[99]
- It was not in dispute that Allianz was aware of the relevant facts (the non-disclosure issue) at the time of the May 2017 Email. By sending the May 2017 Email, exercising rights of subrogation and entering the property for the purpose of adjusting loss under the Policy, Allianz had elected not to rely on section 28(3) to reduce its liability to nil.[100]
- In dissent, Derrington J took the view that the *"right"* conferred by section 28(3) was incapable of founding an election, since it did not empower insurers to alter the contractual relationship between themselves and the insured.[101] By continuing to act in accordance with the Policy, Allianz could not therefore be said to have made an election.

95 *Delor Vue Apartments CTS 39788 v Allianz Australia Insurance Ltd (No 2)* [2020] FCA 588, (2020) 379 ALR 117, 194 [351] ('*Delor Vue First Instance Decision*').
96 *Delor First Instance Decision* [317].
97 *Allianz Australia Insurance Limited v Delor Vue Apartments CTS 39788* [2021] FCAFC 121, [118] ('*Allianz v Delor Appeal*').
98 *Allianz v Delor Appeal* [118].
99 *Allianz v Delor Appeal* [119].
100 *Allianz v Delor Appeal* [133]–[137].
101 *Allianz v Delor Appeal* [550]–[559].

As to estoppel

- Allianz argued that Allsop CJ erred in finding that Allianz was estopped from resiling from the representation it made in the May 2017 Email. In particular, Allianz claimed that Delor had failed to establish that it had suffered detriment in reliance on the representation in the May 2017 Email.

- These arguments were rejected by the majority, who held that the nature of reliance itself can *"manifest the detriment"* and that it is not necessary to prove a counterfactual.[102] The majority upheld Allsop CJ's finding that there was detriment. Delor lost the opportunity to act for itself and sue Allianz because the parties conducted themselves on an entirely different basis; Delor allowed Allianz to pursue investigations, undertake repairs and look to the developer and builder to recover costs.[103] This was sufficient for Allianz to be estopped from resiling from the representation in the May 2017 Email.

- In dissent, Derrington J considered that the estoppel claim could not succeed. This was because Delor's cause of action against Allianz was not lost. In addition, the outcome of the action was known in that Delor's non-disclosure entitled Allianz to reduce its liability to nil under section 28. The result of the action would not have been different had it been commenced earlier.[104]

As to waiver

- The majority refrained from detailed consideration of the waiver doctrine, but confirmed that waiver could exist beyond election and estoppel.[105] The majority concluded that, if election did not apply, Allsop CJ's finding that Allianz had waived its right to rely on section 28(3) was not in error.[106]

- In dissent, Derrington J doubted the existence of a separate principle of waiver, distinct from the doctrines of election and estoppel; his Honour doubted that there was a waiver doctrine pursuant to which contractual rights are lost because a party adopts inconsistent positions in relation to them in circumstances which do not amount to an election.[107]

As to good faith

- Allianz argued that it could not have breached its statutory duty of good faith, since the primary judge found that Allianz had, at least initially, been entitled to rely on section 28(3) of the ICA. The majority rejected this argument, finding that Allianz's conduct had to be assessed at the time it occurred, without the benefit of hindsight.[108] Allianz did not otherwise seek to challenge Allsop CJ's finding that Allianz had breached section 13 of the ICA (by denying liability in the May 2018 Offer after having acted consistently with the representations made in the May 2017 Email for more than 12 months).[109]

- Derrington J dissented, finding that it was *"difficult to identify the gravamen of Allianz's conduct which was characterised as offending the duty of utmost good faith"*.[110] In issuing the May 2018 Offer, his Honour considered that Allianz had done nothing more than offer *"to pay a large gratuitous amount in respect of a liability which did not exist"*.[111] The conditioning of this offer on acceptance within 21 days could not, in the circumstances, be said to contravene commercial standards of decency and fairness.[112]

Result

The Full Court of the Federal Court, by majority, upheld the decision of the primary judge that Allianz was not able to rely on section 28(3) of the ICA to reduce its liability to nil. According to the majority, Allianz was not so able to rely due to election (or failing election, waiver), by estoppel, and because Allianz had breached its statutory duty of utmost good faith.

[102] *Allianz v Delor Appeal* [221].
[103] *Allianz v Delor Appeal* [206]–[212].
[104] *Allianz v Delor Appeal* [463].
[105] *Allianz v Delor Appeal* [236]–[238].
[106] *Allianz v Delor Appeal* [239]–[245].
[107] *Allianz v Delor Appeal* [538], [540].
[108] *Allianz v Delor Appeal* [248]–[249].
[109] *Allianz v Delor Appeal* [252].
[110] *Allianz v Delor Appeal* [572].
[111] *Allianz v Delor Appeal* [577].
[112] *Allianz v Delor Appeal* [599].

CASE NOTE

ONE TO SPECIFICALLY NOTE

***Insurance Australia Ltd trading as CGU Insurance v MOS Beverages Pty Ltd* [2021] FCAFC 165**

SNAPSHOT

- A third party beneficiary to a policy may recover directly from the insurer under an
- "interest of other parties" type of clause provided that they have an insurable interest which has been sufficiently noted in the records of the contracting insured.
- The courts have taken a broad and flexible approach to determining whether an insurable interest is sufficiently noted. However, what is required in each case depends on the nature of the policyholder's business and the language of the relevant policy.

[113] *Insurance Australia Ltd trading as CGU Insurance v MOS Beverages Pty Ltd* [2021] FCAFC 165, [1] ('*Insurance Australia v MOS Beverages*').
[114] *Insurance Australia v MOS Beverages* [6].
[115] *Insurance Australia v MOS Beverages* [7].
[116] *Insurance Australia v MOS Beverages* [5].
[117] *Insurance Australia v MOS Beverages* [15].
[118] *MOS Beverages Pty Ltd v Insurance Australia Ltd trading as CGU Insurance* [2020] FCA 1716, [36] ('*MOS Beverages v Insurance Australia*').
[119] *MOS Beverages v Insurance Australia* [36]. For the relevant text of the Property Endorsement, see *Insurance Australia v MOS Beverages* [20].
[120] *MOS Beverages v Insurance Australia* [38]. Those records included Admiral's email to MOS Beverages providing quotes for services, Admiral's letter providing acceptance of bonded goods on behalf of MOS Beverages, a sublease agreement with MOS Beverages, invoices and statement of accounts from Admiral to MOS Beverages, and import records for MOS Beverages' goods delivered to Admiral: see *Insurance Australia v MOS Beverages No 2* [9]-[13].
[121] *Mos Beverages v Insurance Australia* [39].
[122] *Mos Beverages v Insurance Australia* [44].
[123] *See Insurance Australia v MOS Beverages* [55]-[180] (Derrington J).

INSURANCE ISSUES CONSIDERED BY THE COURT

- On the proper construction of the policy, is a third party "owner" of insured goods entitled to recover from the insurer pursuant to section 48 of the *Insurance Contracts Act 1984* (Cth)?
- If so, what satisfied the requirement of being *"specifically noted in the records of the Insured"* contained in the *"Interests of Other Parties"* clause in the policy?

Facts

- MOS Beverages Pty Ltd (**MOS**), an importer of beverages, stored its imported goods at a warehouse operated by Admiral International Pty Ltd (**Admiral**).[113] In 2018, a fire at Admiral's warehouse destroyed some of the goods that MOS had stored there.[114] MOS had not obtained its own insurance in relation to the goods destroyed.[115] However, Admiral had entered into an Industrial Special Risks Insurance Policy with CGU Insurance (**CGU**) that was current at the time of the fire (**the Policy**).[116]
- MOS did not contend that it was an *"Insured"* under the Policy.[117] Instead, MOS argued that it had a right to recover directly from CGU under section 48(1) of the ICA. CGU declined indemnity. MOS commenced proceedings.
- The *"Interests of Other Parties"* clause in the Policy (**the IOP Clause**) relevantly stated:

  > *The insurable interest of only those lessors, financiers, trustees, mortgagees, owners and all other parties specifically noted in the records of the Insured shall be automatically included without notification or specification […].*

- The Policy also contained an endorsement extending coverage to customer goods and amending the definition of the "Property Insured" (**Property Endorsement**).

Analysis by the Court

In the Federal Court, at first instance, Allsop CJ held that:

- The IOP Clause extended protection to Admiral's customers "*by ensuring that they ha[d] a direct claim to indemnity from CGU"* if the requirements in the clause were met.[118] In addition, the effect of the Property Endorsement was that the Policy insured any property for which Admiral was responsible (including as a bailee in possession) to its full value, including any goods of Admiral's customers that were *"not otherwise insured"*.[119]
- MOS' insurable interest had been *"specifically noted"* for the purposes of the IOP Clause because Admiral's records identified MOS *"in the context of it being a customer whose goods are stored at the premises"*.[120] For the purpose of the IOP Clause, an insurable interest did not need to be recorded in a way that expressly related it to the Policy; a flexible approach was warranted considering the nature of the clause.[121]
- MOS was therefore entitled to indemnity, relying on section 48(1) of the ICA, as a *"third party beneficiary"*.[122]

In the Full Court of the Federal Court, Besanko and McKerracher JJ dismissed the appeal. In dissent, Derrington J held that the appeal should be allowed.[123] This case note focuses on the majority's reasoning.

Are the words "owners" and "all other parties" limited to the class defined by the preceding words "lessors, financiers, trustees, mortgagees"?

- CGU's key argument was that MOS did not fall within the class *"lessors, financiers, trustees, mortgagees, owners and all other parties"* in the IOP Clause. The general words *"owners"* and *"all other parties"* must be read, CGU claimed, with regard to the specific preceding categories of *"lessors, financiers, trustees, mortgagees"* — a class which, CGU argued, did not apply to MOS.[124] CGU claimed that absurd consequences would arise from MOS' proposed construction of the IOP Clause, such as that a third party services provider (e.g. Telstra) would be entitled to cover if its property were damaged at the warehouse premises.[125]
- The majority rejected CGU's proposed limitation as *"ambiguous and uncertain"*.[126]
- In contrast, Derrington J accepted that CGU's proposed construction would appropriately restrict an otherwise open-ended and uncommercial extension to cover.[127]

What degree of noting is required by the words "specifically noted"?

- CGU argued that MOS' insurable interest in the goods destroyed was not *"specifically noted"* in Admiral's records for the purpose of the IOP Clause. In this regard, CGU relied on *Maxitherm Boilers Pty Ltd v Pacific Dunlop Ltd* [1998] 4 VR 559 (**Pacific Dunlop**).[128]
- The majority disagreed. It upheld the finding that both MOS and its insurable interest had been sufficiently noted in Admiral's records.[129] The majority distinguished *Pacific Dunlop* on the basis that the clause in that case required the insurable interest to be *"more specifically noted"*.[130] The majority also noted the provisional nature of the reasoning in *Pacific Dunlop* that CGU had cited.[131] The majority accepted that *"mere mention"* of MOS in Admiral's records was not enough; but it concluded that there was *"a good deal more than that in this case"*.[132] In addition, the majority agreed with the primary judge's view that the extended cover for third parties provided by the IOP Clause removed the need for any formal record or *"activating process"*; if the parties had contemplated maintaining a register of interests, they could have indicated such a requirement.[133]
- In dissent (and having found that there was no need to resolve this question), Derrington J observed that it would likely suffice if a third party was noted "*in some specific manner – such as in a lease, mortgage, [or] hire-purchase agreement"*, while the mere mention of the third party in a letter kept in Admiral's records may not be sufficient.[134]

Result

By majority, the Full Federal Court dismissed CGU's appeal, affirming the primary judge's construction of the IOP Clause and the finding that MOS was a third party beneficiary who could recover directly from CGU pursuant to section 48 of the ICA.

[124] *MOS Beverages v Insurance Australia* [36].
[125] *MOS Beverages v Insurance Australia* [37]-[41].
[126] *MOS Beverages v Insurance Australia* [42].
[127] *MOS Beverages v Insurance Australia* [178].
[128] *MOS Beverages v Insurance Australia* [46].
[129] *MOS Beverages v Insurance Australia* [50].
[130] *MOS Beverages v Insurance Australia* [49] (emphasis added).
[131] *MOS Beverages v Insurance Australia* [51].
[132] *MOS Beverages v Insurance Australia* [50].
[133] *MOS Beverages v Insurance Australia* [52].
[134] *MOS Beverages v Insurance Australia* [147].

CASE NOTE

COSMETIC CORRESPONDENCE - WHEN IS NOTIFICATION UNDER SECTION 40(3) VALID?

***Darshn v Avant Insurance Limited* [2021] FCA 706**

SNAPSHOT

- Written notification under section 40(3) of the *Insurance Contracts Act 1984* (Cth) (**ICA**) must go beyond the *"incidental conveying of information"* to the insurer; there must be a *"recognisable correspondence"* between the facts and circumstances notified and the actual claim made.
- Where lawyers appointed by the insurer to act on behalf of the insured provide the requisite written notification under section 40(3), the insured will be considered to have provided notification to the insurer.

INSURANCE ISSUES CONSIDERED BY THE COURT

- When is there a *"recognisable correspondence"* between the notification of facts or circumstances and the actual claim brought for the purposes of section 40(3) of the ICA?
- Can notification of facts or circumstances be given in more than one document for the purpose of section 40(3)?
- Is notification by lawyers for the insured (appointed by the insurer) of facts or circumstances which may give rise to a claim sufficient for the purpose of section 40(3)?

Facts

- Dr Darshn, a cosmetic surgeon who performed operations at premises owned and occupied by The Cosmetic Institute Pty Ltd (**TCI**), held a professional indemnity insurance policy (the **Policy**) issued by Avant Insurance Limited (**Avant**) during the period 27 September 2011 to 30 June 2019.
- As is typical, under the Policy, Dr Darshn was entitled to indemnity with respect to any "*claim*", being defined as a *"demand for compensation or damages in relation to healthcare"* first made against Dr Darshn during the policy period and notified in writing to Avant during the policy period. To be entitled to indemnity under the Policy with respect to a claim, Dr Darshn needed to provide notice in writing to Avant of the claim, or the facts and circumstances that might give rise to the claim, as soon as practicable during the policy period.
- From 2017 to 2019, several claims were made by former patients of Dr Darshn with respect to cosmetic procedures that he had performed, namely, a Health Care Complaints Commission proceeding commenced by Ms M (**Ms M's Complaint**), a court proceeding commenced by Ms Scotford (**Scotford Proceeding**), and a further court proceeding commenced by Ms Summers-Hall (**Summers-Hall Proceeding**). Dr Darshn gave written notice to Avant of Ms M's Complaint, the Scotford Proceeding and the Summer-Hall Proceeding, and Avant accepted Dr Darshn's claim for indemnity with respect to each proceeding. For the Scotford Proceeding, Avant appointed Makinson d'Apice Lawyers (**MDL**) to act on Dr Darshn's behalf.
- In January 2019, Dr Darshn was served with a subpoena issued in a class action proceeding brought against TCI and various surgeons (**the TCI Proceeding**). Dr Darshn was not a defendant to the TCI Proceeding at the time. The TCI Proceeding was commenced in September 2017. Ms M and Ms Scotford fell within the representative class, although Ms Scotford subsequently opted out of the proceeding.

- In February and May 2019, MDL exchanged emails with Avant primarily in connection with the Scotford Proceeding (the **MDL Correspondence**). Through the MDL Correspondence, MDL indicated that there was substantial overlap and similarity of issues between the TCI Proceeding and the Scotford Proceeding; attached a copy of the judgment of Garling J in the TCI Proceeding which summarised the nature of the proceeding, the parties and so on; raised the possibility of Dr Darshn being joined to the TCI Proceeding; and noted that TCI and related defendants had been denied indemnity by their insurers and were in liquidation.

- In addition, in early 2019, Dr Darshn telephoned Avant's Medico-Legal Advice Service on two occasions to discuss the subpoena issued to him in the TCI Proceeding. Avant suggested Dr Darshn provide a copy of the subpoena to Avant in case Dr Darshn needed further advice about it; but Dr Darshn did not do so.

- In June 2020, Dr Darshn was added as a defendant to the TCI Proceeding.

- Dr Darshn sought indemnity from Avant in respect of the claim against him in the TCI Proceeding. Avant refused indemnification on the ground that no *"claim"* had been made against Dr Darshn during the policy period under the Policy. Dr Darshn then commenced proceedings against Avant seeking declaratory and other relief.[135]

- Dr Darshn relied, in particular, on section 40(3) of the ICA.

Analysis by the Court

In the Federal Court, Moshinsky J held that Dr Darshn was entitled to indemnity under the Policy with respect to the TCI Proceeding.

This decision was upheld on appeal by the Full Court (Jagot, Derrington and Colvin JJ).[135b]

- For the purposes of section 40(3) of the ICA, more is required *"than the incidental conveying of information"* through the provision of documents by the insured to the insurer. That said, the intentions of the insured are not relevant. The critical question is whether there is a *"recognisable correspondence"* between the notification and the claim ultimately made.[136]

- The Court noted:

> *[158] To the extent that the relevant facts were conveyed in several communications, I do not consider it necessary for the purposes of s 40(3) that notice be given in a single document… it is not necessary that the giver of the notice have an intention to give notice of facts that might give rise to a claim under s 40(3).*
>
> [emphasis in the original]

- Through the MDL Correspondence, Avant was notified of facts that might give rise to a claim against Dr Darshn, namely, potential claims by the plaintiffs and group members in the TCI Proceeding against Dr Darshn with respect to cosmetic surgery that he had performed.[137] There was a *"recognisable correspondence"* between the *"facts that might*

[135] Dr Darshn also claimed against his new professional indemnity insurer, Medical Insurance Australia Pty Ltd. The claim was resolved prior to the hearing.
[135b] *Avant Insurance Limited v Darshn* [2022] FCAFC 48.
[136] *Darshn v Avant Insurance Limited* [2021] FCA 706, [145]-[151].

give rise to a claim", as notified through the MDL Correspondence, and *"the claim, when [it was actually] made"*.[138] In particular, the MDL Correspondence noted that the claims in the Scotford Proceeding were substantially similar to those being advanced in the TCI Proceeding, and that there was a possibility, if not a likelihood, that Dr Darshn would be joined as a defendant to the TCI Proceeding.[139]

- The Full Court agreed and considered it could hardly be doubted that the MDL Correspondence put Avant squarely on notice that Dr Darshn was a potential, even likely, future defendant in the TCI Proceeding.[139b]

- The MDL Correspondence was sent by MDL to Avant on Dr Darshn's behalf.[140] On that basis, the MDL Correspondence constituted notice in writing by the insured, as required under section 40(3) of the ICA, with respect to the claim made against Dr Darshn in the TCI Proceeding.[141] It did not matter than notification was effected through more than one communication.[142] This meant that Avant could not deny indemnity to Dr Darshn with respect to the claim (because the only basis upon which Avant denied liability was that the claim was made after expiration of the policy period).

- The other bases upon which Dr Darshn alleged that he had validly notified Avant of the claim against him in the TCI Proceeding were all rejected. The notification of Ms M's Complaint was not sufficient, simply looking at the Policy, because the claim advanced in Ms M's Complaint was not the same complaint advanced on Ms M's behalf in the TCI Proceeding.[143] The notification of Ms M's Complaint and the claims in the Scotford Proceeding and the Summers-Hall Proceeding were not sufficient, either individually or together, for the purpose of section 40(3) of the ICA; for example, the claim in the Scotford Proceeding (the *"high-watermark"* of the three), while identifying systemic issues with Dr Darshn's procedures, did not assert that other patients had also suffered loss or damage.[144] And the oral notification by Dr Darshn of the subpoena issued to him in the TCI Proceeding was also not sufficient for the purpose of section 40(3) (or section 54) of the ICA; section 54 of the ICA could not be read in conjunction with section 40(3) so as to diminish the express requirement for written notification under section 40(3).[145]

Result

The Federal Court found that, pursuant to section 40(3) of the ICA, Avant could not deny indemnity to Dr Darshn with respect to the claim against him in the TCI Proceeding. Through the MDL Correspondence, Dr Darshn gave notice to Avant of facts which might give rise to claims against him in the TCI Proceeding.

These findings were upheld on appeal by the Full Court (Jagot, Derrington and Colvin JJ).

[137] *Darshn v Avant Insurance Limited* [157].
[138] *Darshn v Avant Insurance Limited* [159].
[139] *Darshn v Avant Insurance Limited* [157]-[160].
[139b] *Avant Insurance Limited v Darshn* [2022] FCAFC 48 at [53].
[140] *Darshn v Avant Insurance Limited* [169].
[141] *Darshn v Avant Insurance Limited* [170].
[142] *Darshn v Avant Insurance Limited* [158].
[143] *Darshn v Avant Insurance Limited* [138].
[144] *Darshn v Avant Insurance Limited* [180].
[145] *Darshn v Avant Insurance Limited* [199].

CASE NOTE

NOT QUITE AN OPAL AND SHUT CASE

***Liberty Mutual Insurance Company Australian Branch trading as Liberty Specialty Markets v Icon Co (NSW) Pty Ltd* [2021] FCAFC 126**

SNAPSHOT

- Where possible, a policy of insurance is to be given a business-like interpretation so that it works flexibly in line with its commercial object.
- A defined term in a policy of insurance, particularly one that establishes scope of cover, should be construed in light of the policy as a whole, especially any applicable exclusion clauses. Broader context can be more critical than the literal meaning of specific words.

INSURANCE ISSUES CONSIDERED BY THE COURT

- This case involved two questions regarding the meaning and effect of third party liability insurance policies issued to a construction company.
- The first question focussed on what the insured needed to do to notify the insurer of contracts in relation to which the insured required run off cover.
- The second question focussed on whether a constructed building fell within the definition of a "Product" such that cover for Product Liability was enlivened.

Facts

- Icon Co (NSW) Pty Ltd (**Icon**) was the builder of the Opal Tower, a 37 storey mixed residential and commercial development in Sydney Olympic Park. Icon had entered into a design and construct contract with respect to the development in October 2015 (**the Opal Contract**). Practical completion occurred in August 2018. The contract had a 12 month defects liability period.
- On 24 December 2018, serious defects manifested, including major cracks in the wall panels, slabs and hobs. This caused the evacuation of the building by residents.
- As at 28 February 2020, Icon had expended more than $31 million as a result of the defects. This included $17 million in rectification costs and $8.5 million in alternative accommodation costs.
- Icon sought indemnity for its loss under two separate policies, each being an annual third party liability policy: one issued by Liberty Mutual Insurance (**Liberty**) and one issued by QBE Underwriting Limited (**QBE**). Icon sought declaratory relief in the Federal Court regarding its claims for indemnity against Liberty and QBE.
- Icon's dispute with Liberty concerned whether cover under the Liberty policy had expired.[146] The critical provision in the Liberty policy was Condition 15 titled "Run Off" (the **Run Off Condition**) which provided that the policy would *"continue in full force and effect … for all incomplete contracts as at date of expiry until completion of those contracts including any testing and/or defects liability and/or maintenance periods"*,[147] provided that *"written instructions"* and a *"list of contracts requiring Run Off"* were provided by Icon (as well as the payment of an additional premium by Icon). The details of the Opal Contract had been notified to Liberty through Icon's broker on 2 November 2015.
- Icon's dispute with QBE concerned whether the Opal Tower was a *"Product"* under the QBE policy.[148] The insuring clause in the QBE policy effectively extended cover to "*liability for compensation in respect of and arising out of any Product or Completed Operations"*, with *"Product"* being defined as *"any product or thing (including containers packaging or labelling) sold, supplied, erected, repaired, altered, treated, installed, processed, grown, manufactured, assembled, tested, serviced, hired out, stored, transported or distributed by the Insured"*.

146 [2021] FCAFC [5] ('*Full Court Decision*').
147 Emphasis added.
148 *Full Court Decision* [5].

Analysis by the Court

- In the Federal Court, at first instance, the primary judge found that both insurers were liable to Icon. Justice Lee held that the Liberty policy, on its proper construction, did not respond to the claim,[149] but that Icon was still entitled to be indemnified because the policy should be rectified.[150] Regarding QBE, his Honour found that the Opal Tower fell within the definition of "Product" and was covered by the policy.[151]

- The Full Court of the Federal Court (Allsop CJ, Besanko and Middleton JJ), in a joint decision, upheld the primary judge's finding that Liberty was liable to indemnify Icon, but on the basis that the Liberty policy responded to the claim on its proper construction; rectification of the Liberty policy was not necessary. The Court also overturned the primary judge's decision regarding the QBE policy; Icon was not entitled to indemnity under the QBE policy.

Liberty Policy

- The Run Off Condition needed to be given a *"business-like construction"* so as *"to produce a reasonable and commercially efficacious result"*.[152] In particular, the condition needed to be construed *"flexibly"* [153] in terms of what was required from Icon to notify or instruct Liberty that a contract required Run Off cover. Notification immediately prior to expiry of the policy was not required,[154] nor was "*one set of instructions"*.[155] A notification prior to commencement of each annual policy was also possible (as Icon had alleged here).[156] Icon could instruct Liberty that Run Off cover was required by *"giving instructions … for individual contracts, contract by contract, at its choice"*.[157]

- Critically, the Run Off Condition was *"wide enough"* to be construed in this way *"comfortably and harmoniously with … the balance of the policy"*. [158] The fact that condition 8 indicated an *"annual turnover"* policy did not mean condition 15 could not function in a flexible and commercial way; the nature of the cover was *"annual turnover cover plus run off cover, upon instructions"*.[159]

- In determining whether cover for the Opal Contract had been notified to Liberty, it was important to disaggregate two questions: *"What does [the Run Off Condition] mean? And, if it was open to be engaged, was it engaged?"*[160] On the facts, the condition had been engaged through the notification by Icon's broker on 2 November 2015.

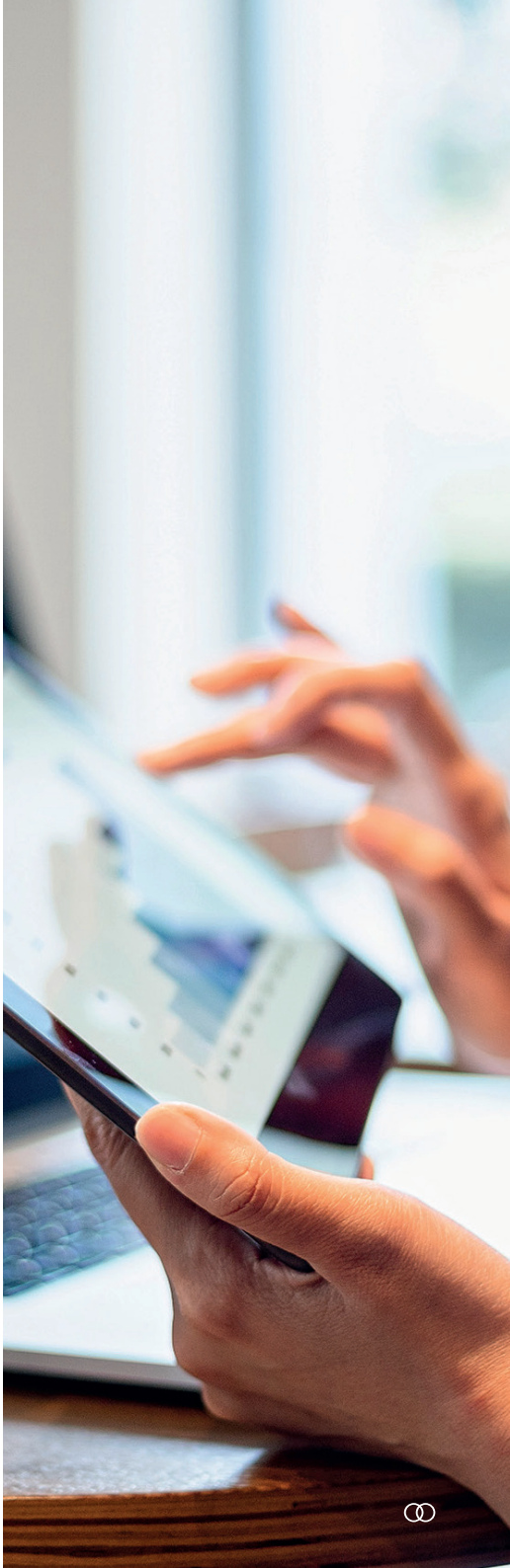
QBE Policy

- The ordinary meaning of *"product"* or *"thing"*, as well as certain words in the definition of *"Product"* (such as *"erected"* and *"supplied"*), were broad enough to apply to the Opal Tower and its component parts.[161] However, ambiguity remained regarding the scope of the definition given that words such as *"built"* or *"constructed"*, which likely would have been used in a building and construction context, had been omitted. [162]

- Looking at the policy as a whole, particularly the exclusion clauses, the parties had used the terms *"Product"* and *"Completed Operations"* as separate concepts, each with its own scope of cover. Adopting the primary judge's broad definition of *"Product"* (so that it included a completed building) would erode that deliberate distinction.[163] Hence, *"Product"* did not include the Opal Tower; QBE was not liable under the policy.

Result

The Full Federal Court upheld Icon's cross-appeal and dismissed Liberty's appeal. With respect to the Liberty policy, the Court held that the Opal Contract had been adequately notified to Liberty and hence, liability arising during the defects liability period was covered by the Run Off Condition. As regards the QBE policy, the Court allowed QBE's appeal, finding that the Opal Tower and its components did not fall within the definition of *"Product",* thus not triggering the insuring clause.



[149] [2020] FCA 1493, [50]–[95] ('*First Instance Decision*').
[150] *First Instance Decision* [107] - [278].
[151] *First Instance Decision* [280] - [314].
[152] *Full Court Decision* [159].
[153] *Full Court Decision* [56].
[154] *Full Court Decision* [162].
[155] *Full Court Decision* [164].
[156] *Full Court Decision* [52]-[53].
[157] *Full Court Decision* [170].
[158] *Full Court Decision* [170].
[159] *Full Court Decision* [166].
[160] *Full Court Decision* [43].
[161] *Full Court Decision* [390].
[162] *Full Court Decision* [392].
[163] *Full Court Decision* [410].

CASE NOTE

CRASHING THE PRIVITY OF CONTRACT PARTY

***Trident General Insurance Co Limited v McNiece Bros Pty Ltd* (1988) 165 CLR 107**

SNAPSHOT

- Under the doctrine of privity of contract, only a person who is a party to a contract may sue on it – a third party to a contract cannot take advantage of the contract even if it is made for the third party's benefit.
- Notwithstanding this doctrine, in the context of insurance, in the 1980s a majority of the High Court of Australia allowed a third-party beneficiary (who was not a party to the relevant insurance contract) to sue on its own behalf. A third party in this instance is a person who is not a party to the contract although they may be mentioned in the terms of the contract.
- This decision relates to the law applicable before the *Insurance Contracts Act 1984* (Cth) (**ICA**) in Australia. If you are considering a similar issue in 2022 – look to section 48 of the ICA.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The issue was whether a third party, who was not a party to the insurance policy but fell within the class of persons expressed to be insured by the policy, could bring an action in its own name under the terms of the policy.

Facts

- McNiece Bros Pty Ltd (**McNiece**) was the principal contractor for construction work being carried out at the limestone crushing plant of Blue Circle Southern Cement Ltd (**Blue Circle**).
- Blue Circle had entered into a contract of insurance (**Policy**) with Trident. The policy insured contract works, liability to the public, and maintenance/defects liability. *"The Assure"* were defined as *"Blue Circle Southern Cement Limited, all its subsidiary, associated and related Companies, all Contractors and Sub-Contractors and/or Suppliers."*
- A crane driver under the direction of McNiece but employed by another firm became injured. The crane driver subsequently brought an action against McNiece and recovered from McNiece. McNiece sought indemnity from Trident for the amount of the judgment awarded. Trident denied liability on the basis that the doctrine of privity of contract meant that McNiece (who did not provide consideration for the Policy) could not bring an action based on a contract of insurance between Trident and Blue Circle.
- At first instance, the Supreme Court of New South Wales inferred an agency relationship between Blue Circle and McNiece and concluded that McNiece could sue under the Policy. The Court of Appeal upheld the outcome but on a different basis, namely, that commercial and social convenience, dictated by the circumstances of the case, compelled the Court to create an exception to the privity of contract doctrine.
- Trident appealed to the High Court and were unsuccessful.

Analysis by the High Court

- With a majority of 5-2, the High Court upheld the New South Wales Court of Appeal's decision and McNiece was entitled to make a claim under the Policy. The majority (Mason CJ, Wilson, Deane, Toohey and Gaudron JJ) gave four separate reasons.

- Brennan J and Dawson J (in dissent) observed the prejudice caused by the doctrine of privity but held that the circumstances of the case did not warrant an exception being created for a settled and fundamental doctrine of contract.

Majority decision

- The intention of the parties was a significant factor in the reasoning of three of the four majority judgments.

- Mason CJ and Wilson J found the state of the common law unsatisfactory with respect to third party beneficiaries, noting that *"the traditional rules…have been the subject of much criticism and of legislative erosion in the field of insurance contracts"*.[164] In their view, it was the role of the High Court to reconsider these rules where they operate unsatisfactorily and unjustly. At least in the context of this policy of insurance, the doctrine of privity of contract operated unjustly because it failed to give effect to the expressed intention of the parties, determined from the wording of the Policy, and the common intention of the parties, evident from their subsequent conduct and the way they ordered their affairs:

> *"It stands to reason that many sub-contractors will assume that such an insurance is an effective indemnity in their favour and that they will refrain from making their own arrangements for insurance on that footing. That, it seems, is what happened in the present case."* [165]

- Toohey J also held that it was necessary to change the common law and create an exception to the doctrine of privity of contract, however, he more expressly confined his comments to public liability indemnity policies. His Honour was comfortable in altering the common law on the basis that the law was *"not so well entrenched as to be incapable of change"*.[166] In particular, it was not an affront to the principles of contract that an exception to the privity doctrine might arise where it is to give effect to the intention of the parties. His Honour observed that the intention of the parties was evident from both the wording of the Policy, which made it clear that the benefit should extend to sub-contractors, and the conduct of both Blue Circle and McNiece, who had arranged their business with the belief that the Policy was to be a basis of insurance in respect of the work being carried out by contractors and sub-contractors alike. In Toohey J's view, the exception should be confined to circumstances where:

> *"an insurer issues a liability insurance policy, identifying the assured in terms that evidence an intention on the part of both insurer and assured that the policy will indemnify as well those with whom the assured contracts for the purpose of the venture covered by the policy, and it is reasonable to expect that such a contractor may order its affairs by reference to the existence of the policy".* [167]

[164] *Trident General Insurance Co Limited v McNiece Bros Pty Ltd* (1988) 165 CLR 107, [31] (Mason CJ and Wilson J) ('*Trident v McNiece*')
[165] *Trident v McNiece* [33] (Mason CJ and Wilson J).
[166] *Trident v McNiece* [18] (Toohey J).
[167] *Trident v McNiece* [27] (Toohey J).

- Deane J dealt with the issue on the basis that a trust attached to the benefit of the Policy. Whether contractual rights are held on trust depends on the intention of the parties. For Deane J, the Policy made clear that McNiece was an intended beneficiary of the 'trust':

> *"In the case of a policy of liability insurance under which the insurer agrees to indemnify both a party to the contract and others, there is no reason in principle or in common sense why the party to the contract should not hold the benefit of the insurer's promise to indemnify him on his own behalf and the benefit of the promise to indemnify others respectively upon trust for those others. Where the benefit of a contractual promise is held by the promisee as trustee for another, an action for enforcement of the promise or damages for its breach can be brought by the trustee. In such an action, the trustee can recover, on behalf of the beneficiary, the damages sustained by the beneficiary by reason of breach. If the trustee of the promise declines to institute such proceedings, the beneficiary can bring proceedings against the promisor in his own name, joining the trustee as defendant…*
>
> *An intention to create a trust of the benefit of a contractual promise can be evidenced and/or carried into effect by the contract itself or by action of the promisee aliunde."*[168]

- Gaudron J approached the issue on the basis of unjust enrichment. Her Honour reasoned that a promisor (Trident) who has accepted consideration for a promise to benefit a third party (McNiece) is unjustly enriched at the expense of the third party to the extent that the promise is unfulfilled.

Result

The practical implication of the decision is that a third party to an insurance contract may bring an action on the contract if it is clear the parties intended that the non-party should benefit. At present, this exception has only been applied to insurance contracts.[169]

Note – A statutory exception to the privity of contract doctrine exists. Section 48 of the ICA permits a third-party beneficiary under a contract of general insurance to recover from the insurer, even though the third-party beneficiary is not a party to the contract. Section 48 of the ICA was recognised by the High Court in Trident v McNiece as an exception to the privity of contract doctrine,[170] but it could not be relied on by McNiece because the case arose before the ICA came into force and the section did not apply retrospectively.[171]

[168] *Trident v McNiece* [11], [12] (Deane J).
[169] *DIF III – Global Co-Investment Fund LP v Babcock & Brown International Pty Limited* [2019] NSWSC 527, [195] (Ball J).
[170] *Trident v McNiece* [20] (Toohey J).
[171] *Trident v McNiece* [5] (Brennan J).

CASE NOTE

SECTION 54 GOES TO THE HIGH COURT AND INSUREDS RETURN WITH A LIFELINE

***FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641**

SNAPSHOT

- This decision considers how section 54 of the *Insurance Contracts Act 1984* (Cth) (Section 54) applies to the late notification of insurance claims. This was a critical decision for claims made policies in Australia.
- In this decision, the High Court held that Section 54 of the *Insurance Contracts Act 1984* (Cth) precluded an insurer from rejecting a claim (made after expiry of the policy period) if the only reason for rejecting the claim was the failure by the insured to notify the insurer of the potential claim during the policy period.

INSURANCE ISSUES CONSIDERED BY THE COURT

- This case considers how section 54 of the ICA applies to the late notification of claims under "claims-made" policies.

Facts

- For the period 20 June 1991 to 20 June 1992, Australian Hospital Care Pty Ltd (**AHC**) was covered under a professional indemnity insurance policy (the Policy) issued by FAI General Insurance (**FAI**) for claims first made and notified during the policy period. It also contained conditions providing that, if the Insured became aware of an occurrence which may subsequently give rise to a claim under the Policy and gave notice of that occurrence during the policy period then any subsequent claim arising out of the occurrence will be covered under the Policy (**Deeming Provision**).
- During the policy period, a former patient of AHC wrote to AHC indicating that he was considering commencing proceedings against AHC for negligent treatment. AHC did not notify FAI of this occurrence during the policy period (so as to engage the Deeming Provision).
- In December 1992, the former patient commenced proceedings against AHC. By this time, the Policy had expired and it had been replaced with a new policy underwritten by a different insurer. AHC subsequently made a claim against FAI.
- FAI argued that it was not obliged to indemnify AHC because the patient's claim was not first made during the policy period (so as to enliven the insuring clause on its terms) and AHC did not notify of FAI of the potential claim during the policy period (so as to engage the Deeming Provision). AHC relied on section 54 of the ICA to remedy its failure to notify; it claimed that, by reason of section 54, FAI could not refuse indemnity.

Analysis by the Court

- A majority of the High Court (McHugh, Gummow, Kirby and Hayne JJ, Gleeson CJ dissenting) held that, by reason of section 54 of the ICA, FAI could not refuse indemnity simply because AHC had failed to notify FAI of the potential claim during the policy period. Below is a summary of the majority's reason, in particular those of McHugh, Gummow and Hayne JJ. (Kirby J wrote separate reasons.)

- AHC's receipt, during the policy period, of the patient's letter contemplating proceedings was an *"occurrence"* contemplated by the Deeming Provision. Therefore, if AHC had notified FAI of the occurrence, the Policy (subject to its terms and conditions) would have covered any claim arising out of it.[172]

- An *"omission"*, for the purpose of section 54 of the ICA, includes a failure by the insured to "exercise a right, choice or liberty which the insured enjoys under the policy"; it is not limited to a failure by the insured to do something it was obliged to do.[173] AHC's failure to notify FAI of receipt of the patient's letter would amount to an *"omission"*.[174]

- FAI argued that section 54 did not apply because the section was only enlivened if the *"effect"* of a policy was that an insurer could refuse a claim based on an *"act"* of the insured or some other person. FAI claimed that it was not refusing indemnity because of AHC's failure to give notice of an occurrence, but *"because the policy never afforded indemnity against claims made by third parties outside the period of cover"*.[175] To put it plainly, FAI argued that section 54 could not apply because the claim was made after conclusion of the policy period.

- McHugh, Gummow and Hayne JJ rejected this argument on the basis that the period of cover provided in the Policy did not *"mark out the duration of the contractual rights and duties of the parties";* it merely provided *"temporal limits"* for some of the terms in the Policy.[176] The parties continued "*to be entitled to require performance of obligations under [the Policy]"*, after conclusion of the policy period, in accordance with the terms of the Policy, including the Deeming Provision.[177]

- McHugh, Gummow and Hayne JJ also rejected FAI's argument that section 54 was limited in its operation to particular forms of insurance, such as a policy where the insurer was entitled to *"refuse"* a claim (to use the wording of section 54) by reason of a condition or exclusion. One has to look to *"the substantive effect of the contract … as a whole"*.[178]

- The claim made by AHC under the Policy was *"for indemnity against liability for an occurrence of which [AHC] first became aware during the period of cover"*. The substantive effect of the Policy was that AHC was entitled to indemnity for this claim unless (as it did) it failed to notify FIA of the potential claim during the policy period; this was the only reason why FAI could refuse to pay the claim. Hence, section 54 was engaged; FAI could not refuse to pay the claim.[179]

- If an insurer's interests would be prejudiced by the operation of section 54, the insurer's liability in respect of the claim is only reduced *"'by the amount that fairly represents the extent to which those interests were prejudiced"*.[180] However, no prejudice to FAI's interests was suggested.[181]

Result

The High Court, by majority, held that section 54 of the ICA precluded FAI from refusing AHC's claim in circumstances where AHC would have been entitled to indemnity for the claim had it given notice of the potential for the claim during the policy period (in accordance with the Deeming Provision).

[172] (2001) 204 CLR 641, 664 [57] (Kirby J).

[173] *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd 652* [22] (Mc Hugh, Gummow and Hayne JJ) (quoting *Antico v Health Fielding Australia Pty Ltd* (1997) 188 CLR 652, 659).

[174] For Gleeson CJ, in dissent, AHC had made a choice not to notify FIA of the potential claim; it had made a choice "to rely on the cover given by the second policy". His Honour was not persuaded that "the exercise of such a choice was intended by the legislature to be regarded as an act or omission to which s 54 applies": FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd 650 [12].

[175] *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* 653 [26] (McHugh, Gummow and Hayne JJ) ('*FAI Insurance v Australian Hospital Care*').

[176] *FAI Insurance v Australian Hospital Care* [26] (McHugh, Gummow and Hayne JJ).

[177] *FAI Insurance v Australian Hospital Care* 654 [27] (McHugh, Gummow and Hayne JJ).

[178] *FAI Insurance v Australian Hospital Care* 656 [32] (McHugh, Gummow and Hayne JJ).

[179] *FAI Insurance v Australian Hospital Care* 660 [46] (McHugh, Gummow and Hayne JJ). See also at [59]-[62] (Kirby J) ("no more than the application to the policy of the plain language of [section 54] of the ICA").

[180] *FAI Insurance v Australian Hospital Care* 652 [21] (McHugh, Gummow and Hayne JJ).

[181] *FAI Insurance v Australian Hospital Care* 660 [46] (McHugh, Gummow and Hayne JJ).

CASE NOTE

D(&)O NOT ASSUME AN INSOLVENCY EXCLUSION WILL APPLY

AIG Australia Limited v Kaboko Mining Limited **[2019] FCAFC 96**

SNAPSHOT

- Insurers should not assume that an insolvency exclusion in a directors and officer's policy automatically applies to claims for indemnity brought by former directors of an insolvent company.
- Policy holders should closely consider the wording of an insolvency exclusions in D&O policies.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether an insolvency exclusion precluded cover under a directors and officers liability policy for claims made by a company (now the subject of a deed of company arrangement) against its former directors and officers?

Facts

- The relevant insurance policy (**Policy**) was issued by AIG Australia Limited (**AIG**) to cover directors and officers of Kaboko Mining Limited (**Kaboko**).
- In 2012, Kaboko entered into agreements with Noble Resources Limited (**Noble**) for the sale of manganese ore (the **Agreements**). Kaboko agreed to sell manganese ore mined in Zambia to Noble, and Noble agreed to immediately advance US$10 million to Kaboko in two tranches, with specific amounts to be used only for specific mining operations. The advances were to be treated as provisional payment by Noble for the ore; the delivery of the ore to Noble was to be treated as a repayment of the advances by Kaboko.
- In 2014, Noble claimed that Kaboko was in default under the Agreements because, among other things, it had sold manganese to third parties without Noble's consent. Noble issued a demand for payment and a statutory demand (which was set aside in February 2015).
- On 26 January 2015, Kaboko was obliged to repay the first tranche of funds advanced by Noble under the Agreements. Noble demanded repayment, Kaboko was unable to repay, and Kaboko then entered receivership and eventually administration.
- In 2016, Kaboko (then the subject of a deed of company arrangement) commenced proceedings in the Federal Court against four of its former officers and directors (the **Former Officers**). Kaboko claimed that the Former Officers breached duties to act with due care and diligence in managing the affairs of the company and to act in good faith and in the best interests of the company. The breaches of duty were alleged to arise from the Former Officer's involvement in the sale of ore by Kaboko to third parties and by the Former Officer's failure to maintain proper financial records, use advanced funds as permitted, and ensure that Kaboko was registered as the holder of relevant mining interests. Kaboko's broad claim was that, if the above matters had not occurred, its commercial opportunity to develop its Zambian mines would have been realised and profits generated.
- The Former Officers made a claim for indemnity under the Policy. AIG asserted that it was not liable to indemnify them, due to an insolvency exclusion endorsed on the Policy (**the Insolvency Exclusion**). The Insolvency Exclusion stated:

> *"The Insurer shall not be liable under any Cover or Extension for any Loss in connection with any Claim arising out of, based upon or attributable to the actual or alleged insolvency of the Company or any actual or alleged liability of the Company to pay any or all of its debts as and when they fall due."*

- **Loss** was defined to mean an amount which the Insured is legally liable to pay resulting from a Claim made against Kaboko or a subsidiary or a Manager, including a claim in the Federal Court. The definition did not include the loss that might be identified in a Claim, but an amount for which there is a *legal liability to pay resulting from a Claim.*
- **Claim** was defined by reference to matters such as a written demand or proceeding, an investigation or an extradition proceeding. Critically, the definition was not expressed in terms of the act of bringing the Claim, or the reasons or motivations for the Claim.
- The operation of the Insolvency Exclusion was determined as a preliminary question by separate hearing in the Federal Court proceedings initiated by Kaboko against the Former Officers.

Analysis by the Court

In the Federal Court, the primary judge (McKerracher J) determined that the Insolvency Exclusion did not preclude cover under the policy for the claims made by Kaboko.[182] AIG appealed this decision to the Full Court of the Federal Court.

In dismissing the appeal, the Full Court of the Federal Court issued joint reasons considering the proper construction of the Insolvency Exclusion and its application to the facts. Below is a summary of the Court's reasons.

- The key question was how the *"specified insolvency link"* applied. That is to say, in order to trigger the Insolvency Exclusion, what needed to *"aris[e] out of"* or be *"based upon or attributable to…"* Koboko's actual or alleged insolvency or inability to pay its debts when due?[183]
- The Court rejected AIG's contention that it was sufficient if simply "*by reason of the circumstances that have led to the bringing of the claim, it can be said that the Claim arises out of, is based upon or is attributable to the actual or alleged insolvency of Kaboko or its inability to pay its debts when due".*[184]
- Instead, the *"subject matter of the Claim"* itself had to arise from, or be based on or attributable to, the actual or alleged insolvency of Kaboko or its inability to pay its debts when due.
- With respect to civil proceedings, such as those brought by Kaboko against the Former Officers, this meant the insolvency link had to be *"derived … from the acts, errors or omissions that are the subject of the proceedings and the associated loss that may become the Loss if the proceedings are successful".*[185]

[182] *Kaboko Mining Limited v Van Heerden* (No 3) [2018] FCA 2055.
[183] *AIG Australia Limited v Kaboko Mining Limited* [2019] FCAFC 96 [43] ('*Kaboko Appeal*').
[184] *Kaboko Appeal* [49]–[50].
[185] *Kaboko Appeal* [50] (emphasis added).

- That this was the proper construction of the Insolvency Exclusion flowed from the following factors among others: neither the definition of *"Claim"*, nor the exclusion itself *"direct[ed] attention to the reasons why the Claim was brought";*[186] the definition of *"Claim"* referred to demands and proceedings *"for a specified act, error or omission"*, thereby enforcing that it was the character of the Claim that was critical; [187] the Policy affords cover for Loss arising from *"Management Liability"*, the extent of cover not being defined by reference to the motivations that may lie behind bringing a claim;[188] and the words *"arising out of"* and *"based upon"* in the qualifying words *"indicate a focus upon the subject matter of the Claim".*[189]

- Applying the Insolvency Exclusion to the facts, Kaboko's claims against the Former Officers in Federal Court proceedings were not founded upon any allegation of insolvency. Each claim could be advanced irrespective of whether Kaboko was placed in administration and was not based upon insolvent trading.[190] The fact that particulars of the claims alleged that it was the breaches of duty by the Former Officers that gave rise to the loss of commercial opportunity (and subsequent insolvency) merely emphasised that it was the breaches of duty, and not the insolvency, that were the focus of the claims.[191]

- That said, if and to the extent that the Former Officers were found liable for the costs of the receivers and managers and the costs of the administrator, these would constitute *"a Loss that is in connection with a Claim of the kind described in the insolvency exception"*. This is because these losses would not have occurred if Kaboko had not been insolvent.[192] Hence, AIG would not be obliged to indemnify the Former Officers for these losses.

Result

The Full Federal Court dismissed AIG's appeal. The Court confirmed that the Insolvency Exclusion did not preclude cover under the Policy for the claims made by Kaboko, except to the extent that the Former Officers were found liable for the costs of the receivers and managers and the costs of the administrator.

[186] *Kaboko Appeal* [51], [53].
[187] *Kaboko Appeal* [52].
[188] *Kaboko Appeal* [54].
[189] *Kaboko Appeal* [56].
[190] *Kaboko Appeal* [58].
[191] *Kaboko Appeal* [62].
[192] *Kaboko Appeal* [60].

CASE NOTE

WHO'S ON FIRST, WHAT'S ON SECOND?

***Zhang v ROC Services (NSW) Pty Ltd; National Transport Insurance by its manager NTI Ltd v Zhang* (2016) 93 NSWLR 561**

SNAPSHOT

- A grammatically ambiguous exclusion clause in a policy of insurance will most likely be construed in line with the background to and commercial purpose of the policy. Punctuation may be ignored if it is used inconsistently or haphazardly.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The proper construction of an exclusion clause in a fleet motor insurance policy, in particular, whether punctuation should take greater precedence over context, contractual purpose and commercial common sense.

Facts

- Mr Zhang was unloading a stationary trailer and suffered injuries when a ramp attached to the trailer fell on top of him. The ramp fell because of a failed weld.
- Mr Zhang sued several defendants including: the driver of the truck, Mr Popovic; the company that employed driver, Interfreight (Aust) Pty Ltd; the registered owner of the trailer, Calabro Real Estate Pty Ltd; and the company which had installed a hydraulic ram supporting the ramp, ROC Services (NSW) Pty Ltd.
- Mr Zhang was granted leave to join National Transport Insurance (**NTI**), a joint venture insurer which had issued a fleet motor insurance policy in favour of the company that employed the driver (**the Policy**). Several defendants — including the driver, his employer at the time, and the owner of the trailer — also cross claimed against NTI seeking indemnity under the Policy (the **Cross Claimants**).
- NTI admitted that the Policy covered the risk, but denied liability relying on an exclusion clause in the Policy. The first paragraph of the exclusion clause relevantly stated:

  > *"We will not pay: for any liability for death or bodily injury arising out of or in any way connected with a defect in Your Motor Vehicle or in a Motor Vehicle, but in Queensland only if it causes loss of control of the vehicle whilst it is being driven…"*

- NTI claimed that the exclusion clause precluded liability because Mr Zhang's injuries were caused by a defect (being the failed weld) and had occurred in NSW. Mr Zhang and the Cross Claimants alleged that the clause did not exclude liability under the Policy because the accident occurred while the trailer was stationary and the exclusion only applied *"whilst [the trailer] [was] being driven".*

Analysis by the Court

In the Supreme Court of New South Wales, Adamson J held that the Cross Claimants were liable for Mr Zhang's injuries. The Court preferred the interpretation of the exclusion clause advanced by Mr Zhang and the Cross Claimants. Hence, NTI was effectively liable for Mr Zhang's injuries.[193]

On appeal, a majority of the Court of Appeal of the Supreme Court of New South Wales (Leeming JA and Sackville AJA, Macfarlan JA dissenting) upheld the construction of the exclusion clause adopted at first instance.[194] Below is a summary of the majority's reasons, for the most part expressed by Leeming JA.

- The first paragraph of the exclusion clause contained three distinct parts, being:
    - the operative exclusion: *"for any liability for death or bodily injury arising out of or in any way connected with a defect in Your Motor Vehicle or in a Motor Vehicle"*;
    - a qualification of the operative exclusion: *"but in Queensland only if it causes loss of control of the vehicle"*; and
    - a further qualification *"whilst it is being driven".*[195]
- The critical question was whether the final qualification applied only to the preceding qualification (as alleged by NTI) or whether it also applied to the operative exclusion (as alleged by Mr Zhang and the Cross Claimants).
- As a matter of grammar, each construction was feasible. *"It is common, but far from inevitable, for a clause to qualify the immediately preceding clause."* [196] A simple example — *"Let's go to the shop and buy that shirt while it's still open"* — demonstrates that a final clause does not always qualify the one immediately before it. With respect to the exclusion clause in the Policy, one could not conclude simply as a matter of grammar that the final clause necessarily qualified the second clause and not the first clause.[197]
- NTI submitted that the punctuation in the clause resolved any grammatical ambiguity, namely, the fact that there was a comma after *"Motor Vehicle"* but not before *"whilst"*. Punctation can be a useful aid in construction, but only if it has been used *"consciously and not haphazardly"*.[198] The use of commas in the exclusion clause was *"plainly wrong"* in parts. Hence, punctuation could not be relied upon to resolve any ambiguity.[199]
- The *"more natural reading of the words"* in the clause supported NTI's construction because it accorded with the *"more regular pattern of grammatical structure, whereby a qualifying clause qualifies that which immediately precedes it".* [200] However, because there was more than one legal meaning, it was permissible to look to the broader text, context and purpose of the Policy.[201]
- The statutory regime governing mandatory third-party motor insurance established that there was a *"special need in Queensland, and Queensland alone, for a policy which provided additional cover to address liability arising out of defects in motor vehicles".* That is to say, the statutory context suggested that the exclusion was meant to provide an extension of cover where an accident occurs in Queensland rather than an exclusion of cover where an accident occurs in a place other than Queensland.[202]

[193] *Zhang v Popovich* [2016] NSWSC 407
[194] An appeal by Mr Zhang on the question of the liability of ROC Services (NSW) Pty Ltd was also heard.
[195] *Zhang v ROC Services (NSW) Pty Ltd*; *National Transport Insurance by its manager NTI Ltd v Zhang* (2016) 93 NSWLR 561, [59] (Leeming JA) ('*Zhang v ROC*').
[196] *Zhang v ROC* [67] (Leeming JA).
[197] *Zhang v ROC* [67] (Leeming JA).
[198] *Zhang v ROC* [73] (Leeming JA).
[199] *Zhang v ROC* [74] (Leeming JA).
[200] *Zhang v ROC* [82] (Leeming JA). In dissent, Macfarlan JA found the punctuation to be persuasive, along with the fact that the primary judge's interpretation required additional words: ibid [4]-[5] (Macfarlan JA).
[201] *Zhang v ROC* [86] (Leeming JA).
[202] *Zhang v ROC* [117] (Leeming JA).

- Critically, the purpose of the Policy was to provide cover beyond compulsory third-party policies.[203] Clearly, one aim of the policy was to obtain cover for liability arising when the trailer was being loaded or unloaded, which is not ordinarily covered by compulsory third party insurance.[204] The construction adopted by the primary judge gave effect to this purpose.

- In addition, construing the Policy as a whole, even if the exclusion clause was limited to liability arising out of or connected with a defect in a motor vehicle whilst it was being driven, there was *"still work for the provision to perform".*[205]

- Ultimately, the exclusion clause was construed to *"avoid … the capricious result that stationary defects liability is excluded throughout Australia, except in Queensland where such liability is covered"*.[206] The exclusion applied to preclude NTI's liability only if the liability arose out of or was connected with a defect in a vehicle whilst the vehicle was being driven, and in the special case of Queensland, only if the defect caused loss of control of the vehicle.[207]

Result

Leeming JA and Sackville AJA (Macfarlan JA dissenting) dismissed NTI's appeal and upheld the primary judge's interpretation of the exclusion clause. The clause did not exclude NTI's liability to Mr Zhang because the exclusion only applied if the liability arose out of or was connected with a defect in a vehicle whilst the vehicle was being driven. Mr Zhang's injuries arose whilst the trailer was stationary. Hence, the exclusion did not apply.

[203] *Zhang v ROC* [126] (Leeming JA), [256] (Sackville AJA).
[204] *Zhang v ROC* [126] (Leeming JA).
[205] *Zhang v ROC* [258] (Sackville JA).
[206] *Zhang v ROC* [144] (Leeming JA).
[207] *Zhang v ROC* [144] (Leeming JA).

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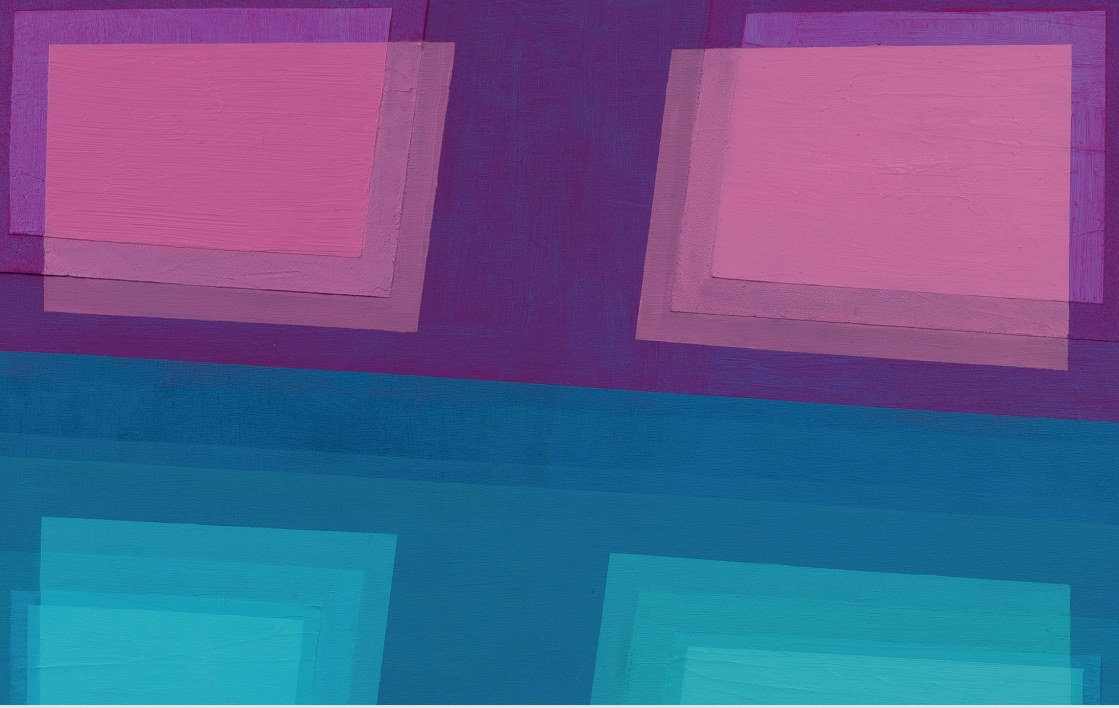

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