KING&WOOD MALLESONS
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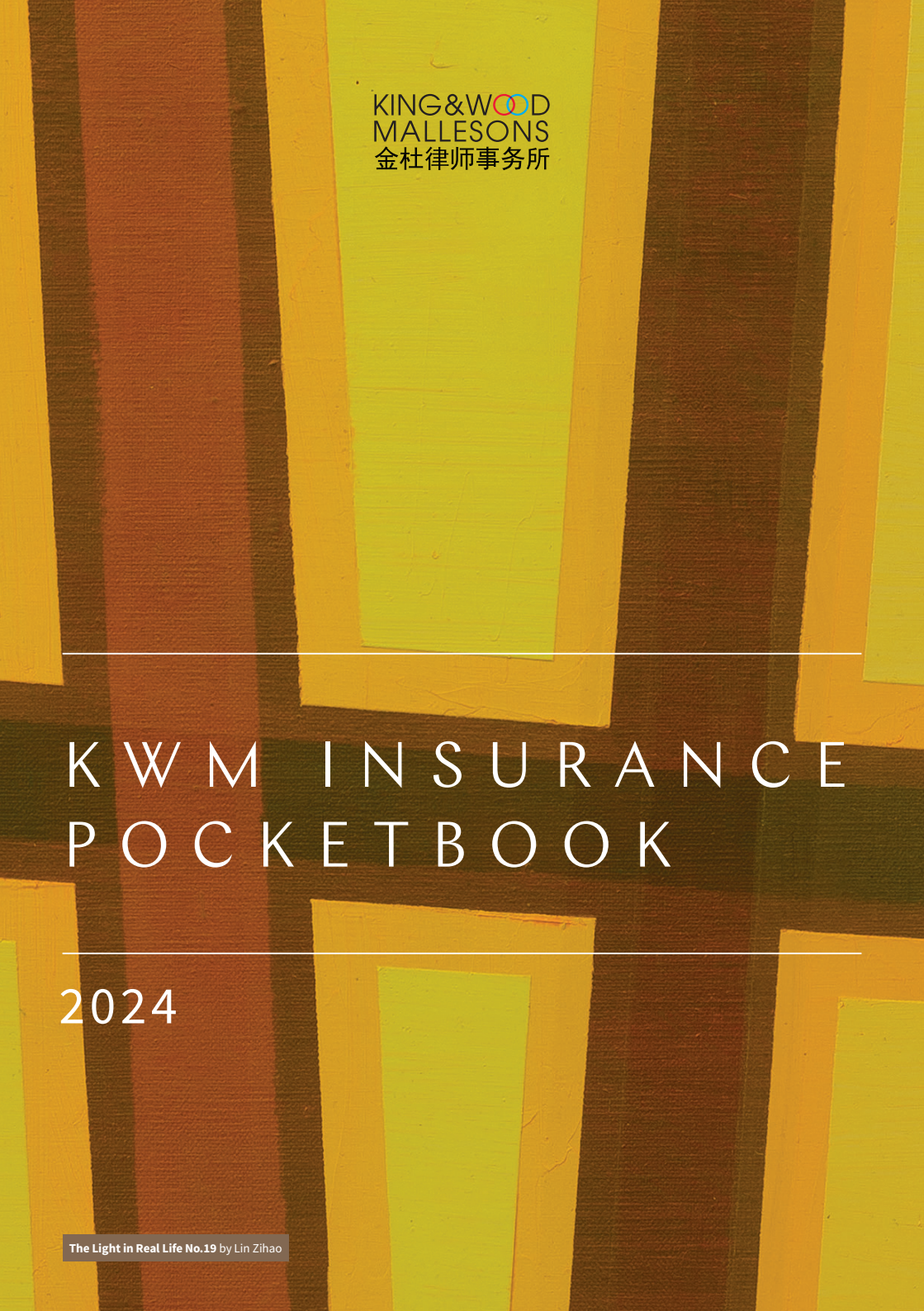
KWM INSURANCE POCKETBOOK

2024



The Light in Real Life No.19 by Lin Zihao

FOREWORD

The last 12 months has seen a period of swings and roundabouts for insurance. After several years of inconsistency and uncertainty, the market saw softening and renewed positivity in some areas, contrasted with a toughening judicial and regulatory approach in others.

In our fourth edition of the *Insurance Pocketbook*, King & Wood Mallesons shares some of our experience and insights into Australia's legislative and regulatory environment, along with a practical view on significant insurance claims and the broader insurance industry.

In this edition you will find:

- informed commentary from Partner Mandy Tsang and her team on trends they are observing in the market, and the impact of current reform (see articles at pages 6 and 12).
- for the first time, an article from Restructuring & Insolvency Partner Samantha Kinsey and her team on how a general insurer's exposure to contingent long tail liabilities can be managed through a scheme arrangement (see page 16).
- succinct case notes on significant decisions from the last year, as well as a spotlight on some classic Australian insurance cases.
- exclusive interviews with:
  - Anne Knight (General Counsel for the Insurance Council of Australia).
  - Christine Cupitt (CEO at the Council of Australian Life Insurers (CALI)).
  - Steven Loveday (Managing Principal, Financial and Professional Liability (FINPRO) Practice at Marsh.

Our Insurance Team have a broad base of experience, and our *Insurance Pocketbook* is the product of combined efforts from our offices, with notable contributions from several industry experts. We are grateful to all of those who were involved in the production of this edition, and also to our clients who have been so encouraging of the publication.

If anything in this publication is relevant to your business – please feel free to contact a member of our team to discuss it further.

We hope that you enjoy this edition of the *Insurance Pocketbook*.

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CONTENTS

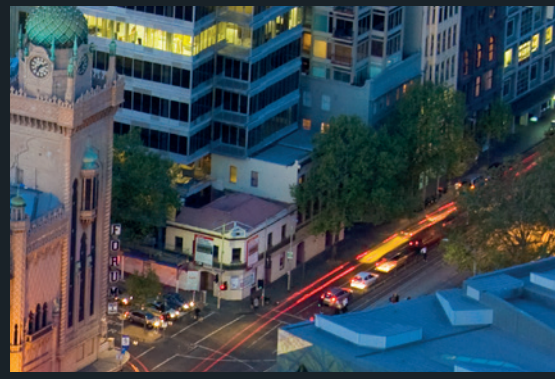
ARTICLES & LEADERS

INTERVIEWS

CASE NOTES

Recent Cases

Classic Cases



FILINGS, FINDINGS AND FINALLY, FAR – REGULATORS' CONTINUED FOCUS ON INSURANCE

Introduction

The insurance industry remains in regulators' sights for 2024. Both APRA and ASIC named insurance as an enforcement or supervision priority for 2024, and, if the end of 2023 is anything to go by, these regulators take their priorities seriously. For instance, last year, ASIC filed 3 unfair contract terms (**UCT**) proceedings against insurers, ahead of UCT reforms commencing only a few months prior to the proceedings.

Overview / Timeline

Financial Accountability Regime (FAR)

On 14 September 2023, the *Financial Accountability Regime Act 2023* (Cth) (**FAR Act**) received Royal Assent, having been first introduced to Parliament in October 2021. The FAR Act, which was introduced to repeal the Banking Executive Accountability Regime (**BEAR**), requires an accountable entity, its "significant related entities", and accountable persons, to comply with certain obligations. The consequences of contravening the FAR Act include civil and criminal fines, imprisonment, and disqualification from acting as an accountable person.[1]

Since our 2023 Pocketbook, the timing of the FAR Act's implementation has been confirmed. FAR applies to authorised deposit-taking institutions (**ADIs**) and their authorised non-operating holding companies (**NOHCs**) from 15 March 2024. It will apply to insurance entities, their licensed NOHCs, and superannuation trustees from 15 March 2025.

Of particular relevance to policyholders of insurance is section 97 of the FAR Act, which includes a prohibition on significant related entities and related bodies corporate from indemnifying, or paying, or agreeing to pay, a premium for a contract insuring accountable entities against the consequences of contravening the FAR Act. However, unlike BEAR, the prohibition does not apply to accountable persons. Notably, section 97:

- contains an exemption, allows indemnification for legal costs; and
- is silent on whether an accountable entity, or an entity that is not a significant related entity of an accountable entity, could pay a premium for a contract insuring or indemnifying an accountable entity against the consequences of contravening the FAR Act.

As part of FAR's implementation, the Minister Rules will be released, which will provide details as to how applications for the registration of accountable persons should be submitted, and complying with core or enhanced notification obligations. As there is no registration and notification guidance currently available, APRA and ASIC have provided accountable entities extra time to comply with these obligations. Accountable entities will have until 30 June 2024 to submit registration applications and make relevant notifications.[2]

After the Minister Rules are released, APRA and ASIC will release Regulator Rules, Transitional Rules and reporting form instructions, to help entities comply with FAR. This should occur sometime in 2024.

Interestingly, although FAR looks to replace BEAR, BEAR will continue to have force despite its repeal, meaning:

- some of the obligations under BEAR will continue to apply after the application of FAR to enable an effective transition from BEAR to FAR;
- FAR can also be used to take action in relation to breaches of BEAR;
- information collected under BEAR can be used to investigate breaches under FAR. This can occur regardless of whether the relevant breach occurred before or after the commencement of FAR; and
- decisions made under BEAR can continue to be reviewed under BEAR, according to the existing review procedures, even after its repeal.

1 <https://www.kwm.com/au/en/insights/latest-thinking/how-far-we-have-come-financial-accountability-regime-passes-senate.html>.
2 'Financial Accountability Regime commencement and implementation', APRA and ASIC, 5 February 2024, <https://www.apra.gov.au/financial-accountability-regime-commencement-and-implementation>.

Unfair Contract Terms

ASIC ramped up its regulation of Unfair Contract Terms (**UCT**) in 2023, taking enforcement action against Auto & General Insurance Company Limited (**Auto & General**), HCF Life Insurance Company Pty Limited (**HCF Life**) and PayPal Australia (**PayPal**). None of these proceedings have been finalised yet.

The Auto & General case concerns a standard form home and contents insurance contract issued by Auto & General. ASIC allege that the term requiring customers of Auto & General to notify it "if anything changes about your home or contents" is unfair. Specifically, ASIC argue that the term:

- cannot be practically met;
- imposes an unclear obligation on customers;
- suggests that Auto & General has a broader right to refuse claims or reduce the amount payable if the customer does not meet the notification obligation; and
- could mislead or confuse the customer regarding their obligations and rights under the contract.[3]

The proceedings against HCF Life concern three types of insurance policies issued by HCF Life to customers under standard form contracts. ASIC allege that the "pre-existing condition" term is an unfair contract term that could mislead the public by purporting to deny coverage if a customer did not disclose a pre-existing condition before entering the contract, and a medical practitioner subsequently forms an opinion that symptoms of the condition existed prior to the customer entering the contract.[4]

In the PayPal proceedings, ASIC allege that PayPal's standard form contracts with small businesses contain an UCT. The alleged UCT gives PayPal business account holders 60 days to notify PayPal of any errors or discrepancies in fees that PayPal has charged them, or else accept those fees as accurate. ASIC claim this term is unfair as its effect is to permit PayPal to retain fees it has overcharged or wrongly charged if the small business does not notify PayPal of the error within 60 days.[5]

As we flagged in last year's Pocketbook, fresh changes to the UCT regime commenced on 9 November 2023. The new reforms make UCTs illegal, attracting penalties under the *Competition and Consumer Act 2010* (Cth) and the *ASIC Act 2001* (Cth), with each unfair term forming a separate contravention.

ASIC Enforcement Priorities relevant for insurance

On 21 November 2023, ASIC Deputy Chair Sarah Court announced ASIC's 2024 enforcement priorities.[6]

The enforcement priorities most relevant to the insurance industry include:

- poor design and distribution of financial products;
- insurance claims handling; and
- compliance with the reportable situation regime.

Insurance claims handling – ASIC 2024 priority

Insurance claims handling is one of ASIC's new enforcement priorities in 2024.

In August 2023, ASIC released Report 768: Navigating the storm: ASIC's review of home insurance claims (**REP 768**). REP 768 concluded that insurers "can and should improve their claims handling practices", calling on insurers in particular to improve on the following areas:

- better communications to consumers about decisions, delays and complications;
- better project management and oversight of third parties;
- better handling of complaints and expressions of dissatisfaction;
- better identification and treatment of vulnerable consumers; and
- better resourcing of claims handling and dispute resolution functions.

Additionally, during ASIC's 2023 Annual Forum in November, Deputy Chair Sarah Court noted:

> *"In 2024, [ASIC] are turning [their] attention to failures in insurance claims handling. For consumers in the unfortunate situation of needing to claim on their insurance policy, timely and fair claims handling is crucial. [ASIC] will focus on delays in claims handling, poor communication and record keeping, and inappropriate use of exclusions".*[7]

While ASIC has not yet commenced enforcement proceedings against an insurer in respect of a breach of the claims handling obligations, we anticipate this to become ASIC's focus in 2024 given its status as an enforcement priority.

Reportable situations – ASIC 2024 priority

The reportable situations regime broadly requires licensees to lodge a report with ASIC whenever there are reasonable grounds to believe a "reportable situation" has arisen in relation to a financial services licensee. In October 2023, ASIC expressed concern that there had been little improvement in compliance with the reportable situation regime.[8] Having now named compliance with the reportable situation regime an enforcement priority for the year, we expect ASIC to give greater regulatory attention to compliance with this regime in 2024.

General insurance represented 28% of reportable situations (up from 19% last year), being the second largest category of reportable situations.[9] This increase was attributed to an increase in reports about motor vehicle insurance (18% if total reports), home building insurance (8%), and home and contents insurance (6%).[10] The most common issue category remains 'false or misleading statements', comprising 44% of the issues reported.

On 19 December 2023, ASIC released new guidance to AFS licensees on meeting their reporting obligations in Regulatory Guide 78: Breach reporting by AFS licensees and credit licensees (**RG 78**). RG 78 explains:

- when AFS licensees must report to ASIC;
- how AFS licensees must report to ASIC, including information about how ASIC deal with the reports they receive and the information they will publish about the reports; and
- ASIC's expectations and guidance regarding AFS licensees' compliance systems for identifying, recording, and reporting breaches to ASIC.

3 'ASIC sues Auto & General Insurance Company for alleged unfair contract terms in insurance', ASIC, 4 April 2023, <https://asic.gov.au/about-asic/news-centre/find-a-media-release/2023-releases/23-088mr-asic-sues-auto-general-insurance-company-for-alleged-unfair-contract-terms-in-insurance/>.

4 'ASIC sues HCF Life for alleged fair and misleading contract terms in insurance', ASIC, 12 May 2023, <https://asic.gov.au/about-asic/news-centre/find-a-media-release/2023-releases/23-123mr-asic-sues-hcf-life-for-alleged-unfair-and-misleading-contract-terms-in-insurance/#:~:text=ASIC%20sues%20HCF%20Life%20for%20alleged%20unfair%20and%20misleading%20contract%20terms%20in%20insurance,-Published%2012%20May&text=ASIC%20has%20commenced%20civil%20proceedings,and%20could%20mislead%20the%20public>.

5 'ASIC sues PayPal Australia for alleged unfair contract term with small businesses', ASIC, 7 September 2023, <https://asic.gov.au/about-asic/news-centre/find-a-media-release/2023-releases/23-246mr-asic-sues-paypal-australia-for-alleged-unfair-contract-term-with-small-businesses/>.

6 'ASIC announces 2024 enforcement priorities', ASIC, 21 November 2023, <https://asic.gov.au/about-asic/news-centre/find-a-media-release/2023-releases/23-310mr-asic-announces-2024-enforcement-priorities/>.

7 'ASIC announces 2024 enforcement priorities', ASIC, 21 November 2023, <https://asic.gov.au/about-asic/news-centre/find-a-media-release/2023-releases/23-310mr-asic-announces-2024-enforcement-priorities/>.

8 '23-288MR ASIC releases second publication on insights from the reportable situations regime', ASIC, 31 October 2023, <https://asic.gov.au/about-asic/news-centre/find-a-media-release/2023-releases/23-288mr-asic-releases-second-publication-on-insights-from-the-reportable-situations-regime/>.

9 'Report REP 775 Insights from the reportable situations regime: July 2022 to June 2023', ASIC, 31 October 2023, < https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-775-insights-from-the-reportable-situations-regime-july-2022-to-june-2023/>.

10 'Report REP 775 Insights from the reportable situations regime: July 2022 to June 2023', ASIC, 31 October 2023, <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-775-insights-from-the-reportable-situations-regime-july-2022-to-june-2023/>.

Due to the expected increased scrutiny by ASIC in the coming year, AFS licensees should familiarise themselves with RG 78, and ensure that robust reporting procedures are in place.

Insurance pricing: ASIC REP 765 - When the price is not right: Making good on insurance pricing promises

On 23 June 2023, ASIC released Report 765: When the price is not right: Making good on insurance pricing promises (**REP 765)**.[11] In REP 765, ASIC highlights:

- failures by general insurers to manage non-financial risk that have led to consumer harm;
- conduct issues being addressed by ASIC;
- pricing failures identified by general insurers after an ASIC-initiated review, and the improvements required to fix them;
- standards general insurers need to meet in designing and promoting pricing promises to ensure consumers get the full benefit of discounts promised;
- general insurers are remediating over $815 million to more than 5.6 million customers in respect of pricing failures reported since 2018; and
- general insurers are fixing the identified pricing failures and improving systems, controls, processes, and product governance to ensure they honour their promises to consumers.

Additionally, in the ASIC forum on 21 November 2023, Deputy Chair Sarah Court noted that ASIC have been active in relation to failures by insurers to deliver on pricing promises, imposing penalties and commencing action against insurers for alleged misleading statements regarding pricing.[12]

APRA's interim 2024 priorities update

APRA's 2024-2025 Corporate Plan is due to be released by the end of August 2024. Ahead of its publication, on 31 January 2024, APRA announced its interim supervision and policy priorities for the first half of 2024.[13] For this period, APRA's focus areas include:

- operational and cyber resilience for APRA-regulated entities;
- changing the prudential framework for authorised deposit-taking institutions (ADIs); and
- in the insurance industry, balancing financial sustainability with the need to increase the affordability and availability of insurance.

APRA finalised Prudential Standard CPS 230 – Operational Risk Management

On 17 July 2023, APRA finalised Prudential Standard CPS 230 Operational Risk Management (**CPS 230**).[14] CPS 230 is a new prudential standard aimed at ensuring banks, insurers, and superannuation trustees can better manage operational risks and respond to business disruptions. APRA Chair John Lonsdale stated "[t]he need for APRA's new standard has been demonstrated by a number of recent operational risk control failures and disruptions, including material cyber breaches. This new standard will ensure that regulated entities set and test controls and maintain robust business continuity plans to respond if disruptions do occur". The new standard will commence from 1 July 2025. The Final Practice Guide (**CPG 230**) which will accompany CPS 230 is set to be released between April and June this year.

Duty of utmost good faith – *ASIC v Zurich*

Under part II of the *Insurance Contracts Act 1984* (Cth) (**ICA**), parties to contracts of insurance are required to uphold a duty of utmost good faith. In December 2023, the requirements of this duty, in the context of determining whether cover is avoided under section 29(2) of the ICA, were clarified by the Federal Court in *ASIC v Zurich Australia Ltd (No 2)* [2023] FCA 1641.

Whilst ASIC conceded that the insurer formed a reasonable conclusion that the insured had been fraudulent in failing to disclose facts on her insurance application form, ASIC maintained that the manner and process adopted by the insurer in reaching that decision breached the duty of utmost good faith. ASIC argued that the insurer breached the duty of utmost good faith in 3 ways. Each argument was rejected by the Court.

Alleged Contravention 1: Making Reasonable Inquiries and Giving Appropriate Consideration

ASIC argued that correspondence from the insured ought to have put the insurer on notice of the need to make further inquiries regarding the insured's reasons for failing to disclose facts on her insurance application form. This argument was rejected by the Court on the basis that the Avoidance Letter issued by the insurer made clear that the insurer rejected the insured's explanation regarding her failed disclosure, and that no further inquiries were necessary.

Alleged Contravention 2: Identifying and Seeking a Response Regarding Specific Concerns as to Fraud

ASIC further submitted that the insurer failed to act with utmost good faith by avoiding the policy without notifying the insured that the insurer held concerns that non-disclosures or misrepresentations within the application form were fraudulent, and by failing to identify the bases for such concerns. This argument was also rejected by the Court. The Judge held that the insurer provided the insured with ample opportunity to explain the circumstances in which the misrepresentations and non-disclosures in the application form occurred, and the insurer clearly set out what information supplied by the insured they believed was false.

Alleged Contravention 3: Informing the Insured of her Dispute Rights and Appeal Processes

Finally, ASIC argued that the insurer breached its duty of utmost good faith by failing to inform the insured of her rights to dispute or appeal the decision to avoid her income protection cover. The Court found that the information concerning rights of review and appeal was likely omitted by the insurer through oversight or administrative error. It was held that whether a failure was deliberate or innocent must be relevant to whether there has been a breach of the utmost duty of good faith, citing *Australian Securities and Investments Commission v TAL Life Limited (No 2)* (2021) 389 ALR 128. Additionally, the Court found that in assessing whether the omission by the insurer to provide information regarding dispute rights or appeal processes breached the duty of utmost good faith, it was relevant that the insured had competent legal representation at the time the policy was avoided.

11 'Report REP 765 When the price is not right: Making good on insurance pricing promises', ASIC, 23 June 2023, <https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-765-when-the-price-is-not-right-making-good-on-insurance-pricing-promises/>.

12 'ASIC Annual Forum 2023 – Enforcement session opening remarks', ASIC, 21 November 2023, <https://asic.gov.au/about-asic/news-centre/speeches/asic-annual-forum-2023-enforcement-session-opening-remarks/>.

13 'Interim Policy and Supervision Priorities Update', APRA, 31 January 2024, <https://www.apra.gov.au/interim-policy-and-supervision-priorities-update>.

14 'APRA finalises new prudential standard on operational risk', APRA, 17 July 2023, <https://www.apra.gov.au/news-and-publications/apra-finalises-new-prudential-standard-on-operational-risk>.

THE ROAD LESS TRAVELLED:

WARRANTIES BY THE TARGET, SYNTHETIC WARRANTIES AND EXCESS LIABILITY COVER FOR W&I INSURANCE

M&A activity softened in 2023. What prevailed, however, was the competitive W&I insurance market that had started in the previous year. 2023 saw W&I insurers continue to offer flexible terms and more attractive pricing, with insurers keen to secure business in a deflationary market impacted by steep interest rate increases. Notwithstanding the softening state of the market, the take-up of W&I insurance endured. To illustrate, 44% of our deals had W&I insurance, representing just about a 5% decline[15] despite the Australian M&A deal count for Q3 2023 having dropped by 35% compared to the previous year.[16] W&I deals constituted 76% of deals valued above $100 million (up by 4%), 60% of deals with private equity involvement (down by 3%) and 53% of cross-border deals (down by 4%).[17]

What this article will cover

As W&I insurance trends regarding pricing, areas of underwriting focus and exclusions have remained consistent since 2022 (as laid out in the 2023 edition of this publication), this year's W&I article takes a different form. This article will provide an overview of some of the less utilised concepts to tailor W&I insurance to your particular transaction.

Target as warrantor

In an M&A transaction, warranties are usually given by the sellers of the target. However, this may not always be possible or suitable. For example, shareholders of the target in a public M&A transaction who have not been involved in the day-to-day management of the target, or administrators of a distressed business who are not its owners, may not have enough knowledge to verify or stand behind the warranties. Founding shareholders of a now-established business wanting a clean exit may similarly be reluctant to give warranties.

15 King & Wood Mallesons, 'DealTrends FY23' (publication, 24 October 2023).

16 S&P Global Market Intelligence, 'Australia M&A by the Numbers: Q3 2023' (Web Page, 6 November 2023) <https://www.spglobal.com/marketintelligence/en/news-insights/blog/australia-ma-by-the-numbers-q3-2023>.

17 King & Wood Mallesons, 'DealTrends FY23' (publication, 24 October 2023) c.f., King & Wood Mallesons, 'W&I', *DealTrends* (Web Page, 14 February 2023) <https://dealtrends.au.kwm.com/2022-report/w-i/>.

In these circumstances, it may be commercially desirable and practicable for the target to give the warranties so as to enable W&I insurance to be secured.

The process of placing W&I insurance where the target gives the warranties is substantially the same as where the sellers give the warranties, requiring thorough due diligence and arm's-length negotiations between the buyer and the target to develop and verify the warranties. Buyers should not, however, expect to be able to secure cover for a warranty that is not normally given by the target (e.g., a warranty that the sellers have title). In these circumstances, the buyer should seek those warranties from the sellers under the sale agreement or procure alternative or additional insurance where diligence allows it (e.g., title insurance). The buyer can also explore the possibility of attaching synthetic warranties under a W&I policy (see further on this below).

Further, given it is the target that gives the warranties, the buyer should secure a right of recourse for fraud by the target. Unlike a regular W&I insurance policy in Australia where a breach of warranty in the event of fraud by the warrantor may be covered (subject to the insurer obtaining subrogation rights), a W&I insurance policy covering warranties given by the target will likely exclude loss arising from the fraud of the target. The reason is that the insurer will not be in a position to recover its loss by subrogation against the target, being a member of the insured group. This would also lead to circularity in the process if the buyer were to claim under the policy and the insurer then subrogated against the target. Therefore, in the event of fraud by the target, the buyer may wish to consider recourse to other parties or individuals to recover its loss.

KWM has acted in numerous deals involving the target as warrantor (on both buy-side and sell-side) and is able to assist with the nuances on both M&A and insurance fronts.

Synthetic warranties

Synthetic warranties are another concept for deals where warranties are not given by the sellers. However, unlike the above scenario where warranties are still given in the sale document (albeit by the target), synthetic warranties are not given in the sale document at all. Synthetic warranties are, in short, warranties that are negotiated with the W&I insurer under the W&I policy, as opposed to with the sellers under the sale document, and so are 'synthesised' into the transaction.

Similar to warranties given by the target, synthetic warranties can also be used where the sellers cannot give the warranties (e.g., public M&A or distressed transactions), but their utility can extend to other transactions. By way of example, synthetic warranties can be useful in a pre-emptive sale process, where the sellers need to balance making a better-than-market initial offer to their partners or co-owners, whilst leaving room to negotiate a market (but still attractive) offer with third-party buyers. In this example, the sellers may decide to offer no or limited warranties in the sale agreement, leaving it to each potential buyer to develop and conduct due diligence on its own warranties and obtain coverage for these synthetically under the policy.

Procuring W&I insurance for synthetic warranties is usually more expensive than for a regular W&I policy. The pricing reflects the increased risk for the buyer and, therefore, the insurer of the acquisition of an asset, with the buyer relying on warranties which have not been negotiated with either the seller or the target. Further, there is usually no or limited sell-side verification. Not only does this add to the risk and increase the price, but it also means that the buyer needs to undertake more fulsome diligence which will require more of the buyer's resources. There is, however, a silver lining: by undertaking a targeted diligence exercise, the buyer may be able to secure warranties and coverage which it may not have been otherwise able to obtain from the sellers.

Anecdotally, synthetic warranties have not yet been taken up for many deals in Australia. However, we are aware that insurers have expressed an interest in the area and may offer terms on a case-by-case basis. Where insurers do not offer primary capacity, they may still provide excess insurance subject to the underlying warranties and diligence.

Excess liability cover

Most W&I insurers exclude certain third-party liability matters (e.g., product liability or professional negligence) from their policies as a matter of market practice. In the past 2 years, however, some W&I insurers have been open to providing cover for liability matters under the W&I insurance policy in accordance with, and in excess of, the target's existing liability insurance policies (where diligenced to the insurers' satisfaction) including general liability, professional indemnity and cyber liability. There has also been a growing trend of W&I insurers providing specific tax liability policies to cover risk in respect of discrete taxation issues.

Liability losses, and in particular cyber liability losses, can be very large, so this shift in the W&I insurance market is welcomed. Insureds should ensure that the cover provided under the W&I policy in this respect is suitable and, if not, consider whether they need alternative protections, noting that the retention for liability losses is usually high and the financial impact of a breach may be large so as to erode the policy limit quickly. Further, even if a liability matter is covered under the underlying insurance, it will still need to jump over the coverage hurdles in the W&I policy. W&I insurers are mindful of the time-sensitive nature of the relevant transactions and can facilitate these specific liability matter policies in a short timeframe to meet the applicable transaction deadlines.

Concluding remarks

Warranties provided by the target, synthetic warranties and excess liability cover are only 3 ways in which a W&I insurance policy can be tailored to a particular transaction and its unique circumstances. Some of these concepts, such as target warranties, are tried and tested in the market whereas others, such as synthetic warranties, are newer, at least in Australia. With W&I insurance showing no sign of slowing down and new solutions constantly evolving, KWM looks forward to assisting you in ensuring that your deal's vanguard insurance program protects your interests, whether you are the buyer or the seller.

RESTRUCTURING A GENERAL INSURER – CATHOLIC CHURCH INSURANCE LTD SCHEME OF ARRANGEMENT

Background

Since the collapse of HIH in 2001, the Australian insurance industry has largely weathered the storms that have impacted overseas insurers. The increased prudential regulation and minimum capital requirements for general insurers since the HIH collapse have no doubt played an important role in avoiding the failure of any general insurers post-HIH in Australia. However, recent increases in claims in most insurance categories caused by increased natural perils and the health impacts of COVID continue to have a negative impact on underwriting profitability for general insurers.

For example, in the year to 30 June 2023, underwriting profitability for general insurers was $5.70 billion, compared to the underwriting result of $6.08 billion in the previous 12 months. One of the main drivers being this decline is an increase in net incurred claims for the March 2023 quarter to $9.17 billion, which had increased by 20.4% compared to the December 2022 quarter ($7.62 billion) and increased by 36.5% compared to the March 2022 quarter ($6.72 billion).[18]

Late last year, in the first restructure of its kind in the Australian insurance market, policyholders of Catholic Church Insurance Limited (**CCI**) voted unanimously to approve a creditors' scheme of arrangement in respect of CCI (the **Scheme**). The Scheme was subsequently approved by the Federal Court of Australia and became effective in November 2023. KWM advised CCI in respect of the Scheme.

What is CCI?

CCI is an APRA authorised general insurer that is also licenced to provide workers' compensation insurance in several Australian States and Territories. CCI is largely owned by various Australasian Catholic entities and has traditionally written contracts of insurance covering a wide range of risks largely to policyholders within the faith community, including schools, hospitals etc. Due to a sustained increase in claims (particularly long tail claims associated with historical misconduct) and an anticipated increase in future claims, CCI's net asset position had deteriorated such that it could no longer maintain the minimum Prudential Capital Ratio (**PCR**) required by APRA. CCI was unable to secure sufficient capital contributions from shareholders to enable its business to continue operations in line with regulatory capital requirements and, as a consequence, CCI's board placed CCI into run-off in May 2023.

Why did CCI propose the Scheme?

As part of the orderly run-off of the business, CCI proposed a scheme of arrangement under Part 5.1 of the *Corporations Act 2001* (Cth) (the **Corporations Act**) with its policyholders (other than workers' compensation policyholders). A scheme of arrangement is a Court approved procedure to compromise the arrangements between a company and certain classes of its creditors (in this case, policyholders). Once the scheme is approved by the requisite majority of policyholders at the scheme meeting (75% in value and 50% in number of policyholders present and voting) and approved by the Court, all of the relevant class of policyholders are bound by the Scheme.
The Scheme was proposed to manage the uncertainty associated with a potential further deterioration of CCI's net asset position (and associated inability to meet the minimum PCR) and to mitigate the risk of CCI potentially being the subject of an insolvency process, such as an administration or a winding up. To that end, the Scheme was designed to ensure that claims continue to be handled in as orderly a manner as possible in the event of further deterioration in the financial position of CCI.

What are the key features of the Scheme?

The form of scheme of arrangement that is historically used to restructure insurance liabilities in Australia is a "cut-off" scheme. Under a cut-off scheme, all actual and potential future claims of policyholders are assessed and valued at a point in time by an appropriately qualified actuary. The insurer's assets are then distributed rateably to policyholders in respect of the claim values as assessed. The HIH liquidators implemented a cut-off scheme of arrangement with HIH's policyholders.[19] The challenge with this sort of scheme lies in seeking to achieve fairness for policyholders whose entitlements under the scheme will be based on an actuarial assessment of the likelihood of the insured risks coming to pass rather than whether or not the insured risks actually come to pass over the passage of time. This means that, by definition, under a "cut-off" scheme, some policyholders will recover more than their entitlement under their contract of insurance and other policyholders will recover less than their contractual entitlements. This issue becomes more acute in the context of very long tail liabilities.

In light of this, CCI's Scheme was designed as a "contingent reserving scheme" which operates through two periods:

(a) the **Initial Scheme Period** in which all liabilities of CCI are met on a business as usual basis. Policyholders can make claims under or in connection with a relevant insurance contract in the same way as they did before the Scheme. CCI assesses if the policyholder's claim is valid and, if valid, the amount payable by CCI in respect of it. The Initial Scheme Period started on the date that the Scheme became effective and ends on the date that an event, called a Trigger Event,[20] occurs (the **Trigger Date**); and

18 See: <https://kpmg.com/au/en/home/insights/2021/07/general-insurance-insights-dashboard.html#:~:text=Increases%20in%20net%20incurred%20claims,2022%20quarter%20(%246.72%20billion)>.

19 *Re HIH Casualty and General Insurance Ltd* (2005) 56 ACSR 295; *Re HIH Casualty and General Insurance Ltd* (2006) 57 ACSR 791; *Re HIH Casualty and General Insurance Ltd* (2006) 58 ACSR 1.

20 A Trigger Event occurs if the board has concluded that in its opinion, disregarding the effect of the Scheme on CCI, CCI would be insolvent or would be likely to become insolvent, at some future time (in each case as defined in section 95A of the Corporations Act).

(b) the **Reserving Period** (if required) where policyholders will continue to be entitled to make a claim under their insurance contract in the same way as they do now. CCI will continue to assess that claim as usual. However, for those policies that are subject to the Scheme (broadly, excluding workers' compensation claims) where CCI determines that a policyholder has a valid claim, CCI will no longer pay that claim in full at that time. Instead, once a payment percentage has been set by PwC as the Scheme Advisers, CCI will pay a percentage of the claim reflecting the payment percentage. The payment percentage is calculated by reference to an assessment of future scheme liabilities and non-scheme liabilities. The payment percentage endeavours to ensure that, from the Trigger Date onwards, all non-scheme liabilities will be paid in full, and all claims made will be paid at the same percentage going froward. In this way, policyholders with current claims are less likely to be given preference over policyholders whose claims do not eventuate until well into the future.

The Reserving Period starts on the Trigger Date and ends on the date that the Scheme terminates.

The Scheme also contains an optional finalisation mechanism to enable policyholders to resolve to bring the Scheme to an end early by moving to a "cut-off" scheme once the short tail policies run off to bring to an end the remaining long tail policies.

Other key features of the Scheme are:

(a) the continuing governance of CCI by its board with the appointment of PwC as Scheme Advisers to set the payment percentage and to approve certain other transactions; and

(b) the appointment of a creditors' committee to consult with CCI's board and the Scheme Advisers on various key matters.

What are the benefits of the Scheme?

Certainty: The adverse effects which would have arisen from any disruption in the run-off of CCI were CCI to become insolvent have been, as far as is reasonably possible, been removed by the Scheme.

Orderly, seamless and efficient run-off: The Scheme was designed and intended to ensure the continuation of an efficient claims-handling operation in run-off whilst, at the same time, minimising the adverse effects which would arise from any disruption if CCI became insolvent.

Potential insolvency: If the Scheme had not been approved or implemented, CCI would have remained vulnerable to claims deterioration and other factors which would have endangered its solvency in the future. An insolvency process (such as an administration or a winding up) or APRA exercising its enforcement powers would likely have reduced the realisable value of CCI's business and assets, and therefore amounts available to meet claims of policyholders. The Scheme process is also less costly than an insolvency process.

Minimal disruption: The Scheme ensures that the liabilities of CCI continue to be established in the normal course with the prospect of payments being made to policyholders by CCI earlier than would otherwise be likely if CCI were to become insolvent. In an insolvent winding up it is unlikely that interim payments would be paid to creditors before substantially all claims were identified and quantified.

Fairness: If the trigger event occurs, CCI will make payments to policyholders in such a way as to be fair both to policyholders whose claims are established quickly and those whose claims may not be established for some time. This enables claims to be settled quickly and as fully as possible. The Scheme is also a transparent and open process which required the support of creditors and the approval of the Court.

Reinsurance recoveries: Certain of CCI's reinsurers may have sought to cancel reinsurance contracts upon insolvency or regulatory action, resulting in the potential loss of reinsurance assets. The Scheme seeks to protect CCI's ability to maximise its reinsurance recoveries, a key asset of CCI. Maximising reinsurance recoveries will increase the assets available to CCI and put it in a position to make greater payments to policyholders.

Cost savings: If CCI were to become insolvent and enter into liquidation, further significant costs would likely be incurred.

Approval of the Scheme

Ultimately, the Scheme received unanimous approval from those policyholders present and voting at the scheme meeting and the approval of the Court.[21] While APRA and ASIC appeared before the Court at the first and second Court hearings, and ASIC made certain submissions at the first court hearing in relation to aspects of the design of the Scheme, the Scheme was approved by the Court in the form proposed by CCI. The Scheme was carefully crafted to observe as far as possible within the scope of the affected class of creditors the priorities and complex application of assets that would have arisen had the company been wound up in insolvency, having regard to the operation of the Corporations Act, in particular as it reflects the application of proceeds of reinsurance, the *Insurance Act 1973* (Cth), in particular as it modifies the Corporations Act winding up rules, and the particular entitlements arising under various workers' compensation regimes in the various States that would apply in a winding up of CCI. This was noted by the Court in its reasons for making orders to dispatch materials to policyholders and convene a meeting to approve the Scheme.[22] Further, the Court accepted CCI's submissions that given the operation of the Scheme, the affected creditors could be treated as a single class for the purposes of the meeting, and with their claims valued on the basis proposed by CCI.

Conclusion

The Scheme is an important modern example of how a general insurer's exposure to contingent long tail liabilities can be managed in the best interests of policyholders in circumstances where the uncertainty surrounding those liabilities is threatening its ability to maintain the minimum PCR and potentially also the general insurer's solvency. The first of its kind in Australia, the Scheme built on international restructuring practices in the UK and New Zealand. However, the Scheme has taken that practice one step further by also including a finalisation mechanism to enable policyholders to bring the Scheme to an end early once the short tail policies have run off. If an insurer finds itself in similar circumstances of severe difficulty, a contingent reserving scheme along the lines seen in the CCI case may provide a useful and flexible tool to manage solvency concerns while ensuring fairness is afforded to policyholders.

21 *Re Catholic Church Insurance Ltd (No 2)* [2023] FCA 1352.
22 *Re Catholic Church Insurance Ltd* [2023] FCA 1197.

INDEMNITIES: IS THE WHOLE GREATER THAN THE SOME OF ITS PARTS

For whatever reason, indemnities are ripe for dispute and litigation. This article is related to that class of dispute about the indemnification of legal costs. Contests can turn on the express wording of the contract or the (often undefined) concepts of reasonableness, necessity, the time at which costs were incurred, hourly rates of engaged counsel, and the conduct of the parties.

Indemnities

Conceptually, an indemnity is an agreement for one party to keep another party harmless against loss as a result of a specified matter.[23] The precise way in which an indemnity is written is critical to how and when the indemnity will operate. An indemnity for legal costs may be achieved by the insuring clause itself (provided there is a sufficiently wide definition of 'Loss').

Across insurance and non-insurance contracts, disputes can arise with the following issues:

- what costs are covered by the indemnity?
- is the indemnity on costs moderated by any measure (reasonableness, necessity or quantum)?
- should the costs be assessed on a party/party basis, or an indemnity basis?
- will a court exercise its discretion as to costs in accordance with the indemnity?

The answer to such issues usually depends on the description of costs, contract wording, and the specified circumstances in which the indemnity operates.

Coverage

Insurance policies and contractual indemnities alike,[24] are commercial documents subject to ordinary principles of construction, including that:[25]

- contracts are construed objectively by reference to their text, context (including documents referred to) and purpose.
- the standard to which contracts are assessed is what a reasonable businessperson would have understood the terms to mean.
- in the case of ambiguity, evidence of surrounding circumstances (events, circumstances and things external to the contract which are known to the parties or which assist in identifying the purpose of object of the transaction) may be admissible. It is not relevant where the meaning of the text is clear.

The rub for parties that enter into an indemnity is that where ambiguity exists, and a constructional choice is open, such ambiguity is to be resolved in favour of the indemnitee.[26]

If you proceed on the basis that an indemnity is an obligation to make someone whole (or hold harmless),[27] an indemnity referring to 'costs' or 'loss' may include legal costs.[28] *Cantone* is instructive of such a clause. This case involved a professional liability insurance policy covering insolvency practitioners against 'Claims for Civil Liability', where 'Civil Liability' was defined as 'compensatory damages, costs and expenses in respect of a Claim which includes the legal costs of the person making the Claim'.[29] In this case, there was a dispute as to whether a separate costs order was a 'Claim for Civil Liability'. Here, the policy's purpose and context were determinative in the finding that such an indemnity was not limited to costs orders in proceedings seeking compensation. Indeed, it was 'plainly foreseeable' (and indeed, relatively routine) that an insolvency practitioner may incur costs in proceedings for which they are not the primary defendant, or where no compensation is sought.[30]

Where a clause refers to 'legal costs and expenses', the reference to 'expenses' is naturally limited to expenses of a kind

23 *Sunbird Plaza Pty Ltd v Maloney* (1988) 166 CLR 245, 254; *Andar Transport Pty Ltd v Brambles Ltd* (2004) 217 CLR 424 [22].
24 *Pacific Carriers Ltd v BNP Paribas* (2004) 218 CLR 451 [22].
25 *Mount Bruce Mining Pty Ltd v Wright Prospecting Pty Ltd* (2015) 256 CLR 104 [46]-[50].
26 *Andar Transport Pty Ltd v Brambles Ltd* (2004) 217 CLR 424 [23].
27 A distinction between whether the relevant indemnity is prospective of, or reactive to, loss.
28 *Forney v Dominion Insurance Co Ltd* [1969] 3 All ER 831, 835.
29 *Cantone v Insurance Australia Ltd* [2022] FCA 1009 [36].
30 *Cantone v Insurance Australia Ltd* [2022] FCA 1009 [65]-[66].

concerned directly with the legal enforcement of the parties' obligations.[31] Such a result can be avoided (if intended) by including the 'legal costs' component within 'costs' or 'loss' (often by way of parentheses), rather than qualifying the costs themselves.

All, some, reasonable, reasonably incurred or indemnity costs

A common dispute in the enforcement of a contractual indemnity for legal costs is whether the costs should be assessed on the standard basis (or party-party basis) or an indemnity basis.[32] Ordinarily, a successful litigant would have an expectation that the relevant Court would award it costs on a party-party basis. This is not a complete indemnity, and such an order extends to such reasonable costs the litigant has reasonably incurred. In special circumstances, a litigant may be entitled to indemnity costs, where only unreasonable costs are excluded. The difference between such orders can be enormous.

Where a contract includes an indemnity for legal costs, there is authority that Courts will presume that the indemnity is assessed on a party-party basis.[33] That said, parties to a contract can displace such a presumption with express wording.[34] Indeed, as the English High Court in *Re Adelphi Hotel* said:[35]

> *[…] every taxation in which more than one party (in addition to the solicitor) is interested is prima facie a taxation as between party and party, any other basis of taxation is only justified when the party asking for it can show that he is entitled to it, either on some well-recognised principle, or under some contract plainly and unambiguously expressed.*

While an indemnity for legal costs (on an indemnity basis) must be 'plainly and unambiguously expressed', the many varieties of drafting has led to inconsistent application of this standard. While costs are in the complete discretion of the court, this does not wholly explain the discrepancies in application.[36] One thing is clear - no matter how comprehensive the indemnity, a court may still decline to order indemnity costs.

The cases of *Ringrow*[37], *Re Shanahan*[38] and *Irani*[39] are instructive of indemnities for 'all costs and charges', 'all costs and expenses' and 'all costs' respectively.

(a) In *Ringrow*, Rares J said the expression 'all costs' was straightforward, and meant what it said – there was no basis for an argument that legal fees were not included in such an expression.[40] With the indemnity clause stating that it was the indemnifier's 'sole responsibility' to indemnify, Rares J held that there was a clear intention that the indemnitee not be out of pocket for its costs arising from the counterparty's default.[41]

(b) In *Re Shanahan*, a similar indemnity was expressed to be 'in addition to those for which the mortgagor might have been liable at law or in equity to pay to the mortgagee'. It was held that this was a clear contractual intention for costs to be assessed on an indemnity basis.[42]

(c) By contrast, in *Irani*, an application for indemnity costs was refused as the clause did not refer to legal costs, and was not 'as clear and unequivocal as such provisions can be'.[43] Further, the failure to plead the claim for indemnity costs was a relevant factor counting against the exercise of the court's discretion as to costs.[44]

The failure to mention legal costs in *Irani* being a relevant matter of construction is difficult to reconcile with *Ringrow*. While the view in *Ringrow* is preferable, *Irani* is not a fringe case, and the takeaway from such decisions is that 'costs' in such clauses ought refer to 'legal' costs explicitly (whether by definition or other means). Care must be taken if the indemnity is intended to be broader than legal costs – inclusive wording referencing legal costs in parentheses is a common solution to this issue.

That said, some comfort can be found from the decision in *Dyno Nobel*, where a policy indemnity in respect of 'all expenses arising out of an occurrence insured against',[45] only excluded legal costs that were not 'reasonably incurred' (ie costs were awarded on an indemnity basis).[46]

In *Kheirs*,[47] there was an indemnity for 'any liability or loss, expenses, damages, actions, claims and costs (including legal costs on a solicitor and own client basis) sustained or incurred as a result of a breach'.[48] Clearly, the indemnity was very broadly worded, and explicitly referred to costs being assessed on an indemnity basis.

As to clauses where costs or expenses must be 'reasonable', the authors consider that this will generally be taken to be a reference to costs assessed on a party-party basis.[49] The rationale for this is identified in *Carbure*:[50]

> *[…] It does not seem to me that it is appropriate to decide that the addition of the adjective "reasonable" requires the tenant to pay more of the landlord's expenses than would have been the case without that addition, which would be the effect of an order for solicitor-client rather than party-party costs […].*

This can be contrasted with the decision in *Van Der Velde*, where costs not only had to be 'reasonable' but also 'reasonably incurred', to be awarded on an indemnity basis. However, this was a 'special' case where legal expenses were only incurred as a result of fraudulent conduct of the counterparty, a relevant consideration in construing the clause as assessing costs on an indemnity basis.[51]

Finally, one observation we have is that while the rate at which legal services are obtained in the market is relevant in whether costs are 'reasonable', the fact that services have been at market rates does not mean that the costs are 'reasonable'.[52]

We have reviewed a number of cases in putting this article together – and we think that the central learning is (unsurprisingly) the words of the contract matter, and the parties to a contract should be as specific as they can about what an indemnity for legal costs covers.

31 *Pacific Indemnity Underwriting Agency Pty Ltd v Maclaw No 651 Pty Ltd* (2005) 13 VR 483 [33].
32 Some clauses and decisions refer to these costs as solicitor-client costs, but they are the same thing - *Deen v Harburg Nominees Pty Ltd* [2021] QCA 44 [65].
33 *Chen and Xu v Kevin McNamara & Son Pty Ltd* [2012] VSCA 229 [8].
34 *Kyabram Property Investments Pty Limited and Anor v Murray and Anor. Murray and Anor v Kyabram Property Investments Pty Limited and Anor* [2005] NSWCA 87 [12].
35 *Re Adelphi Hotel (Brighton) Ltd; District Bank Ltd v Adelphi Hotel (Brighton) Ltd* [1953] 2 All ER 498, 502.
36 *Chen and Xu v Kevin McNamara & Son Pty Ltd* [2012] VSCA 229 [9].
37 *Ringrow Pty Limited v BP Australia Pty Limited* [2006] FCA 1446.
38 *Shanahan, Re; Re Solicitors Bill of Costs* (1941) 58 WN (NSW) 132.
39 *Irani v St George Bank Ltd (No 3)* [2005] VSC 456.
40 *Ringrow Pty Limited v BP Australia Pty Limited* [2006] FCA 1446 [18].
41 *Ringrow Pty Limited v BP Australia Pty Limited* [2006] FCA 1446 [84].
42 *Shanahan, Re; Re Solicitors Bill of Costs* (1941) 58 WN (NSW) 13, 136.
43 *Irani v St George Bank Ltd (No 3)* [2005] VSC 456 [20].
44 *Irani v St George Bank Ltd (No 3)* [2005] VSC 456 [21].
45 *Placer (PNG) Pty Ltd v Dyno Nobel Asia Pacific Ltd* [1999] NSWSC 1292 [31]-[33].
46 *Placer (PNG) Pty Ltd v Dyno Nobel Asia Pacific Ltd* [1999] NSWSC 1292 [500].
47 *Kheirs Financial Services Pty Ltd v Aussie Home Loans Pty Ltd; Aussie Home Loans Pty Ltd v Bank of Western Australia; Kheirs Financial Services Pty Ltd v Bank of Western Australia* (2010) 31 VR 46 ('***Kheirs v Aussie Home Loans***').
48 *Kheirs v Aussie Home Loans* [38].
49 *Spencer v Dowling* [1997] 2 VR 127, 147.
50 *Carbure Pty Ltd v Brile Pty Ltd* [2002] VSC 313 [17].
51 *Van Der Velde v Ng* [2011] FCA 594 [83]-[87].
52 *Pacific Indemnity Underwriting Agency Pty Ltd v Maclaw No 651 Pty Ltd* (2005) 13 VR 483 [47].

SHOW ME THE (DETAILS OF THE) MONEY:

WHEN WILL THE COURT ORDER THE PRODUCTION OF AN INSURANCE POLICY IN CLASS ACTION PROCEEDINGS?

One of the first questions we are asked by other parties when our clients attend mediations is: are any insurers coming? Applicants in class actions are levelling up, and in recent years, a number of applications have been made by applicants seeking the production of copies of insurance policies (often ahead of an impending mediation). The terms of insurance policies are almost always confidential.

The purpose for seeking a copy of an insurance policy is axiomatic, and not, on one view, altogether altruistic. Our view is that whilst the Court has power to compel a class action respondent to produce its insurance policy to an applicant in an appropriate case to ensure that justice is done, the Court will not readily exercise the discretion to do so. Contested attempts by applicants to obtain such documents for the purpose of assessing the commercial viability of a proceeding or to assist in the context of a mediation have almost all been unsuccessful. Australian courts recognise that the disclosure to an applicant of a respondent's insurance policy risks placing the respondent at an "asymmetric commercial disadvantage" in the proceeding,[53] in the sense that "documents and information relevant to the motivation to settle would become known in respect of one party but not the other".[54]

This article discusses the circumstances in which a Court may order a respondent to produce an insurance policy under which it is, or may be, indemnified for claims made against it in a class action proceeding.

53 See, for example, *Evans v Davantage Group Pty Ltd (No 2)* [2020] FCA 473 ('***Evans***'), [4] and [98]; *Commonwealth Bank of Australia v ACN 076 848 112 Pty Ltd* [2015] NSWSC 666 at [23].

54 *Agnello v Heritage Care Pty Ltd; Fotiadis v St Basil's Homes for the Aged in Victoria (No 2)* [2023] VSC 653 ('***Agnello***'), [54].

General Position

Discovery

The general position is that a respondent's insurance policy is "not usually discoverable under the Court's processes of discovery unless it is relevant to an issue on the pleadings".[55] Courts have traditionally been reluctant to compel the disclosure of details of a party's insurance cover, based largely on the underlying justification that "the existence of policies of insurance held by a party or the details of such policies will not normally be relevant to the proof of any cause of action pleaded against that party".[56]

Exceptions to the general position in the insolvency context

There are some recognised exceptions to the general position, including that an insurer may be compelled to produce a policy on the application of a liquidator to access information concerning the insurance cover of a potential defendant,[57] and where a party has a direct right to bring a claim against an insurer.[58]

A further exception is where the insurance policy is relevant to an application for leave to proceed against an insolvent respondent under subsection 440D(1) or section 471B of the Corporations Act.[59] This exception arises because the question of availability of insurance is a matter that is proper for the Court to consider in determining whether to grant leave to proceed.[60]

Applications under the class action regimes

The power to compel a respondent to produce its insurance policy

Outside of the exceptions set out above, in recent years, representative applicants in the class action context have also sought the production of a respondent's insurance policy (or similar information regarding the respondent's financial position) pursuant to specific provisions in Part IVA of the *Federal Court Act 1976* (Cth) (**FCA Act**) or the equivalent provisions in State class action legislation.[61]

Three principal arguments have been relied upon by class action applicants to compel the production of insurance policies:

1. the general power of the Court to make any order the Court thinks appropriate in a representative proceeding (for example, section 33ZF of the FCA Act).[62]

2. the Court's case management powers to facilitate the overarching purpose of resolving disputes as quickly, inexpensively and efficiently as possible (for example, section 33P of the FCA Act).[63]

3. the notion that insurance documents will assist the applicant's lawyers to assess the reasonableness of any settlement offer, having regard to the requirement for the Court to approve the settlement of a representative proceeding (for example, under section 33V of the FCA Act).[64]

55 *Evans*, [31]; see also *Agnello*, [31] – [35].

56 *Kirby v Centro Properties Limited (ACN 078 590 682)* [2009] FCA 695 ('***Kirby***'), [13].

57 See, for example, *Grosvenor Hill (Queensland) Pty Ltd v Barber* (1994) 48 FCR 301, 311; *Re Banksia Securities Ltd (Receivers and Managers Appointed)* (2013) 278 FLR 421; *Korda (Receiver and Manager), in the matter of South Eastern Secured Investments Limited (Receivers and Managers Appointed)* (2010) 191 FCR 63.

58 For example, under s 562 or 601AG of the *Corporations Act 2001* (Cth) or s 117 of the *Bankruptcy Act 1966* (Cth).

59 See, for example, *Re Gordon Grant and Grant Pty Ltd* (1982) 1 ACLC 196; *Glaister v Banwell Pty Ltd (Subject to a Deed of Company Arrangement)* [2003] WASC 101; *Company Solutions (Aust) Pty Ltd v Keppel Cairncross Shipyard Limited (In Liq)* [2004] QSC 379; *Treadstone Developments Pty Ltd Wever Family Trust v The Salisbury Group Pty Ltd* [2014] QSC 109.

60 See, for example, *Watson & Co Superannuation Pty Ltd v Dixon Advisory and Superannuation Services Ltd* [2022] FCA 1273 and *Lopez v Star World Enterprises Pty Ltd* [1997] FCA 454.

61 *Kirby*, *Simpson v Thorn Australia Pty Ltd trading as Radio Rentals (No 4)* [2019] FCA 1229 ('*Simpson (No 4)*'), *Mallonland Pty Ltd v Advanta Seeds Pty Ltd* [2019] QSC 250 ('***Mallonland***'), *Evans*, *Agnello*, *Watson & Co Superannuation Pty Ltd v Dixon Advisory and Superannuation Services Ltd (No 3)* [2023] FCA 988 ('***Watson (No 3)***').

62 See, for example, *Simpson (No 4)* and *Evans*.

63 See the discussion in *Evans*, [76] – [80].

64 See, for example, *Kirby*, *Mallonland*, *Watson (No 3)* and *Agnello*.

The High Court in *Brewster*[65] explained that section 33ZF is a "supplementary or gap-filling provision"[66] and may not be relied upon "as a source of power to do work beyond that done by the specific provisions which the text and structure of the legislation show it was intended to supplement".[67] The Federal Court since *Brewster* has taken the view that section 33ZF cannot be used to override the conventional position that insurance documents are not discoverable.[68] In any case, however, the recent authorities make clear that the Court has power to compel the production of a respondent's insurance policy in an appropriate case to ensure that justice is done (for example, under section 23 of the FCA Act).[69]

Principles in relation to the exercise of the Court's discretion

Whether it is appropriate for a Court to order such a production is a matter for the Court's discretion. That threshold is a high one; the applications in the class action context have been decided adversely to the applicant in all but one reported decision, where relevantly the insurer was also a party to the proceeding.[70]

The principles that may be distilled from the recent cases on the considerations the Court will take into account in considering whether to exercise its discretion are as follows:

- A relevant starting point for the Court is that insurance documents are commercially confidential as between insurer and insured.[71] A respondent should not be obliged to disclose private information unless the course of justice requires that be done.[72]
- An applicant has no right to examine a respondent as to its financial means to decide whether it is worth proceeding with the case (save for limited exceptions in the insolvency context).[73]
- Case management principles do not, of themselves, justify an order for production of an insurance policy that is not otherwise discoverable.[74] Nor is it a sufficient justification that the production of insurance documents may be of assistance to group members.[75]
- If the production of a document will confer a tactical advantage on the applicant, and a corresponding disadvantage upon the respondent, thereby creating an asymmetry in the parties' positions, facilitating such a course would not usually be appropriate to ensure that justice is done.[76] The Court will be reluctant to compel a party to produce commercially confidential documents for the purpose of a mediation and "even more reluctant" where that would "confer an asymmetric commercial advantage in favour of one party at the expense of another".[77] This is generally likely to be the case where one party seeks to compel another party to produce insurance documents.[78]
- The fact that a class action settlement requires curial approval does not support the disclosure of a respondent's insurance policy. An applicant's lack of knowledge as to the respondent's insurance position does not preclude the applicant's advisers from forming an opinion as to the reasonableness of a proposed settlement.[79] The fact that information contained in any insurance documents may conceivably be relevant to whether a settlement is approved by the Court is not an appropriate reason to order that they be produced to the applicant.[80] If the Court requires further information in order to consider whether or not to approve a settlement, it has an "armoury of powers by which further information can be obtained" at that stage.[81] For example, the Court could receive the insurance policies from the respondent on a confidential basis, in the context of such an application.[82]
- It can be expected that an insured respondent will be motivated to take the necessary steps to advance any claim for indemnity and to contest any declinature which it contends was wrongly made.[83] An application for production of a respondent's insurance policy is not the appropriate vehicle for an applicant to determine whether to commence proceedings against the respondent's insurer.[84] In any event, considerable difficulties would be faced by a plaintiff as a stranger to the policies in bringing proceedings against an insurer outside an insolvency scenario.[85]

Corporations Act s 247A: An alternate basis for applicants in securities class actions?

An alternate basis that applicants in securities class actions may seek to rely upon is section 247A of the Corporations Act, whereby the Court may authorise a member of a company or registered scheme to inspect books of the company or scheme. Such an order can only be made where the Court is satisfied the applicant "is acting in good faith and that the inspection is to be made for a proper purpose".[86] This is a "subjective jurisdictional fact on which the discretionary power is conditioned".[87] If that condition is met, the Court will determine whether to grant access to inspect the relevant documents as a matter of discretion.

Two recent decisions provide welcome guidance on the circumstances in which an application to inspect an insurance policy in the context of a securities class action may be granted.

In *Ingram atf Ingram Superannuation Fund v Ardent Leisure Ltd* [2020] FCA 1302, the representative applicants in a securities class action brought against Ardent Leisure Group sought the inspection of documents, including policies of insurance held by the company and notifications of any claims to insurers.[88] The purposes for which the applicants sought the documents was threefold, namely:

1. to assess the commercial viability of pursuing the class action;
2. to conduct the class action in a proportionate and efficient manner; and
3. to facilitate the holding of a mediation with the company.[89]

Derrington J considered that "the object of the application is to substantially improve and

65 *BMW Australia Ltd v Brewster* (2019) 262 CLR 574 ('***Brewster***').
66 *Brewster*, [46].
67 *Brewster*, [70].
68 *Evans,* [58].
69 *Evans*, [5] and *Owners - Strata Plan No 87,231 v 3A Composites GmbH (No 6)* [2023] FCA 188 ('***3A Composites***'), [17].
70 *Simpson (No 4)*.
71 *Evans*, [22]; *Agnello*, [57].
72 *Agnello*, [57].
73 *Evans*, [47]; *Agnello*, [57].
74 *Evans*, [77]; *Agnello*, [60].
75 *Evans*, [58].
76 *Evans,* [98]; *Agnello,* [58].
77 *3A Composites,* [19].
78 *3A Composites,* [22].
79 *Evans,* [104] – [106]; *Kirby,* [25]; *Mallonland*, [23].
80 *Evans*, [99] - [102]; *Agnello*, [59].
81 *Watson (No 3)*, [24]; *Agnello*, [59].
82 *Evans*, [99] - [102].
83 *Evans*, [85] – [87].
84 *Evans*, [88].
85 *Evans*, [90].
86 Corporations Act s 247A(1).
87 *Ingram atf Ingram Superannuation Fund v Ardent Leisure Ltd* [2020] FCA 1302 ('***Ingram***'), [53].
88 *Ingram*, [47].
89 *Ingram*, [70].

advance the applicants' position in the class action" and "[n]ecessarily, that will involve a concomitant diminution of the respondents' position".[90] His Honour dismissed the application, holding that there was no "proper purpose" because none of the applicants' purposes were connected to their rights as shareholders, each being related to allegations that the respondents engaged in misleading or deceptive conduct or contravened the continuous disclosure obligations at a time at which they were no more than prospective investors.[91] Further, even if the applicants had established a proper purpose, his Honour would not have exercised the discretion in favour of permitting access to the insurance policies.[92] The facts that there was no evidence of impending insolvency and that the applicants' claim in the class action was unlikely to exceed the value of the respondents' net assets weighed heavily against the exercise of discretion.[93]

In *Furniss v Blue Sky Alternative Investments Ltd* (2021) 7 QR 426, the applicant sought to inspect any policies of insurance that might respond to a claim against the company's directors and officers, in the context of investigating a potential class action for losses sustained as a shareholder of the company and to assess the utility in bringing any available claim against the directors and officers.[94] In that case, the applicant was investigating causes of action which accrued both prior to, and at the time of, being a shareholder. Justice Crow held that "the pursuit of a reasonable suspicion of a breach of a duty" is a proper purpose within the meaning of section 247A[95] and noted that the applicant's purpose was to investigate "a potential representative claim or class action for his losses sustained as a shareholder of Blue Sky".[96] Accordingly, on the facts of that case, Crow J was satisfied that the application was made in good faith and for a proper purpose. Given the evidence that the insurance position was "critical" to any ability to recover from the respondent, his Honour held that the circumstances of the case were such that it was appropriate to exercise his discretion in favour of permitting the applicant access to inspect the insurance policies.[97]

This is an article we have prepared having reviewed the cases which are cited. This is not legal advice and if this issue is relevant to you – please contact our team.

90 *Ingram*, [71].
91 *Ingram*, [73] – [77].
92 *Ingram*, [81] and [100].
93 *Ingram*, [85] – [86].
94 *Furniss v Blue Sky Alternative Investments Ltd* (2021) 7 QR 426 ('***Furniss***'), [8].
95 *Furniss*, [54].
96 *Furniss*, [66]. Le Miere J in *Snelgrove v Great Southern Managers Australia Ltd (in liq) (Receivers and Managers Appointed)* [2010] WASC 51, [67] similarly held that "[t]he purpose of the plaintiffs in seeking access to the relevant insurance policies is to assist them in considering the economic viability of pursuing their proposed action against the company" was a proper purpose.
97 *Furniss*, [68].

INTERVIEW WITH ANNE KNIGHT

Anne Knight is General Counsel at the Insurance Council of Australia.

KWM chatted with Anne over lunch in February 2024 to learn more about her journey from Grace Bros to commercial litigator to the Insurance Council of Australia.

Please tell us about your first job!

My first job was at a retailer called Grace Bros, in their fashion section at Warringah Mall. I did everything there, from working the checkout to fashion parades.

It was my first experience dealing with members of the general public. It is a great experience when you are young, to work with customers and try to meet their expectations. It was good training for my career in the law as I learnt you have to look after your client.

When you were young – what did you want to do?

I wanted to be an actress and win an Academy Award. A love for theatre runs through my family. My brother was head of NIDA for 20 years. When I was young, I did a lot of amateur drama productions, everything from playing Eurydice in Orpheus in the Underworld to touring Sydney in a production of Winnie the Pooh. It was all great fun.

By fifteen I had started to think seriously about the law. But the experience in the theatre was so valuable to me. It gave me the confidence to stand up and talk, to negotiate and advocate my position.

Can you describe the path to your current role at the Insurance Council of Australia?

For most of my career I have been a commercial litigator with a focus on financial services (including at Mallesons!). As a commercial litigator in private practice, I acted for insurers in a variety of matters.

After being in practice for many years, in 2014 I was seconded to the Commonwealth Bank and was eventually appointed Head of Litigation at the bank. In that role I was involved with various aspects of the insurance business that the bank had at that time.

In around August 2020, I celebrated a significant birthday and had time to reflect. Whilst I had really enjoyed working at the bank I decided it was time to 'turn the page' as I had been working very intensively for many years. I took a break with no intention of working again.

But then, I received a call from Andrew Hall, the CEO at the Insurance Council of Australia. I had known Andrew for quite a few years as we had worked together at the Commonwealth Bank. He told me that the insurance industry was dealing with a significant issue as to whether business interruption policies responded to losses arising from the COVID-19 pandemic. Test cases on the issue were before the Courts, and Andrew said he needed my help. I was assured it would be a six-month position and only three days a week. Needless to say, three years later I am still here.

I really enjoy this job. After a career in private practice, the position has a very different focus and purpose. I feel that, in a small way, I am contributing to our society as insurance plays a critical role in Australia for our communities, businesses and families when something goes wrong. I feel I am doing something useful in supporting the advocacy work we do with government, consumers and our own members on important issues such as climate change and technology led innovation. I enjoy the work, and I am enjoying the challenge of doing new things.

What does your current role involve and what energises you about it?

When I first started at the Insurance Council of Australia, I was brought in primarily to coordinate the COVID-19 business interruption test cases, but now I have broader responsibility for legal, risk and governance.

What I like about the position of General Counsel is that you end up being a "jack of all trades". In one day I can review a contract, consider guidance in respect of the General Insurance Code of Practice, review a submission to

a government agency, manage a governance issue or identify a risk.

I regularly engage with regulators and government agencies. We have recently engaged with ASIC on their latest project into IDR processes, with Treasury and on the possible standardisation of clauses and the ACCC on guidelines for industry sustainability initiatives. It's the variety that keeps me here, because I am not sure what will make its way across my desk.

What do you see as the burning issues for the general insurance industry in 2024?

There are three burning issues for the general insurance industry in 2024: the protection gap, regulation and climate change.

In Australia there is a growing protection gap with consumers having insurance that does not cover the damage caused. We are seeing this a lot, particularly in the context of natural disasters as Australia's exposure to extreme weather events is more acute. There is clearly a rise in people who are not insured or are under insured. This has serious implications. It can not only make households and families more vulnerable but it also places greater pressure on governments to bear recovery costs. We are working alongside community, government and industry to encourage strengthening the resilience of our homes and businesses by mitigating risk. This in turn will enable insurers to price risk better and provide insurance coverage at affordable pricing.

This leads into the regulatory issue. We need to consider how to address the protection gap, without making the regulatory burden too onerous for insurers. If regulation becomes too burdensome, operating costs increase for insurers, and ultimately this impacts whether people can afford insurance. Our members can only help people with insurance, and those individuals who don't have insurance have to look for assistance from government. Currently, the insurance industry has a heavy regulatory burden and I think the government should proceed with a post-implementation check now that most of the legislation recommended by the Hayne Royal Commission has been passed.

We also need to keep our eyes open to the ongoing implications of climate change. Climate change has meant that Australia is not as attractive to reinsurers. In September last year representatives of the Insurance Council of Australia and the Assistant Treasurer, Stephen Jones, met with global reinsurer leaders in London and Munich. The reinsurers not only explained why they have repriced risk in Australia because of the severe and frequent weather events but the importance of taking steps to mitigate risk such as building flood levees and not building homes in the bottom of floodplains.

Does the Insurance Council of Australia frequently visit other markets?

We are planning a United States study tour to Washington DC and California later this year. California is of particular interest where some insurers have taken themselves out of the market, specifically in relation to fire risk. At the same time there are climate adaption and mitigation programs being implemented throughout California designed to foster resilient communities. Whilst in Washington DC there will be discussions with members of the US Congress, insurers and industry associations so we can obtain some insight on other issues relevant to the insurance industry. So many of the risks and issues in Australia's insurance market are not limited to Australia including the capacity and provision of capital, data protection and analytics management.

When you are not working - where might we find you?

I have an addiction, and it is travel. This is also something that runs through the family. My mother was an airhostess with QANTAS in the '40s and my father was a sea captain. Something I love about my job is that it allows me the flexibility to travel. I'm off to Paris for the Olympics in July.

Travel has been something I've always loved. For my fiftieth birthday I climbed Mt Kilimanjaro and last year I walked the Camino. If I'm not in the office, you will find me travelling.

INTERVIEW WITH CHRISTINE CUPITT

Christine Cupitt is the Chief Executive Officer at the Council of Australian Life Insurers (CALI).

KWM sat down with Christine to learn more about her experience at CALI and her views on the current issues facing the life insurance industry.

What was your first job?

I worked at a children's play centre, one of those ones that have ball pits and birthday parties. I spent a lot of time making fairy bread.

Those kinds of jobs are good, you have to do everything – make coffees, clean up after others, and generally help people with what they need.

When you were young – what did you want to do?

I always wanted to be a lawyer. I remember I was in very early primary school when Mary Gaudron was appointed to the High Court. I was six years old and that had a real impact on me, I just thought it was so cool. I was so excited about her being the first female appointment.

Did you always want to work in insurance?

Not at age six.

I honestly hadn't considered working in insurance until October of 2022 when I got the call about this job.

This opportunity came totally out of the blue but quickly got my interest because of its close connection to positive social and economic changes for Australians of all walks of life.

If it wasn't for a persistent recruiter, I might have missed this opportunity. If she had not been so supportive of mid-career people with children, then I would not have put myself forward in the recruitment process.

What drew you to your current role at CALI?

I had been working in banking and was very connected to the social and economic purpose of banking and the way banking supports people to make major life decisions and start businesses. With that background, it was easy to connect with the purpose of insurance.

Insurance plays a number of roles.

At a social level, there is contributing to the financial resilience of the community and ensuring people are not left behind, which is such a clear and guiding value for our industry.

But there are also the individual outcomes. People who need to claim on their life insurance are often experiencing some of their worst days. They are dealing with so much in their personal lives that having the financial support from life insurance allows them to focus on managing their health or disability, or grieving the loss of a loved one.

Can you tell us more about what CALI's role in the life insurance industry is?

CALI was established by leaders of the life insurance industry in July 2022, and I started as CEO in January of 2023.

We set up CALI in response to changes in the market and the consolidation of specialist life insurers.

Everyone who comes to work in our industry is connected with a strong social purpose. Australian customers are at the heart of everything people in our industry do every day. To reflect that, life insurers need a clear and trusted voice.

At CALI, we ensure there is dedicated representation of life insurers and the needs of Australian customers in Canberra, with regulators and with other stakeholders like the Australian Financial Complaints Authority and the Life Code Compliance Committee. Specifically, we talk to regulators about how life insurance fits into the health and disability landscape, not just the financial services and wealth protection landscape. This has been a new conversation that would not be happening without CALI. If life insurers don't have their own voice, there is a real risk that the specific needs of this industry, and most importantly of the people we serve, are overlooked.

It has been a privilege to help set CALI up and to build a team that believes in the contribution life insurance makes and has ambition for it. I use that word, ambition, a lot to describe CALI and what we are aiming to do. The board wants CALI to lead improved life insurance outcomes for Australians and to grow a sustainable and vibrant industry.

What energises you about your current role?

Being in a start-up is so varied. Your day can start by picking the pay-roll software and end with preparing the five-year plan.

Part of my focus in establishing CALI is ensuring that it is an organisation that recognises everyone has commitments outside of work. For me that's kids, but it could be sport or any other obligation. At CALI we have twelve children under twelve among eight staff members, so it is important to me that we are a very flexible and innovative workplace.

I have also really enjoyed working with the Board and member CEOs to understand how they want CALI to progress a customer centred policy agenda that continues to lift the reputation of life insurance.

What do you see as the burning issues for the life insurance industry in 2024?

We have to get financial advice right. It is a big focus area for the Federal Government, for CALI and our members, and it should be a focus for the broader community.

There are only around 1000 financial advisers in Australia who regularly provide financial advice on life insurance. Australians shouldn't have to wait in line to pay $3,500 on average for financial advice.

There is a huge unmet need for financial advice.

This is about giving people more choice. With the correct safeguards and consumer protections in place, we need to provide more services in this area to ensure better outcomes for Australian workers and their families.

When you are not working - where might we find you?

Outside of work, I enjoy spending time with my children and husband. I have two children, an eight-year-old and a two-year-old. We love getting away to the Snowy Mountains and skiing or hiking together.

INTERVIEW WITH STEVEN LOVEDAY

Steven Loveday is Managing Principal for Marsh FINPRO (Financial and Professional Services).

Steven has a wealth of knowledge and experience in the insurance industry. We recently caught up with him to discuss his role at Marsh and for some wonderful insights.

About your role at Marsh

You've worked at Marsh for close to 40 years! Tell us about your role, and how you got there.

As Managing Principal for Marsh FINPRO (Financial and Professional Services) I look after large law firms and professional services firms. I deliver insurance products and solutions across a breadth of financial lines – including PI, D&O, statutory liability, crime, EPL and cyber, in collaboration with our cyber placement and advisory teams.

In recent years we began to run the Marsh Australia Lawyers practice group which harnesses a wealth of insightful content shared by our lawyer practice group colleagues in London and New York. This allows us to offer rich insight and updates on market shifts to our law firm clients in Australia, who face similar issues.

I also support clients who have their programmes placed with reinsurers, and work closely with the alternative risk solutions team delivering for clients involved with captive insurance companies, as well as the claims team.

My broking career began in 1977 as an insurance clerk at Stenhouse Insurance brokers. After working at a number of smaller brokers I moved to Fenchurch Insurance brokers which was subsequently bought by Marsh Australia. I took this opportunity to move into Marsh's FINPRO division as a broker and have enjoyed a variety of leadership roles in the years since.

PI Insurance / work with Solicitors / Law Firms

How would you describe the current state of the professional indemnity insurance market for solicitors?

It really is a two-speed market. Small law firms are able to readily purchase affordable and appropriate levels of cover in Australia.

For the larger law firms, the market is more challenging. There is less local capacity and they must access international markets. Many insurers are increasingly concerned with the severity of claims. As a result, they have not only reduced the capacity they provide for law firm PI programmes but also attach higher up in the programme, often above $50m and in some cases $100m.

There are also hard market conditions with increased premiums, restrictions around insurer capacity and greater underwriting scrutiny, and insurers have been particularly selective around the risks they underwrite.

How do you see the balance between adequate coverage and affordability for solicitors, and what strategies do you employ to strike that balance?

Our role as brokers is to ensure that the appropriate insurers are positioned into the client's programme to help drive favourable long-term results.

For example, the selection of the insurer for the primary layer is not only important for the coverage and pricing they are willing to provide but also their ability to manage claims efficiently. When clients purchase large PI programmes and a number of layers are placed into the market to produce the necessary cost benefits, the selection of the lead insurers for each of those layers is a key consideration.

Other strategies include reviewing client risk management strategies and identifying any key risk areas through the lens of their client-base, including client claims history.

Have there been any recent notable changes to policy terms/coverage within the professional indemnity insurance market? What issues/ areas are insurers seeking additional information?

The biggest change in terms of coverage or clarification of coverage in the past few years has been to provide affirmative cover or exclusions (as mandated by Lloyd's of London) to clarify

insurers' position in the event of a claims issue or cyber event.

Insurers are also focusing heavily on the application of a sanctions exclusion with additional countries being added to the list, as well as seeking additional information around the adoption of generative AI, new technology and cyber risks.

Other emerging issues include the gratuitous use of the Financial Interest clause that is used in global PI programmes, and the application of anti-money laundering legislation.

Misinformation is also gaining prominence as a business risk. As Marsh flags in the latest Global Risks Report, which we co-author annually with the World Economic Forum: "*To combat growing risks, governments are beginning to roll out new and evolving regulations to target both hosts and creators of online disinformation and illegal content*." It is too soon to gauge the likely effects of the Australian Labor Party's draft Misinformation and Disinformation bill.

What recent key trends or developments in the professional indemnity insurance space do you find most impactful and what strategies do you adopt to deal with them?

The impact of generative AI, how lawyers are trained to use generative AI and how it impacts a firm's resourcing are likely to be the biggest driver for the next few years. We predict that insurance coverage is likely to change due to generative AI, and risk control and governance will gain greater prominence. We are developing risk presentations for our clients in relation to evidencing compliance with generative AI risk control and governance and designing governance structures.

2023 has seen numerous high profile cyber-attacks on law firms. What recommendations do you have for insureds in relation to cyber risk management?

Many firms, including law firms consider a data breach as one of the highest risk issues they face - not only due to the impact of the breach but also due to the reputational damage that potentially results.

Data management, including the data management by third-party suppliers, are priority areas. Well-developed incident response plans are now considered essential by insurers. A firm's cyber risk management plan should prescribe multi-factor authentication, privileged access protocols, back-up and patching plans; and offensive and defensive detection mechanisms.

Do cyber-attacks have the potential to result in a D&O claim?

Yes, absolutely. We are seeing a number of D&O claims in other jurisdictions such as the US and UK where actions have been taken against directors following a cyber attack. In Australia there have been a number of high-profile companies that have experienced data breaches and brand damage as a result of these attacks.

AI and ChatGPT was all the hype in 2023! Do you have any words of wisdom for insureds in relation to their use of AI?

There are numerous opportunities for law firms to benefit from adopting AI, including automating administrative tasks such as document searching, where it would boost efficiency and accuracy. However, it is paramount that firms have a clear and detailed policy in relation to AI use which addresses confidentiality, data privacy, security, and ethical implications, plus user training. Additionally, we recommend firms carry out ongoing monitoring and audits of AI systems to identify and address potential risks or issues.

And on a lighter note…

Where can we find you when you aren't at Marsh?

You are likely to find me down at the beach, walking or swimming.

CASE NOTE

NOTHING UP MY SLEEVE

***Koolan Iron Ore Pty Ltd v Infrassure Ltd (No 2)* [2023] FCA 1654**

SNAPSHOT

- This case was primarily about the quantification and calculation of loss under a business interruption policy.
- Construing a business interruption indemnity clause involves balancing the need to give a fair indemnity for the loss suffered and calculating the insurer's liability by reference to an agreed formula with an identifiable starting point.
- It is possible in theory to make a claim based on a future business plan, but it is necessary that the plan has been objectively manifested or formally adopted. The plan cannot be purely hypothetical, nor can it be formulated purely for the purpose of the insurance claim (or substituted after the insured peril has occurred).
- Adjustment clauses in business interruption policies are intended to capture the results that the business would have achieved had the interruption not occurred.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The appropriate interpretation of business interruption and adjustments clauses in property damage policies.
- The basis upon which the insured is entitled to calculate its claim under the Policy. Namely, whether an insured can submit a hypothetical business plan as the basis of its loss?
- Section 57 of the *Insurance Contracts Act* (**ICA**).

Facts

- Koolan Iron Ore Pty Ltd (**KIO**) operated an iron ore mine on Koolan Island off the coast of Western Australia. The Main Pit, which had high quality iron ore, was separated from the Indian ocean by a seawall (**Seawall**).[98]
- On 24 October 2014, an initial slump occurred in the Seawall.[99] The Seawall collapsed on 25 November 2015, flooding the Main Pit with water (**Seawall Collapse**).[100]
- KIO held a Material Damage and Business Interruption Insurance Policy (the **Policy**) underwritten by a market of insurers, which included Infrassure Ltd (**Infrassure**).[101]
- KIO made a claim on the Policy. The business interruption claim was settled in July 2017 with all insurers except Infrassure.[102] It was not in dispute that Infrassure was liable to indemnify KIO for business interruption. Infrassure was liable for 7.5%. The reason Infrassure did not settle is not explicitly addressed in these reasons. However, it is apparent from this dispute that Infrassure did not agree with the basis and quantum of that claim.[103]
- On 10 June 2021, Infrassure assessed and paid KIO $801,832 for business interruption loss. KIO commenced proceedings in the Federal Court of Australia to recover Infrassure's share of the loss, which KIO said was $8,491,337, plus interest.[104]
- The difference between the parties' assessment of quantum was attributed to several issues, including:
  - differences in the construction of the Business Interruption clause (**BI Clause**);
  - whether KIO established it would have adopted a revised hypothetical mine plan (**RMP**) or continued with the existing mine plan (**EMP**) which KIO had been working from at the time of the Seawall Collapse.[105] KIO argued that it would have mined according to the RMP but for the Seawall Collapse. The RMP had not been proposed, adopted or implemented before the Seawall Collapse, but was developed for the purposes of its insurance claim;[106]

98 *Koolan Iron Ore Pty Ltd v Infrassure Ltd (No 2)* [2023] FCA 1654 [1] ('***KIO v Infrassure***').
99 This became the date of loss for the start of the Indemnity Period.
100 *KIO v Infrassure* [1].
101 *KIO v Infrassure* [2].
102 *KIO v Infrassure* [3].
103 *KIO v Infrassure* [4].
104 *KIO v Infrassure* [4].
105 *KIO v Infrassure* [26].
106 *KIO v Infrassure* [30].

- whether a clause permitting adjustments based on trends, variations and other circumstances of the business (**Adjustments Clause**) allowed adjustments to the claim, and the basis on which those adjustments were calculated;[107] and
- whether KIO was entitled to be paid interest from 31 August 2017, under section 57 of the ICA.[108]

Analysis by the Court

The counterfactual: EMP vs RMP

- As a preliminary issue, the Court was asked to determine whether, had the Seawall Collapse not occurred, KIO would have worked the mine according to:
  (a) the EMP (being the existing plan) for the entirety of the indemnity period; or
  (b) the EMP and then the RMP (the revised plan) once it was prepared on 28 February 2015.
- The Court concluded that KIO was committed to the EMP.[109] For the purpose of its claim, KIO had prepared a "hypothetical board paper" in an attempt to prove what it would have done but for the collapse of the seawall.[110] However, the contemporaneous documentary evidence showed a consistent commitment to the EMP, and an uncertainty as to whether any significant revision to the EMP was planned or whether it would be approved by the board.[111]

Indemnity under Business Interruption Clauses

- KIO submitted that the BI Clause, the Basis of Settlement and the adjustments clause should be construed to allow KIO to make a claim based on the RMP, as the RMP was a "trend, variation or other circumstance" that could be used to adjust the Rate of Gross Profit and Standard Output.[112] KIO tried to overcome definitional limitations by submitting that the Adjustments Clause was broad and was intended to "err on the side of indemnity".[113]
- Infrassure's position was that the correct way to calculate KIO's loss was by reference to Output during the 12 months immediately before the Seawall Collapse, based on the EMP and make adjustment for any variations.[114]
- The Court rejected the proposition that KIO could be indemnified on the basis of the RMP because:
  - the concept of adjustment does not entitle KIO to use rates of gross profit and output based on the RMP;
  - inherent in the nature of an "adjustment" is that it must still be based on and referable to actual numbers and historical data;[115] and
  - adopting the RMP did not fall within the meaning of "trend of the business" in the policy. A "trend" is an observable direction in which the business is heading. The Court concluded that an internal business decision is not the same as a trend.[116]

107 *KIO v Infrassure* [31]-[32].
108 *KIO v Infrassure* [54].
109 *KIO v Infrassure* [416].
110 *KIO v Infrassure* [87], [397]-[403].
111 *KIO v Infrassure* [417].
112 *KIO v Infrassure* [31].
113 *KIO v Infrassure* [135].
114 *KIO v Infrassure* [159].
115 *KIO v Infrassure* [141].
116 *KIO v Infrassure* [144]-[148].

- Further it was inconsistent with the objective of an adjustment clause to posit a "trend, variation or circumstance" that was entirely hypothetical.[117]
- Having found that KIO would have continued with the EMP for the indemnity period, the Court considered whether KIO would have achieved the EMP in its entirety. KIO had consistently fallen short of its monthly targets for ore mined, and therefore would only have achieved 91% of the EMP.[118]

Other issues

- There were some secondary issues considered the Court, including:
  - KIO claimed increased costs of working in subsidiary pits. The Court did not rule out KIO's claim that its variable costs of mining were higher in the subsidiary pits than they would otherwise have been.[119] Yet, the Court did not accept that these costs fell within "additional expenditure" that was necessary for the sole purpose of mitigating KIO's losses and as such cover was not available.[120]
  - KIO sought to claim foreign exchange losses it had suffered as a result of hedging arrangements agreed with its main purchasers. The Court found these losses would have been suffered regardless of the Seawall Collapse (and therefore KIO's claim could not be adjusted to incorporate those losses, and KIO was not entitled to be indemnity under the Policy).[121]

Interest under section 57 of the ICA

- KIO submitted it was entitled to interest from 31 August 2017 (the date Infrassure accepted it was liable at least on the EMP basis). The Court determined interest could be charged from 7 December 2020, being one month after the numbers of the EMP claim had crystallised, accounting for the time that Infrassure had to consider the claim and to arrange payment.[122]
- The orthodox approach to determine if and from when an insurer is liable to pay interest under section 57 of the ICA turns on two matters.[123] First, when did Infrassure have sufficient time to investigate KIO's claim and form a view on it? Second, was Infrassure's decision to withhold payment correct in light of the Court's determination on its liability to pay?
  - On the first question, the Court found that Infrassure would not have been expected to deal with or consider the EMP versus RMP issue until it was quantified and put before it. The onus was on KIO to define its claim, and that only occurred once a witness statement from KIO's loss adjustment consultant was finalised and submitted.[124]
  - On the second issue, KIO did not succeed on any of its pleaded grounds in this case and therefore it was not unreasonable for Infrassure to withhold payment.[125]
- Interest under section 57 of the ICA can only begin to accrue at the point at which it becomes unreasonable for the insurer to withhold payment. This means that an insured will need to formulate the terms of its claim, and furnish the insurer with sufficient information to determine it, before the insured can claim interest under section 57.

117 *KIO v Infrassure* [168].
118 *KIO v Infrassure* [572].
119 *KIO v Infrassure* [617].
120 *KIO v Infrassure* [653]-[654].
121 *KIO v Infrassure* [729] and [732].
122 *KIO v Infrassure* [757].
123 *KIO v Infrassure* [753].
124 *KIO v Infrassure* [754].
125 *KIO v Infrassure* [758].

CASE NOTE

THE LIGHTS ARE ON BUT NOTIFICATIONS ARE HOME

***Hakea Holdings Pty Ltd v Neon Underwriting Ltd* [2023] FCAFC 34**

SNAPSHOT

- The Court considered the meaning of "personal advantage" in the context of an exclusion clause in a Directors and Officers policy (**D&O**).
- Where a clause excludes liability for claims in connection with a director or officer gaining a "personal advantage", those words, defined by their ordinary and natural meaning, are capable of including a commercial opportunity, even when that opportunity is not regarded as property, a contractual right, or a legal status.
- Where an insuring clause requires a claim to be "first made" during the period of insurance and "claim" is defined as "written notice received" by an insured; a claim is taken to have been made when the written notice was "received".

INSURANCE ISSUES CONSIDERED BY THE COURT

- What is the meaning of "personal advantage" in an unfair advantage exclusion in a D&O policy?
- Does a claim need to be read and understood to be received or is it merely required to come into the recipient's possession?

Facts

- Mr McGrath was the sole director, shareholder, secretary and general manager of Denham Constructions Pty Ltd (**Denham**), and also a director of Hakea Holdings Pty Ltd (**Hakea**).
- Hakea held a D&O policy (the **Policy**) underwritten by the defendant, Neon Underwriting Limited for and on behalf of the underwriting members of Lloyds Syndicate 2468 (**Neon**).[126]
- Hakea engaged Denham to design and construct a residential aged care facility on property owned by Hakea (the **Building Contract**). Work stalled due to Denham's severe financial distress.
- In *Hakea Holdings Pty Ltd v McGrath (No 2)*[127] it was held that Mr McGrath knowingly and deliberately did not disclose Denham's financial hardship (and consequent inability to complete the Building Contract in a timely fashion) to Hakea in an attempt to prevent termination of the contract or replacement of the builder.[128] Mr McGrath's non-disclosures and positive misrepresentations that the works would be completed in a timely fashion were found to breach Mr McGrath's duties as a director, pursuant to section 180(1) of the *Corporations Act*.[129]

Personal Advantage

- The primary judge concluded that Mr McGrath was not entitled to be indemnified under the Policy because of an exclusion clause which stated:

  > *The Underwriters shall not be liable for Loss in connection with any Claim…in connection with any Director or Officer gaining any personal profit or advantage…to which he or she was not or is not legally entitled.*[130]

- On appeal, Hakea argued that the exclusion clause did not apply as Mr McGrath had not received any personal profit or advantage within the meaning of the exclusion clause.

Claim first made

- Separate to the application of the personal advantage exclusion, there was a separate contest about whether a Claim had been made during the policy period. The principal question for the Court was whether the Policy required that the insured have actual knowledge of a claim in order for that claim to have been "made".[131]
- The insuring clause in the Policy required a claim to be "first made" during the period of insurance, with "claim" defined as "written notice received".[132]

126 *Hakea Holdings Pty Ltd v Neon Underwriting Ltd* [2023] FCAFC 34, [80] ('***Hakea v Neon***').
127 [2022] FCA 995.
128 *Hakea v Neon* [91], [92], [122].
129 *Hakea v Neon* [94].
130 *Hakea v Neon* [101].
131 *Hakea v Neon* [22].
132 *Hakea v Neon* [28].

- Hakea argued that a claim had been made against Mr McGrath during the period of insurance by way of a letter of demand sent by email to Mr McGrath on 20 January 2017.[133] The period of insurance ended on 23 January 2017.[134] Evidence before the Court was that the email address to which the letter was sent was "never check[ed]" by Mr McGrath as it was "rarely used".[135] This proposition needed to be weighed against the fact that the same email address had been used for communications between Mr McGrath and Denham's liquidators in September 2016.[136]

- The primary judge concluded that there was a claim made during the period of insurance. Neon appealed.[137]

Analysis by the Court

Claim first made

- The Full Court held that the primary judge did not err in concluding that the claim was made during the period of insurance.[138]

- On appeal, Colvin and Button JJ, with Jackman J agreeing, concluded that actual knowledge of receipt of a demand by an insured was not necessary for a claim to be "made" for the purpose of the Policy. Colvin and Button JJ clearly set out their view that "*[t]he definition of the word 'Claim' requires that the written notice has been 'received'; it says nothing about the insured having read, let alone read and absorbed the content of, the written communication*".[139]

- It was not contentious that, by the terms of the Policy, where a written notice satisfied the definition of "claim", a claim would have been made.[140] The definition of "claim" required that a written notice be "received". Their Honours concluded that the natural and ordinary meaning of "received" was that the notice be put into the possession of the insured, and that there was no basis to read in a requirement of knowing receipt.[141]

- Colvin and Button JJ said that "*the words of the policy…are paramount*" and that "*[p]articular terms of the policy are to be construed according to their natural and ordinary meaning, read in light of the contract as a whole, and having regard, where relevant and admissible, to surrounding circumstances*".[142]

- The Policy imposed an obligation on the insured to notify the insurer of any claims "*as soon as is reasonably practicable and in any event within 30 days after the end of the Period of Insurance*".[143] Colvin and Button JJ did not consider that this obligation meant a "claim" was confined to a claim that was known to the insured. Rather, the definition of "claim" and the notification requirement were two separate conditions that both needed to be satisfied for Mr McGrath to be indemnified.[144] The amount of time after a claim had been made in which the insurers could be notified pointed to a situation being contemplated by the parties whereby a "claim" may have been made before the insured became aware of it.[145]

133 *Hakea v Neon* [23].
134 *Hakea v Neon* [23].
135 *Hakea v Neon* [25].
136 *Hakea v Neon* [24].
137 *Hakea v Neon* [27].
138 *Hakea v Neon* [46].
139 *Hakea v Neon* [51].
140 *Hakea v Neon* [48].
141 *Hakea v Neon* [52], [54].
142 *Hakea v Neon* [49].
143 *Hakea v Neon* [31].
144 *Hakea v Neon* [56].
145 *Hakea v Neon* [57].

- Button and Colvin JJ also drew attention to the commercial undesirability of requiring proof of knowledge of a claim by an insured. They considered that a reasonable businessperson would prefer the certainty of proving that notice was received at a point in time ascertained by objective evidence, as is the case with an email landing in an inbox, over the uncertainty of proving the point in time when the content of the notice passed into the mind of the insured.[146]

Policy Exclusion – "Personal Advantage"

- Jackman J's reasons considered Hakea's appeal, in which Hakea submitted that continuation of the building contract did not constitute a "personal advantage" to which Mr McGrath was not "legally entitled" and, as such, the exclusion clause relied on by Neon to deny liability for the claim against Mr McGrath did not apply. His Honour accepted that there was a lack of Australian authority regarding these types of exclusion clauses (being "personal advantage" exclusion clauses).[147]

- Hakea provided a two-fold argument for this position:

    1. that Denham was legally entitled to the continuation of the contract until Hakea exercised its right to terminate or suspend the contract.

    2. that the continuation of the building contract was not a personal advantage to Mr McGrath because he was not a party to the contract.[148]

- Jackman J (with Button and Colvin JJ agreeing) rejected both of these arguments, holding that the primary judge was correct to characterise the continuation of the contract as a personal advantage to Mr McGrath.

- Jackman J considered that the words "personal advantage" should be construed to mean "*any matter which makes the director or officer better off or improves his or her circumstances*", and is not confined, as argued by Hakea, to an item of property, a contractual right, or a legal status and would include a commercial opportunity such as, in this case, the continuation of the building contract.[149]

- Jackman J rejected the argument that continuation of the contract for Denham was not an advantage to Mr McGrath because he was not a party to the contract, saying that "*the question of profit or advantage is a factual one, and there is no reason why the sole shareholder of a company which has enjoyed the continuation of such a contract and its revenue stream is not benefited as a matter of fact when the company itself has benefited*".[150] Jackman J also pointed out that, as sole director of Denham, Mr McGrath had full control of Denham's funds and could use them for his own personal use.[151]

Result

- The Full Court determined that the primary judge had been correct in concluding that:

    - the continuation of the building contract was a "personal advantage", such that the exclusion clause operated to exclude Neon's liability; and

    - the notification requirements in the Policy did not require notice of a claim to be knowingly received by the insured.

146 *Hakea v Neon* [58].
147 *Hakea v Neon* [136].
148 *Hakea v Neon* [111].
149 *Hakea v Neon* [118].
150 *Hakea v Neon* [128].
151 *Hakea v Neon* [122].

CASE NOTE

FCA CONCRETE IN ITS DECISION: THE ARTICLE IS DEFINITELY IMPOURTANT

***Prestige Form Group NSW Pty Ltd v QBE European Operations PLC* [2023] FCA 749**

SNAPSHOT

- The decision reinforces the key principles to be applied when interpreting contracts, including policies of insurance.
- When drafting and interpreting contracts, close attention should be paid to the words used in the clause under consideration, along with other clauses in the contract, to come to a harmonious interpretation and to give effect to the objective commercial intention of the parties to the contract.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Should exclusion clauses be interpreted in accordance with the ordinary principles of commercial contractual construction?

Facts

- On 24 February 2022, Prestige Form Group NSW Pty Ltd (**Prestige**) entered into a contract with Richard Crookes Construction Pty Ltd (**RCC**) to erect formwork for a construction project that RCC were completing.[152]
- RCC engaged a third-party contractor to pour concrete into the formwork erected by Prestige. The structure failed, causing the concrete slab to collapse (**Incident**).[153] RCC sought to recover its loss associated with the collapse from Prestige.[154]
- At the time of the Incident, Prestige had an active indemnity insurance policy with QBE (**Policy**). Both Prestige and RCC were Insureds under the Policy.
- Prestige sought indemnity under the Policy in relation to any liability for property damage it had to RCC as a result of the Incident.[155] The Policy provided cover for personal injury, property damage or advertising liability. The Policy contained a Contract Works Exclusion, which excluded liability "*in respect of or in any way connected with any liability in respect of damage to property which consists of or forms part of the Contract Works.*"[156]
- "Contract Works" was defined in the Policy as: "*engineering, construction, electrical or mechanical, installation or erection works, including formwork, hoardings, temporary buildings or works, scaffolding, principal supplied or free issue materials, materials for incorporation in the works and additions, alterations, refurbishing or overhaul of pre-existing property*"."[157]
- Prestige argued that the exclusion only applied to damage to property that it owned or that was in its possession. Prestige submitted that if that narrow construction were not adopted, it could give rise to anomalies.[158] In its argument about the text of the Policy, Prestige pointed to the use of the definite article "the" before "Contract Works" in the Contract Works Exclusion, rather than the use of "any" or "all" immediately preceding "Contract Works", which could have been used had the parties intended a broader meaning.[159]
- Prestige submitted (*inter alia*) that a broader interpretation: would be absurd and non-business-like; would result in commercially nonsensical results; and would be inconsistent with the intent of the Policy,[160] including because construction-related risks formed the majority of the risks to Prestige given it operated in the construction industry.
- QBE denied indemnity, arguing that the natural and ordinary words used in the contract meant that the exclusion was not so

152 *Prestige Form Group NSW Pty Ltd v QBE European Operations PLC* [2023] FCA 749 ('***Prestige***') [3].
153 *Prestige* [4].
154 *Prestige* [5].
155 *Prestige* [6].
156 *Prestige* [11].
157 *Prestige* [11].
158 *Prestige* [18].
159 *Prestige* [19].
160 *Prestige* [20].

limited.[161] In its response to the proposition that the use of the definite article ("the" Contract Works) enabled the Contract Works Exclusion to be construed in the manner contended for by Prestige, QBE submitted that it was difficult to reconcile with the wide array of entities captured by the definition of Insured (including RCC).[162]

- In terms of commercial outcomes, QBE's position was that Prestige's construction of the Policy would produce an uncommercial outcome.[163]

Analysis by the Court

- The issue between the parties was one of interpretation. There was no contest between the parties on the applicable principles.
- Prestige was unsuccessful. Justice Jackman concluded:

  "The use of the definite article "the" is too slender a hook to bear the weight of the proposed distinction between Contract Works which are owned by, or in the possession of, the Insured which makes the claim under the Policy, and those which are not."[164]

- In addition, his Honour considered that Prestige's construction could not be reconciled with the express language used in other exclusions.[165]

Applicable Legal Principles

- In coming to his decision, Jackman J considered and confirmed longstanding principles of contractual interpretation, including that:

  1. a reader must look to the ordinary and natural meaning of language used in a contract;
  2. commercial contracts must be construed with reference to the commercial purpose sought to be achieved by the terms, and should make commercial sense and avoid making commercial nonsense or working commercial inconvenience;[166]
  3. the terms of a contract (including an insurance policy) must be considered in their entirety, and the ordinary meaning of the words are to be prioritised when answering questions of ambiguity;[167]
  4. exclusion clauses are to be interpreted according to their ordinary and natural meaning, as understood from the entirety of the contract;[168]
  5. the insuring clause and any exclusion clauses must be read together in a harmonious way so that due effect is given to each;[169]
  6. where the literal meaning of a clause produces absurd results, the objective intention of the parties will prevail over the words strictly used;[170]
  7. the purpose of interpretation is to ascertain the parties' objective intention through the application of ordinary principles of construction;[171]
  8. to move beyond the ordinary and natural meaning of these words, there must be a strong commercial incentive or need to do so;[172] and
  9. the *contra proferentum* rule is one of last resort to be applied after orthodox processes of construction have failed to resolve any ambiguity.[173]

Result

- Applying these principles and looking at the words of the exclusion clause itself and of surrounding clauses, Jackman J denied indemnity to Prestige and the construction of the Policy it advocated for. This was largely on the basis that his Honour was not convinced:

  10. that the ordinary and natural meaning of the language used in the exclusion clause supported the narrow construction submitted by Prestige;[174] or
  11. that the interpretation submitted by QBE would produce commercial nonsense or absurd results.[175]

161 *Prestige* [22].
162 *Prestige* [24].
163 *Prestige* [26].
164 *Prestige* [27].
165 *Prestige* [28].
166 *Prestige* [14] citing *Ecosse Property Holdings Pty Ltd v Gee Dee Nominees Pty Ltd* (2017) 261 CLR 544 [17] (Kiefel, Bell and Gordon JJ); *Electricity Generation Corporation v Woodside Energy Ltd* (2014) 251 CLR 640 [35] (French CJ, Hayne, Crennan and Kiefel JJ).
167 *Prestige* [15].
168 *Prestige* [15] citing *Hakea Holdings Pty Ltd v Neon Underwriting Ltd* (2023) 164 ACSR 591 [103]-[104] (Jackman J, with whom Colvin and Button JJ relevantly agreed); *Star Entertainment Group Ltd v Chubb Insurance Australia Ltd* (2022) 400 ALR 25 [14] (Moshinsky, Derrington and Colvin JJ).
169 *Prestige* [15] citing *Hakea Holdings Pty Ltd v Neon Underwriting Ltd* (2023) 164 ACSR 591 [103]-[104] (Jackman J, with whom Colvin and Button JJ relevantly agreed); *Star Entertainment Group Ltd v Chubb Insurance Australia Ltd* (2022) 400 ALR 25 [14] (Moshinsky, Derrington and Colvin JJ).
170 *Prestige* [16] citing *HDI Global Speciality SE v Wonkana No. 3 Pty Ltd* (2020) 104 NSWLR 634 [48]-[53].
171 *Prestige* [16] citing *HDI Global Speciality SE v Wonkana No. 3 Pty Ltd* (2020) 104 NSWLR 634 [48]-[53].
172 *Prestige* [16].
173 *Prestige* [17] citing *LCA Marrickville Pty Ltd v Swiss Re International SE* (2022) 290 FCR 435 [83]-[102] (Derrington and Colvin JJ, with whom Moshinsky J agreed); *Hakea Holdings Pty Ltd v Neon Underwriting Ltd* [105] (Jackman J, with whom Colvin and Button JJ relevantly agreed).
174 *Prestige* [27].
175 *Prestige* [29]-[31].

CASE NOTE

UNDER THE WEATHER: A RAIN CHECK ON THE MEANING OF "LOCATION INSURED"

***Acciona Infrastructure Australia Pty Ltd v Zurich Australia Insurance Ltd* [2023] FCAFC 47**

SNAPSHOT

- The Full Court of the Federal Court of Australia unanimously 'rained' on the Contractors' parade in construing an exclusion for damage to contract works caused by rain, favouring the Insurers' 'common sense' approach. Ultimately, the Full Court favoured a construction of an insurance clause or policy that was conducive with the objective purpose of the exclusion, namely, to limit cover to damage caused by unusually intense rainfall.
- The construction was determined by the Full Court following a rare referral of an insurance case by the Chief Justice of the Federal Court to the Full Court, pursuant to section 20(1A) of the Federal Court of Australia Act 1976 (Cth) (which permits the Chief Justice to so refer in matters of "sufficient importance").

INSURANCE ISSUES CONSIDERED BY THE COURT

- The proper construction of an exclusion clause, specifically, the meaning of the (undefined) expression "location insured".

Facts

- Acciona Infrastructure Australia Pty and Ferrovial Construction (Australia) Pty Ltd (together, the **Contractors**) were retained by NSW Roads and Maritime Services (**RMS**) to design and construct a 19.5-km stretch of dual carriageway road between Warrell Creek and Nambucca Heads in northern New South Wales (**Project Works**).[176]
- In June 2016 and during the course of construction, a complex atmospheric low-pressure system caused heavy rainfall and flooding in areas of the east coast of Australia.[177] Significant rainfall was experienced across part of the site and damage was sustained to the Project Works in that area (**Rain Event**).[178]
- The Contractors were 'added insureds' to RMS's 'Construction Risks – Material Damage Project Insurance Policy' (**Policy**) in respect of the Project Works.[179] The insurers were Zurich Australian Insurance Limited, Allianz Australia Insurance Ltd, and XL Insurance Co SE (together, the **Insurers**).[180] The Contractors claimed under the Policy in respect of the Rain Event.[181]
- The relevant Policy terms included clauses 1.1 and 3.12, extracted below:[182]

1.1 Insured Property

The Insurers will indemnify the Insured in accordance with the Basis of Settlement, against Damage to the Insured Property other than from a cause specifically excluded, occurring at the Project Site or in transit within the Territorial Limits during the Construction Period.

3.12 Earthwork Materials and Pavement Materials

*…the Insurers will not indemnify the Insured for loss or damage due to rain on earthwork materials and or pavement materials, except where such loss or damage is due to an event with a minimum return period of 20 years for the location insured on the basis of the 24 hour statistics prepared by the Bureau of Meteorology for the nearest station to the **location insured**, or such other independently operated weather station situation near or adjacent to the **location insured**.*

- The expression, "Project Site", was defined to mean:[183]

[T]he situation(s) stated in the Schedule against this item and any other situation where the Insured is performing the works or has property stored or being processed together with all surrounding areas in connection with the Project…

176 *Acciona Infrastructure Australia Pty Ltd v Zurich Australian Insurance Ltd* [2023] FCAFC 47 [1], [3] ('***Acciona***').
177 *Acciona* [3].
178 *Acciona* [3].
179 *Acciona* [3].
180 *Acciona* [1].
181 *Acciona* [5].
182 *Acciona* [6], [15].
183 *Acciona* [9].

- Two independently operated weather stations were situated on the Project Site at the time of the Rain Event.[184] The first recorded rainfall that exceeded a rainfall event with a minimum return period of 20 years. The second had power supply issues and did not record rainfall.
- The Bureau of Meteorology (**BOM**) also operated two weather stations, which were the closest weather stations to the damaged area.[185] Neither of the BOM stations recorded rainfall which exceeded a rainfall event with a minimum return period of 20 years.

Analysis by the Court

- The issue for the Full Court of the Federal Court (Full Court) was whether the words "location insured" in clause 3.12 referred to the weather station most proximate to the damaged area (as submitted by Insurers) or the Project Site generally (as submitted by the Contractors).[186] Given the different rainfall recorded by the weather stations, the Court's ruling would determine whether the exclusion had been triggered.
- This specific issue was referred to the Full Court for determination by a direction of the Chief Justice made on 1 March 2023 pursuant to section 20(1A) of the *Federal Court of Australia Act 1976* (Cth) as it was "pivotal to many issues in the proceedings" and because its determination may "resolve, or assist in resolving, a substantial part of the questions before the referee".[187]
- The Insurers contended that the "location insured" was limited to the location of the damage the subject of the claim, whereas the Contractors sought a wider construction, defining "location insured" as "the situation that comprises the 'Project Site'… and within which the loss or damage… occurred" (which could conceivably extend to rainfall recorded some 19 km away from any damage).[188]

Logic and Business Efficacy

- The Full Court (comprised of Derrington, Button and Jackman JJ) found that the Insurers' construction was "supported by logic and business efficacy" because the Policy sought to insure a "lengthy geographical area within which the intensity of a single rainfall event might vary considerably from place to place".[189] Therefore, it would make greater logical sense if the degree of rainfall intensity was to be ascertained by reference to the rainfall at, or at least closest to, the location of the resulting loss or damage.[190]
- Demonstrating this point, the Court noted that the Contractors' construction would produce the unbusinesslike result of cover being denied if the weather station closest to the relevant damage recorded a one in 20-year rainfall event, but the weather station nearest to the Project Site (but potentially significantly further from the damage) did not.[191]
- Moreover, the Court found that the Insurers' construction was supported by the text of clause 3.12 as the term 'location' "connotes a degree of exactness" and,[192] had the parties intended to refer to the entire project, they could have done so by using the defined term 'Project Site'.[193]
- The Court rejected the Contractors' submission that the term "location insured" could be equated to the defined term "Project Site" (which is defined as referring to various "situations").[194] The Court held that the geographic scopes in the definition of "Project Site" and the clause 3.12 were entirely and understandably distinct, with the former identifying the general area within which cover is available, and the latter having specific operation.[195] It was 'futile' to suggest the mere reference to "Project Site" in other parts of the Policy could control the meaning of a different expression in a distinct clause.[196]

Result

- The Full Court found the words "location insured" meant the location of the loss or damage, such that the proper construction of clause 3.12 was that, where damage was caused by a rainfall event to earthwork or pavement materials, reference is to be had to the weather station nearest to the location of the damage.[197] The Court made a declaration in favour of the Insurers, with the result that the Contractors were not entitled to cover for the damage claimed in respect of the Rain Event.[198]
- On 7 September 2023, the High Court of Australia dismissed (with costs) the Contractors' application for special leave to appeal from orders of the Full Court of the Federal Court of Australia on the basis that such did not "raise a question of law of public importance sufficient to warrant a grant of special leave to appeal and otherwise advances no arguable ground of appeal".[199]

184 *Acciona* [3].
185 *Acciona* [3].
186 *Acciona* [18].
187 *Acciona* [1]-[2].
188 *Acciona* [18].
189 *Acciona* [23].
190 *Acciona* [23].
191 *Acciona* [25], [40].
192 *Acciona* [29]-[30].
193 *Acciona* [31].
194 *Acciona* [32].
195 *Acciona* [33].
196 *Acciona* [33].
197 *Acciona* [45].
198 *Acciona* [46].
199 *Acciona Infrastructure Australia Pty Ltd v Zurich Australian Insurance Limited* [2023] HCASL 123 [2].

CASE NOTE

MISTAKEN IDENTITY AND A LINE-UP OF USUAL CONSTRUCTION ISSUES

WSP Structures Pty Ltd v Liberty Mutual Insurance Company t/as Liberty Specialty Markets **[2023] FCA 1157**

SNAPSHOT

- Insurance policies are to be viewed through a commercial lens, wherein, absent a clear intention to the contrary, the definitions of words will be construed through their ordinary business meaning, rather than a policy-specific construction.
- When covered under more than one policy, insureds are entitled to simultaneously pursue indemnification under each policy until the first point of actual payment.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether a subcontractor was an insured under the head contractor's public liability policy?
- If so, whether it had already been indemnified by its own professional indemnity insurer?

Facts

- These proceedings involved the determination of the proper construction of a policy issued by Liberty Mutual Insurance Company (**Liberty**) obtained by Icon Co Nominee Pty Ltd (**Icon Nominee**) (**Liberty Policy**). Excess layers of cover were provided by Chubb Insurance Australia Limited and Tokio Marine & Nichido Fire Insurance Co Ltd (together, **Excess Insurers**) on the same terms as the Liberty Policy.
- In 2015, WSP Structures Pty Ltd (**WSP**) was engaged as structural engineer for the construction of Opal Tower in Sydney by the head contractor, Icon Co (NSW) Pty Ltd (**Icon**).[200]
- The Liberty Policy named various entities within the Icon group of companies as the "Insured", including Icon.
- On Christmas Eve 2018, Opal Tower sustained significant structural damage, leading to a mass evacuation of over 3,000 people from the tower and its surroundings.
- Subsequent litigation, consisting of three sets of proceedings in the Supreme Court of NSW, all settled in 2022.[201] The following payments were made to settle the claims against WSP:[202]
    1. WSP Australia Pty Ltd (**WSP Australia**), WSP's parent company, paid an amount to settle the claim by Icon against WSP (**WSP Payment**), as well as the legal costs incurred during the proceedings.
    2. WSP's professional indemnity insurers paid an amount to settle WSP's portion of the class action brought by the apartment owners (**WSP Indemnity Insurer Payment**).
- WSP sought indemnity under the Liberty Policy for the WSP Payment and its legal costs.[203]
- The positions adopted by the insurers to WSP's claim were as follows:
    1. Liberty accepted that WSP was an insured under the Liberty Policy and was entitled to indemnity for the WSP Payment. Liberty disputed an entitlement to recovery by WSP for its legal costs on the basis that WSP had elected to proceed with a claim as to those costs under its own professional indemnity policy.
    2. The Excess Insurers argued WSP was not an insured under the terms of the Liberty Policy and as such was not entitled to be indemnified under the excess policies.[204]
    3. The Excess Insurers maintained that WSP had been granted indemnity under its own policy and the principles of "double insurance" would determine the extent to which the professional indemnity insurer could seek contribution.[205]

200 *WSP Structures Pty Ltd v Liberty Mutual Insurance Company t/as Liberty Specialty Markets* [2023] FCA 1157 ('***WSP Structures***') [1].
201 *WSP Structures* [1].
202 *WSP Structures* [3].
203 *WSP Structures* [5].
204 *WSP Structures* [12].
205 *WSP Structures* [13].

4. Given that it was the holding company, WSP Australia, that made the WSP Payment, the Excess Insurers contended that WSP Australia was the proper party to bring any claim in respect of the WSP Payment.[206]

Analysis by the Court

Was WSP an insured?

- The Liberty Policy contained the following provisions, the first of which directly proceeded an identification of Icon Nominee as the Insured:

  > *and/or subsidiary and/or controlled and/or joint venture companies and/or principals and/or financiers and/or contractors and subcontractors, all for their respective rights, interests, and liabilities.*[207]

- The definition for "Insured" included at items 4 and 8:

  > *4 sub-contractors engaged by any of the above; and/or*
  >
  > *…*
  >
  > *8 architects, engineers and other professional consultants, but only in relation to their manual on-site activities and/or*[208]

- Despite serving as the project's structural engineers, WSP accepted that its lack of on-site activities meant that it did not satisfy the requirements of item 8 of the definition of "insured".[209] That said, WSP maintained that as a subcontractor, it fell within the terms of item 4 of the definition of "insured", a position which was denied by the Excess Insurers.[210]

- In concluding that WSP was an insured, the Court confirmed the principles that:

  1. a business-like construction informed by the commercial purpose that is served by the whole of the policy should be taken;[211] and

  2. in the absence of evidence that words are used in some technical sense or have acquired some established meaning amongst the contracting parties (or the market in which the agreement is made), words should be given their natural and ordinary meaning.[212]

- The Court concluded:

  - the Liberty Policy plainly sought to extend the scope of those who were insured beyond named insureds;[213]

  - the words "and/or" following each item in the list implied that an entity could at once be multiple types of 'Insured', thus WSP's role as engineers did not prohibit it from also being considered a sub-contractor;[214]

  - the evident interest of the Icon parties in obtaining the insurance was to ensure there was coverage for activities Icon entities would be undertaking as part of the business defined in the Schedule to the Liberty Policy. Coverage for those who had been subcontracted by Icon was "obviously necessary to obtain that kind of coverage";[215] and

  - WSP was an insured under the Liberty Policy.[216]

206 *WSP Structures* [14].
207 *WSP Structures* [17].
208 *WSP Structures* [19].
209 *WSP Structures* [21].
210 *WSP Structures* [22].
211 *WSP Structures* [28].
212 *WSP Structures* [28].
213 *WSP Structures* [97].
214 *WSP Structures* [92].
215 *WSP Structures* [98], [99].

Had WSP been indemnified?

- WSP had made a claim with its professional indemnity insurer for the WSP Payment and had been invited to claim reimbursement of its legal costs of conducting the defence of the claims against it in Supreme Court proceedings. Although indemnity under that policy had been confirmed in writing by the insurer, no payment had been made (although the insurer had paid the WSP Indemnity Insurer Payment). The Excess Insurers argued that these circumstances meant that WSP had received "full indemnity" under the professional indemnity policy.[217]

- The issue for the Court to determine was "*how far matters have to proceed in respect of the claim made under one policy before the insurer under another policy can plead an indemnity under the first policy as a defence*".[218]

- Liberty argued that it had no liability to indemnify WSP of its legal costs on the grounds that the structural engineers had 'elected' to proceed with a claim under its own professional indemnity policy.

- The Court rejected the insurers' arguments, determining that "*it is the receipt of the indemnity from one insurer that means there is nothing for the second insurer to indemnify*"[219]. Put another way, until the insured receives the funds, it has not been indemnified.

- The Court found that there is no inconsistency for an insured in pursuing rights under two policies covering the same risk. Inconsistency only arises when it comes to receiving the benefit under one policy and continuing to maintain there is an obligation to indemnify under the second policy.[220]

The appropriate applicant in a reimbursement claim

- The Excess Insurers argued that WSP Australia's making of the WSP Payment rendered *it* the correct applicant to bring a claim for reimbursement, consequently invalidating WSP's claim for indemnification.[221]

- The Excess Insurers made the following submissions:

  - In meeting the WSP Payment, WSP Australia had essentially absolved WSP of its liability to pay it.[222]

  - As WSP Australia made the payment directly, rather than loaning the required funds to WSP, the latter had no legal obligation to repay it.[223]

  - Having met the payment, WSP Australia had suffered an economic loss that could potentially be remedied if it sought recoupment against the insurers, noting that in such circumstances it would constitute a "proper plaintiff".[224]

- The Court rejected these submissions, determining that it was WSP that was the appropriate applicant for a claim under the policy.

- The Court held that the insurers operated on the erroneous assumption that WSP Australia's payment gave rise to their right to

216 *WSP Structures* [104].
217 *WSP Structures* [110].
218 *WSP Structures* [107].
219 *WSP Structures* [118].
220 *WSP Structures* [127].
221 *WSP Structures* [129].
222 *WSP Structures* [131].
223 *WSP Structures* [131].
224 *WSP Structures* [133].

be indemnified. While it served the functional purpose of alleviating WSP's liability to pay monies to those it was obliged to, this did not strip WSP of its legal liability to meet the WSP Payment.[225]

- As such, WSP was found to be the appropriate applicant for the claim, and it was WSP, not the insurers, who WSP Australia would have any right of recoupment against.[226]
- The Court rejected the Insurers' argument that the payment of legal costs by WSP Australia meant that WSP now had no loss on which it could seek indemnity.[227] This was largely because the court found that WSP Australia's payment was made on the assumption that WSP would "*pursue any and all rights that it may have to recoup or recover the costs and account for those monies to WSP Australia*".[228]

As it stands

- An appeal to the Full Court of the Federal Court was filed by the Excess Insurers on 27 November 2023, with a cross-appeal lodged by Liberty on 14 December 2023.

225 *WSP Structures* [137].
226 *WSP Structures* [137].
227 *WSP Structures* [138].
228 *WSP Structures* [143].

CASE NOTE

NO GROUNDHOG DAY FOR SOLICITORS' ADVICE ALREADY PROVIDED

***Shoal Bay Beach Constructions No. 1 Pty Ltd v Mark Hickey & the persons listed in Schedule A to the Notice of Appeal trading as Sparke Helmore* [2023] NSWCA 23**

SNAPSHOT

- The NSW Court of Appeal was required to consider the scope of a solicitor's duty to advise in determining whether Sparke Helmore had breached their duty of care by failing to provide advice already given or seek instructions.
- Ultimately, in overturning a decision of the NSW Supreme Court, this case proved a 'win' for lawyers (and Sparke Helmore) by reiterating the 'general rule' that a solicitor is not negligent in failing to remind a client of advice already given, or to advise the client of what the client already knows.
- The evidence adduced was sufficient in proving that officers of the Developer understood the advice received.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The main issue considered was whether Sparke Helmore was negligent in failing to reiterate or repeat advice previously given close to the expiry of a time limit to extend certain contracts.

Facts

- The Respondent (**Sparke Helmore**) was retained by Shoal Bay Beach No. 1 Pty Ltd (the **Developer**), to provide legal services in connection with the construction and sale of units on land in Shoal Bay.[229]
- Sparke Helmore prepared, and the Developer entered, numerous contracts for the sale of units off the plan. Each contract provided either party with a right of rescission if conditions precedent were not satisfied before the "Registration Date". In certain circumstances, the Developer could extend the Registration Date, provided it notified the affected purchaser at least one month's notice before the Registration Date.[230]
- On a number of occasions, Sparke Helmore advised the Developer that, should it wish to exercise those extension rights, it needed to give at least one month's written notice. Sparke Helmore also provided numerous updated schedules setting out the different Registration Dates of each contract.
- Following a series of construction delays, the Developer could not complete by the Registration Date, and two Purchasers rescinded their contracts. The Developer was wound up and its liquidator assigned to the Appellant the Developer's interest in any claims available.[231]
- The Appellant brought proceedings in the NSW Supreme Court against Sparke Helmore, claiming loss in the form of rescinded contracts as a result of Sparke Helmore's negligence in failing to alert the Developer of the impending deadlines for the exercise of its extension rights, or to seek instructions before the notice deadlines.[232]
- The primary judge held that Sparke Helmore was negligent and had breached an implied term of its retainer to exercise reasonable care and skill, and should have sought instructions from the Developer about its intentions regarding the contracts subsequently rescinded.[233] The Appellant was awarded damages, reduced by 30% for the Developer's contributory negligence.[234]
- The Appellants appealed the primary judge's decision on the finding of contributory negligence, calculation of damages, and failure to make an order as to costs, and Sparke Helmore cross-appealed on the findings of negligence and breach of contract.[235]

229 *Shoal Bay Beach Constructions No. 1 Pty Ltd v Mark Hickey & the persons listed in Schedule A to the Notice of Appeal trading as Sparke Helmore* [2023] NSWCA 23 [9] ('***Shoal Bay Beach Constructions***').
230 *Shoal Bay Beach Constructions* [21].
231 *Shoal Bay Beach Constructions* [9].
232 *Shoal Bay Beach Constructions* [11].
233 *Shoal Bay Beach Constructions* [11] citing the *Shoal Bay Beach Constructions No. 1 Pty Ltd v Mark Hickey and the persons listed in Schedule A to this Statement of Claim trading as at all material times Sparke Helmore (No 5)* [2021] NSWSC 1499, [183] (the '***Primary Decision***').
234 *Shoal Bay Beach Constructions* [11] citing the *Primary Decision* [195].
235 *Shoal Bay Beach Constructions* [12]-[14].

Analysis by the Court

Sparke Helmore's appeal

- Sparke Helmore argued the "general rule" that a solicitor is not negligent in failing to remind a client of advice already given or to advise the client of what the client already knows.[236] This was rejected by the primary judge on the basis that Sparke Helmore was allegedly aware that the Developer did not appreciate the effect of clauses which gave a right of extension to the Developer and right of recission to the parties.[237]

So, where does a solicitor's duty to advise end?

- The Court considered *Groom v Crocker*, which considered implied terms in a solicitor's retainer such that "the solicitor should consult with his client in all questions of doubt which do not fall within the express or implied discretion left him, and should keep the client informed to such an extent as may be reasonably necessary according to the same criteria." [238]

- However, their Honours also referred to *Midland Bank Trust Co Ltd,* an English decision in which Oliver J warned against a court imposing upon solicitors, or other professionals, duties which went beyond the scope of what they were requested and undertook to do, and that the test was not whether *"…a particularly meticulous and conscientious practitioner would, in his client's general interest, take it upon himself to pursue a line of inquiry beyond the strict limits comprehended by his instructions*."[239]

Result

- The Court unanimously found that Sparke Helmore was not negligent in failing to remind the Developer of the advice previously given, or in not seeking instructions over a month before the rescinded contracts' Registration Date.[240]

- Whilst Sparke Helmore was engaged to negotiate such extensions for certain contracts due for completion prior to the rescinded contracts' Registration Dates, there was no reason why the Developer could not itself negotiate those extensions. Sparke Helmore was not obliged to go beyond the Developer's express instructions and negotiate and advise on all pending sale contracts.[241]

- The Court's extensive analysis of the evidence (being the communications and interactions between the Developer and Sparke Helmore) provides a reminder of the importance of maintaining a complete file.

- Notwithstanding this finding, White JA also stated that he would have assessed the Developer's contributory negligence at 80%, rather than 30% as assessed by the primary judge.[242]

236 *Shoal Bay Beach Constructions* [84] citing *Yager v Fishman & Co and Teff & Teff* [1944] 1 All ER 552, 558; *Scottsdale Homes Pty Ltd v Gemkip Pty Ltd* [2008] QSC 326, [93]-[101]; *Fitzwood Pty Ltd v Unique Goal Pty Ltd (in liq)* [2001] FCA 1628, [175]; *Capebay Holdings Pty Ltd v Sands* [2002] WASC 287, [7], [97]-[98]; *Nigam v Harm (No 2)* [2011] WASCA 221, [139]-[142].
237 *Shoal Bay Beach Constructions* [86] citing the *Primary Decision* [169]-[170], [176].
238 *Shoal Bay Beach Constructions* [80] citing *Groom v Crocker* [1939] 1 KB 194, 222 (Scott LJ).
239 *Shoal Bay Beach Constructions* [81] citing *Midland Bank Trust Co Ltd v Hett, Stubbs & Kemp* [1979] Ch 384, 402-3 (Oliver J). See also *Heydon v NRMA Ltd* (2000) 51 NSWLR 1, [364] (McPherson AJA).
240 *Shoal Bay Beach Constructions* [87].
241 *Shoal Bay Beach Constructions* [1] (Gleeson JA), [3]-[5] (Leeming JA), [75]-[81] (White JA).
242 *Shoal Bay Beach Constructions* [95].

CASE NOTE

FEDERAL COURT DOESN'T FAUCET UNDER FUSION ENDORSEMENT

***Rheem Australia Pty Ltd v Mitsui Sumitomo Insurance Co Ltd* [2023] FCA 1570**

SNAPSHOT

- A commercial contract should be construed to avoid it making commercial nonsense or working commercial inconvenience. However, it is not necessary to identify a line of commercial reasoning for the particular language adopted if the ordinary and natural meaning of the words is clear.
- The relevant context for the construction of words in an insurance policy is the use of those words in the policy as a whole, which may be more persuasive than expert evidence about the use of the words as terms of art.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Is the commercial rationale of a provision in an insurance policy relevant to the construction of the insurance policy?

Facts

- Rheem Australia Pty Ltd (**Rheem**), a company that manufactures and supplies commercial and residential hot water systems and solar products, held an industrial special risks policy (**ISR Policy**) with Mitsui Sumitomo Insurance Co Ltd and Tokio Marine & Nichido Fire Insurance Co Ltd (**Insurers**).[243]
- An electrical fault (**Electrical Fault**) occurred in a main switchboard at a Rheem factory in Rydalmere, NSW (**Premises**). The electrical fault originated in a device in the main switchboard, known as a combination fuse switch unit (**CFS**), and caused significant damage to the switchboard and an extended power outage at the Premises.[244]
- Rheem made a claim for indemnity under the ISR Policy for loss and damage it incurred as a result of the Electrical Fault.[245]
- The matter turned on the construction of two endorsements to the ISR Policy. One endorsement extended cover to certain damage to the Property Insured subject to various exclusions (**Machinery Breakdown Endorsement**), and another endorsement extended cover to the burning out by the electric current of electrical machines in certain circumstances (**Fusion Endorsement**).[246]
- The Insurers denied the claim on the basis that neither endorsement covered the Electrical Fault. Rheem commenced proceedings in April 2023.
- Jackman J determined (as separate and preliminary questions in the proceeding) whether Rheem was entitled to indemnity for the Electrical Fault under the Machinery Breakdown Endorsement and/or the Fusion Endorsement.[247]

Analysis by the Court

Principles of construction of an insurance policy

- Jackman J summarised the relevant principles of construction of an insurance policy as set out below. All of the principles summarised are familiar.
- *First,* an insurance policy should be construed according to the principles of businesslike interpretation which are applicable to commercial contracts generally,[248] namely:[249]

  1. the rights and liabilities of parties under a provision of a contract are to be determined objectively by reference to its text, context and purpose;
  2. in determining the meaning of the terms of a commercial contract, it is necessary to ask what a reasonable businessperson would have understood those terms to mean; and

243 *Rheem Australia Pty Ltd v Mitsui Sumitomo Insurance Co Ltd* [2023] FCA 1570 (‘***Rheem***’) [1]-[2].
244 *Rheem* [3].
245 *Rheem* [5].
246 *Rheem* [9]-[10].
247 *Rheem* [1], [16]-[17].
248 *Rheem* [11] referring to *CGU Insurance Limited v Porthouse* [2008] HCA 30; (2008) 235 CLR 103 at [43].
249 *Rheem* [11] referring to *Mount Bruce Mining Pty Ltd v Wright Prospecting Pty Ltd* [2015] HCA 37; (2015) 256 CLR 104.

3. unless a contrary intention is indicated in the contract, a commercial contract should be construed to produce a commercial result, and to avoid it making commercial nonsense or working commercial inconvenience.

- *Second*, words and phrases used in a contract are usually given their ordinary meaning, unless there is a good reason to depart from that approach, such as where the term is intended to be used as a term of art.[250]
- *Third*, the insuring clause and any exclusion clause must be read together in a harmonious way so that due effect is given to both.[251]
- *Fourth*, exclusion clauses are to be construed according to their natural and ordinary meaning, read in the light of the contract as a whole.[252]
- *Finally,* the *contra proferentem* rule (being that an ambiguous contractual term is to be construed against the party seeking to rely on it) is only to be applied as a last resort after the orthodox process of construction has failed to resolve ambiguity.[253]

Was Rheem entitled to indemnity for the Electrical Fault under the Machinery Breakdown Endorsement?

- This issue turned on whether an Electric Wiring Exclusion applied.
- The effect of the Machinery Breakdown Endorsement was that the ISR Policy provided no cover for *"loss, destruction or damage … arising in relation to … Any electric wiring and fittings associated with lighting and power circuits"* (**Electric Wiring Exclusion**).[254]
- Jackman J was required to consider the proper construction of the term *"electric wiring"* in the Electric Wiring Exclusion.
- It was common ground between the parties that the CFS did not itself contain electric wires or cables and, instead, that it was a lever operated switch.[255]
- Rheem submitted that the term *"electric wiring"* meant cables or wires in an electrical system or installation, but not a component which does not have cables or wires within it and is not itself cabling or wiring. The effect of this construction was that the Electric Wiring Exclusion was not triggered.[256]
- The Insurers submitted that the term *"electric wiring"* meant the complete electrical installation or system within the Premises, including switchboards, mains and submains cables, final sub-circuit wiring and power outlets. On the Insurers' construction, *"electric wiring"* would capture the CFS, meaning that the Electric Wiring Exclusion applied.[257]
- Jackman J concluded that the Electric Wiring Exclusion was not triggered, on the following basis.
- *First*, in relation to the text and context of the Electric Wiring Exclusion (see principle 1 in the previous section):

1. Rheem's construction was consistent with other sections of the ISR Policy, namely, the definition of insured property in the Machinery Breakdown Endorsement which referred to an *"individual switchgear for starting and controlling motors and interconnecting wires and/or cables"*. His Honour considered that this indicated that switchgears were intended to be treated separately from the concept of interconnecting wires.[258]

2. The requirement in the Electric Wiring Exclusion that the electric wiring and fittings be *"associated with"* lighting and power circuits indicated that the Electric Wiring Exclusion was not intended to apply to lighting and power circuits as a whole, but only to the electric wiring and fittings which were specifically referred to.[259]

3. Elsewhere in the ISR Policy, a different word, *"installations"*, was used to refer to electrical systems as a whole.[260]

- *Second*, in relation to the ordinary meaning of the Electric Wiring Exclusion, Rheem's construction of the Electric Wiring Exclusion was consistent with the ordinary meaning of *"electric wiring"*, namely the cables and wires used to carry electricity.[261]
- *Third*, in relation to the commercial construction of insurance policies:

1. The Insurers' argument that Rheem's construction of the Electric Wiring Exclusion could not be adopted because there was no evident commercial rationale in selectively removing components of the system from the scope of the Electric Wiring Exclusion was rejected.[262] This is because the ordinary and natural meaning of *"electric wiring"* was *"too clear and intractable for the issue to require that Rheem must identify a line of commercial reasoning for the particular language adopted"*.[263]

2. Similarly, his Honour declined to consider the parties' expert evidence about the meaning of *"electric wiring"* on the basis that the natural and ordinary meaning of it was clear.[264]

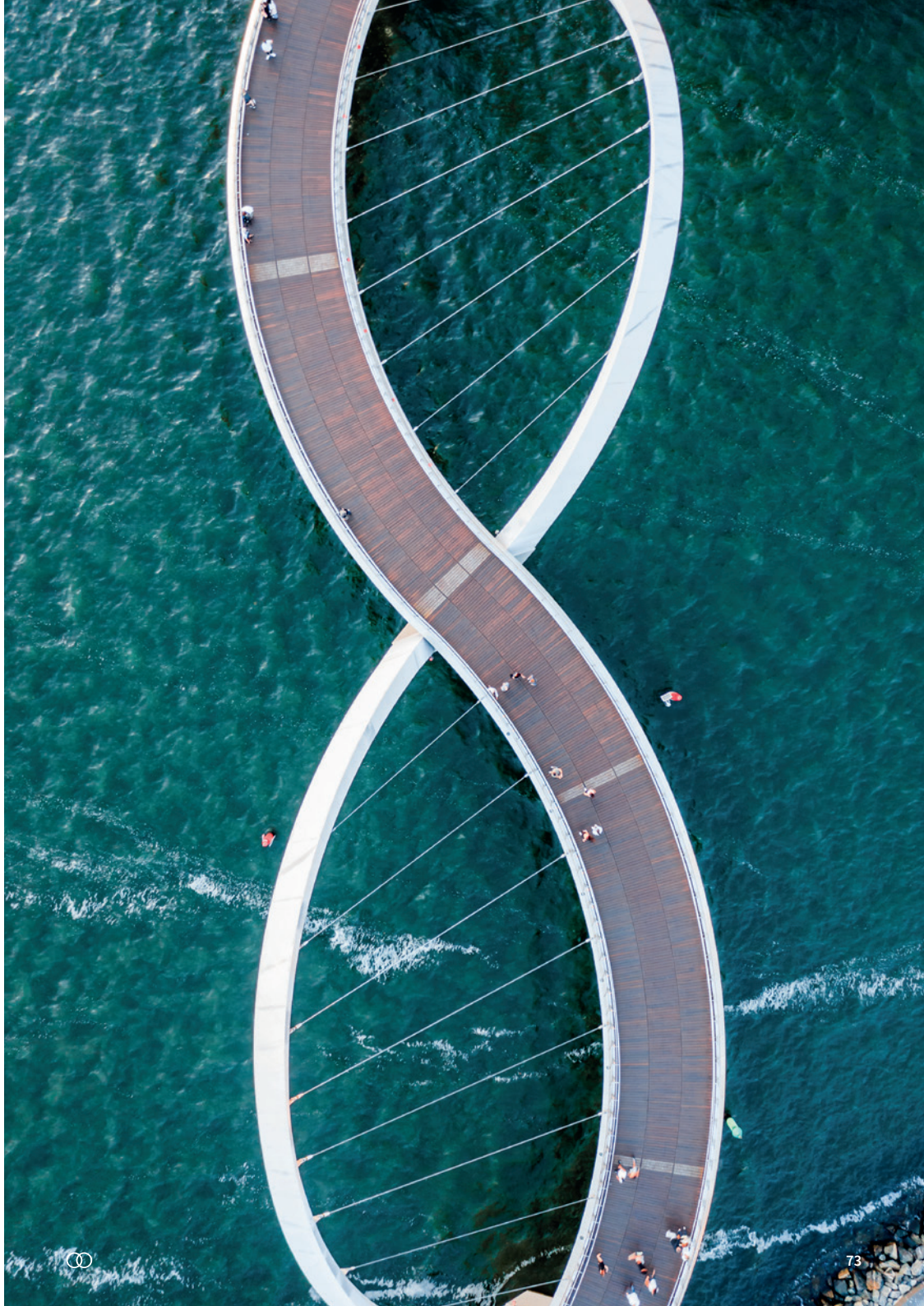
Was Rheem entitled to indemnity for the Electrical Fault under the Fusion Endorsement?

- In the alternative, Rheem argued that cover was available under the Fusion Endorsement.[265]
- The Fusion Endorsement extended cover to *"the actual burning out by electric current of any part or parts of electrical machines, installations or apparatus other than … fuses or protective devices or electrical contacts at which sparking or arcing occurs in ordinary working"*.[266]
- It was common ground between the parties that the CFS was a protective device.
- The question before the Court was whether the words *"at which sparking or arcing occurs in ordinary working"* qualified only the term *"electrical contacts"* (as the Insurers submitted) or whether it qualified all three concepts of *"fuses or protective devices or electrical contacts"* (as Rheem submitted). Jackman J concluded that the syntax of the Fusion Endorsement produced an ambiguity on this question requiring consideration of the commercial purpose of the terms.[267]

250 *Rheem* [12] referring to *L Schuler AG v Wickman Machine Tool Sales Ltd* [1974] AC 235 at 264 (Lord Simon); *Lasermax Engineering Pty Ltd v QBE Insurance (Australia) Limited* [2004] NSWSC 483 at [16] and [24].
251 *Rheem* [13] referring to *Weir Services Australia Pty Ltd v AXA Corporate Solutions Assurance* [2018] NSWCA 100; (2018) 359 ALR 314 at [54]; *Woodlawn Capital Pty Ltd v Motor Vehicles Insurance Ltd* [2016] NSWCA 28; (2016) 111 ACSR 377 at [133]; *Impact Funding Solutions Ltd v AIG Europe Insurance Limited* [2016] UKSC 57; [2017] AC 73 at [7].
252 *Rheem* [14] referring to *Selected Seeds Pty Ltd v QBEMM Pty Ltd* [2010] HCA 37; (2010) 242 CLR 336 at [29].
253 *Rheem* [15] referring to *LCA Marrickville Pty Ltd v Swiss Re International SE* [2022] FCAFC 17; (2022) 290 FCR 435 at [83]-[102].
254 *Rheem* [9].
255 *Rheem* [18].
256 *Rheem* [19].
257 *Rheem* [19].
258 *Rheem* [21].
259 *Rheem* [22].
260 *Rheem* [22].
261 *Rheem* [23].
262 *Rheem* [24].
263 *Rheem* [24].
264 *Rheem* [26].
265 *Rheem* [30].
266 *Rheem* [10].
267 *Rheem* [27].

- On the Insurers' construction, cover for the burning out of all protective devices would be excluded from cover under the Fusion Endorsement. On Rheem's construction, cover for only the burning out of protective devices at which sparking or arcing occurs in the ordinary working would be excluded.
- In circumstances where Rheem accepted that there are no protective devices at which sparking or arcing occurs in ordinary working, Jackman J rejected Rheem's submission, finding that such a construction would be otiose.[268] For that reason, Jackman J concluded that indemnity was not available under the Fusion Endorsement.[269]

268 *Rheem* [27].
269 *Rheem* [28].



CLASSIC CASE NOTE

HOP TO IT: EMBRACING THE BURDEN OF PROOF ON POLICY TERMS

***Wallaby Grip Ltd v QBE Insurance (Australia) Ltd & Anor; Stewart v QBE Insurance (Australia) Ltd & Anor* (2010) 240 CLR 444**

SNAPSHOT

- The decision confirmed the importance of both parties to an insurance contract (insured and insurer) having at front of mind those matters which they are each required to prove and where the onus of doing so lies.
- The insurer failed to produce any evidence and prove any limit on the amount of the insurance cover provided, such that the insured was entitled to recover under the insurance for its full actual loss.

INSURANCE ISSUES CONSIDERED BY THE COURT

- On what issues an insured and insurer bear the onus of proof when seeking to prove a claim under a policy of insurance, including any limitations or exclusions.

Facts

- Mr Stewart suffered personal injury during the course of his employment.[270] Mr Stewart passed away during the proceedings, and the proceedings were continued by the representatives of his estate.[271] It was not contested that Mr Stewart's employer was liable for damages for the personal injuries suffered.
- By statute, Mr Stewart's employer was required to hold insurance with a licenced insurer "*for the full amount of his liability under this Act… and for an amount of at least forty thousand dollars in respect of his liability independently of this Act*".[272]
- The employer held a relevant policy of insurance with QBE Insurance (Australia) Ltd (**QBE**).[273] The issue in the proceeding was whether the insurance was for the statutory minimum of $40,000 or for some other amount.
- QBE admitted that it was liable to indemnify the employer under the policy terms, but not beyond the statutory minimum.
- In the course of the proceedings, QBE did not produce:
  - the relevant policy;
  - any evidence of any limit of liability under the policy; or
  - any other evidence as to what had been agreed as to the level of indemnity available under the insurance policy.[274]
- At its highest, QBE referred to the general terms and conditions of the statutory form of the policy which was annexed to the relevant statute.[275]
- The three issues in the proceeding concerned:
  1. whether QBE was liable only for the statutory minimum of $40,000 or some other amount;
  2. the onuses on a policyholder and on the insurer in proceedings in proving relevant terms of an insurance policy; and
  3. whether it was the plaintiff or QBE who was obliged, in the proceeding, to prove any limitations on the insurance, including the limit of liability.[276]

Analysis by the Court

Relevantly, the Court (In a unanimous decision) found that:

- Such matters go back to basic propositions of contractual construction and the nature of the insurance provided by the contract.[277]
- Which party bears the onus of proof, on what issues and the consequences of failing to meet that burden, depends on:[278]

270 *Wallaby Grip Ltd v QBE Insurance (Australia) Ltd & Anor; Stewart v QBE Insurance (Australia) Ltd & Anor* (2010) 240 CLR 444 ('***Wallaby Grip v QBE***') [2].
271 *Wallaby Grip v QBE* [2].
272 *Wallaby Grip v QBE* [3], with the relevant statute being section 18(1) of the *Workers' Compensation Act* 1926 (NSW) (since repealed and replaced).
273 *Wallaby Grip v QBE* [5].
274 *Wallaby Grip v QBE* [5].
275 *Wallaby Grip v QBE* [5].
276 *Wallaby Grip v QBE* [33].
277 *Wallaby Grip v QBE* [23].
278 *Wallaby Grip v QBE* [23].

- how the particular contract of insurance is intended to operate; and
- the circumstances in which, and the conditions under which, an insurer's obligation to indemnify arises.

- An insured has the onus of proving that the facts and circumstances necessary to give rise to an insurer's liability under a policy exist.[279] This will usually require proof:
  - that a relevant contract of insurance was in existence; and
  - of the occurrence of an event insured by the insurance policy (including the existence of the subject matter of the insurance and the cause of the loss).[280]
- An insurer must prove that the loss falls within any exception sought to be relied upon, or any limitation on the insurance.[281]
- As to the amount of the insured loss, in contracts of indemnity insurance (where the insurer insures for the *actual* loss suffered by an insured, not some form of agreed value):
  - the insured must prove the extent or amount of the loss suffered, and to give the loss a value;[282] and
  - an insurer must prove any limit on the amount the insurer is obliged to pay under the policy of insurance (because, except for that limitation, the insurer would be obliged to pay the full amount of the loss actually suffered by an insured).[283]

Result

- The insured had proven that the claim was within the terms of cover provided by QBE and that QBE's obligation to indemnify arose.[284]
- QBE had to allege and prove any limit on the amount of cover, which it failed to do.[285]

279 *Wallaby Grip v QBE* [28], [29].
280 *Wallaby Grip v QBE* [36].
281 *Wallaby Grip v QBE* [25], [35].
282 *Wallaby Grip v QBE* [31].
283 *Wallaby Grip v QBE* [36].
284 *Wallaby Grip v QBE* [36].
285 *Wallaby Grip v QBE* [36].

CLASSIC CASE NOTE

IT'S A LONG WAY TO THE COURT (IF YOU WANT DECLARATORY RELIEF)

***CGU Insurance Limited v Blakeley* (2016) 259 CLR 339**

SNAPSHOT

- In this classic Australian insurance case, the High Court considered whether the Supreme Court of Victoria, in exercising its federal jurisdiction, was able to hear a claim for declaratory relief in favour of the liquidators of a company against the insurer of the company's director.
- The High Court found that the claim involved determination of a matter arising under Commonwealth law, and so the Supreme Court of Victoria had jurisdiction to entertain the claim, and to grant the relief sought.
- These were circumstances where the liquidators of a company were seeking to recover loss caused by insolvent trading by a director of the company, and that director did not have the assets available to cover the claim, but held a liability insurance policy.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether declaratory relief that an insurer must indemnify a third party may be sought by a liquidator who is not privy to the insurance contract.
- Whether the Supreme Court of Victoria has jurisdiction to grant such declaratory relief.

Note that King & Wood Mallesons acted for the first and second respondents in these proceedings.

Facts

- On 9 April 2013, the liquidators of Akron Roads Pty Ltd (**Akron**) commenced proceedings in the Supreme Court of Victoria against three former directors of Akron, including Mr Trevor Crewe (**VSC Proceedings**). Mr Crewe's company, Crewe Sharpe Pty Ltd (**Crewe Sharp**), was alleged by the liquidators to be a shadow director of Akron.[286]
- The liquidators of Akron sued the former directors for insolvent trading pursuant to section 588M of the *Corporations Act 2001* (Cth) (**Corporations Act**), which states that "[t]*he company's liquidator may recover from the director, as a debt due to the company, an amount equal to the amount of the loss or damage*" suffered by the company's creditors because of the company's insolvency.[287] Recovery under section 588M requires a breach of a director's duty to prevent insolvent trading under section 588G.[288]
- On 4 December 2013, Crewe Sharp made a claim on a professional indemnity policy (the **Policy**) issued by the appellant, CGU Insurance (**CGU**). Mr Crewe, as a director of Crewe Sharp, was also an insured under the Policy.[289] CGU denied the claim on the basis that the Policy did not cover the liability asserted by the liquidators.[290] Crewe Sharp entered into a creditors' voluntary liquidation on 20 June 2014, at which time it was clear that Mr Crewe's assets could not cover the claim brought against him by Akron's liquidators.[291]
- On 20 August 2014, the liquidators of Akron filed an interlocutory process in the VSC Proceedings seeking an order that CGU be joined as a defendant for the purpose of seeking a declaration that CGU was liable to indemnify Mr Crewe and Crewe Sharp under the Policy.[292]
- In the VSC Proceedings, Judd J made the orders sought by the liquidators of Akron.[293] CGU appealed that decision. The Court of Appeal dismissed the appeal.[294] CGU was then granted special leave to appeal to the High Court on the grounds that the Victorian Supreme Court lacked jurisdiction to adjudicate the claim against CGU by Akron's liquidators.[295]

Legislative Regime

- To join CGU, the liquidators relied on section 562 of the Corporations Act which relevantly provides:

> ***(1)*** *Where a company is, under a contract of insurance (not being a contract of reinsurance) entered into before the relevant*

286 *CGU Insurance Limited v Blakely* (2016) 259 CLR 339 [2] ('***Blakeley***').
287 *Blakeley* [16], *Corporations Act 2001* (Cth) s 588M(2).
288 *Blakeley* [3].
289 *Blakeley* [4].
290 *Blakeley* [5].
291 *Blakeley* [6].
292 *Blakeley* [7].
293 *Akron Roads Pty Ltd (in liq) v Crewe Sharp* [2015] VSC 34.
294 *CGU Insurance Ltd v Blakeley* [2015] VSCA 153.
295 *Blakeley* [9].

date, insured against liability to third parties, then, if such a liability is incurred by the company (whether before or after the relevant date) and an amount in respect of that liability has been or is received by the company or the liquidator from the insurer, the amount must, after deducting any expenses of or incidental to getting in that amount, be paid by the liquidator to the third party in respect of whom the liability was incurred to the extent necessary to discharge that liability, or any part of that liability remaining undischarged, in priority to all payments in respect of the debts mentioned in section 556.

- The liquidators also relied on section 117 of the *Bankruptcy Act 1966* (Cth) (**Bankruptcy Act**), which vests a bankrupt's right to indemnity against liabilities to third parties under an insurance contract in the trustee in bankruptcy, and obliges the trustee to use the proceeds of any claim against that insurance contract to satisfy the bankrupt's debts to third parties. In this way, section 117 of the Bankruptcy Act is analogous to section 562 of the *Corporations Act*, but applies to bankrupt individuals rather than companies in liquidation.
- Finally, the Victorian Supreme Court, as with all superior courts, has inherent power to grant declaratory relief. This is in addition to statutory powers under section 36 of the *Supreme Court Act 1986* (Vic) and section 39(2) of the *Judiciary Act 1903* (Cth).

Analysis by the Court

Grounds of appeal

- The grounds of appeal in the High Court were that:[296]

    1. the Court of Appeal was wrong to dismiss the appeal because it did not have jurisdiction, at the suit of the first and second respondents (i.e. Akron and Akron's liquidators), to grant declaratory relief in relation to a contract to which the first and second respondents are not parties, and where the parties to the contract (being the appellant (CGU), the third respondent (Mr Crewe) and the sixth respondent (Crewe Sharp)) are not in dispute; and
    2. the primary judge was wrong to join the appellant (CGU) as a defendant to the proceeding because the Victorian Supreme Court did not have jurisdiction to grant declaratory relief, at the suit of a stranger, in relation to a contract between parties who will not pursue any claim relating to rights or duties under that contract.

Federal jurisdiction of the VSC

- The first issue dealt with by the High Court was whether the Victorian Supreme Court had jurisdiction to determine the dispute and grant the relief sought.
- The High Court concluded the liquidators' proceedings against the directors involved a "matter" arising under Commonwealth law, being sections 588G and 588M of the Corporations Act.[297] The matter, defined by reference to the liquidators' claims against the directors and a third-party claim by the directors against CGU, met the subject matter requirement for the existence of federal jurisdiction and involved claims enlivening the judicial power of the Commonwealth.[298]
- In respect of the relief sought, the High Court concluded that the Victorian Supreme Court possesses the "inherent power to grant declaratory relief"[299] and the power to grant a joinder under s 79 of the *Judiciary Act 1903* (Cth).[300]

296 *Blakeley* [59].
297 *Blakeley* [32].
298 *Blakeley* [32].
299 *Blakeley* [13].
300 *Blakeley* [13].

Was there a "justiciable controversy" between the liquidators and CGU?

- To enliven the Victorian Supreme Court's jurisdiction there needs to be a justiciable controversy. CGU's argument was essentially that there was no "justiciable controversy" between the liquidators and CGU, and there was therefore no "matter" to be determined using the VSC's federal jurisdiction.[301] This argument was rejected by the High Court.
- The liquidators' claim did not depend on principles of contract law or privity of contract.[302] Rather, the liquidators' position was that section 562 of the Corporations Act and section 117 of the Bankruptcy Act gave them a real interest in the question of whether the Policy responds to indemnify the directors. The implications of this position was that the liquidators had a right to the proceeds of the Policy payable to the directors.[303]
- The High Court found that "*[t]he interest upon which the claim for declaratory relief is based and CGU's denial of liability under the policy are sufficient to constitute a justiciable controversy between the Akron liquidators and CGU involving a question arising under a law of the Commonwealth.*"[304]
- The statutory provisions operate so that the benefit of the declaration sought would go to the liquidators, rather than the parties to the Policy.[305] The High Court considered it wrong that the liquidators' interest could be defeated by the inaction of the directors.[306] On this basis, the High Court found that any declaration made would be binding between the liquidators of Akron and CGU, so as not to strip the benefit of the proceedings from the liquidators of Akron.[307]
- Another factor in support of the High Court's conclusion was that, as parties to the proceedings, the insured and CGU would not be permitted to relitigate, in subsequent proceedings, issues which had been, or should have been pursued in these proceedings.[308] Indeed, Nettle J said "*it is appropriate and effective for the liquidators to join CGU in the one proceeding with the directors so that the directors' liability to the liquidators is determined at the same time as the issue of CGU's liability to the directors.*"[309]

Result

- The High Court held that:
    - the liquidators' claim for declaratory relief against CGU involved a matter arising under Commonwealth law and therefore the Victorian Supreme Court had jurisdiction to adjudicate the claim.
    - there was a justiciable controversy to be decided between the liquidators and CGU, because of the interest the liquidators had in the outcome of the declaration.
- The liquidators of Akron were able to contest CGU's denial of the claim made by the insureds, Mr Crewe and Crewe Sharp, despite Akron not being a party to the insurance contract.

301 *Blakeley* [62].
302 *Blakeley* [67].
303 *Blakeley* [67].
304 *Blakeley* [67].
305 *Blakeley* [67].
306 *Blakeley* [67].
307 *Blakeley* [68].
308 *Blakeley* [68].
309 *Blakeley* [110].

CLASSIC CASE NOTE

IN MY DEFENCE, I CAN'T AFFORD ONE!

***Chubb Insurance Company of Australia Limited v Moore* (2013) 302 ALR 101; [2013] NSWCA 212**

SNAPSHOT

- This classic case considers section 6 of the *Law Reform (Miscellaneous Provisions) Act 1946* (NSW) (**Reform Act**) - a notoriously vague section (now repealed) which enabled claimants to have a statutory charge placed on monies available under an insurance policy, giving them a preferential entitlement, over that of the insured person, to the policy proceeds (including in relation to the insured person's defence costs).
- In 2009, a major agribusiness managed investments scheme operated by Great Southern Limited (**GSL**) and its subsidiaries collapsed, giving rise to numerous litigated proceedings, including against the various company directors (**Great Southern Litigation**). A dispute arose over competing claims of entitlement by third party claimants from the Great Southern Litigation to the insurance monies available under policies held by the directors of GSL. The claimants sought to rely on section 6.
- In this decision, the New South Wales Court of Appeal held that a statutory charge extended to claims-made policies but did not attach to monies payable for defence costs before any judgment or settlement. This not only provided comfort to directors and officers that their insurers need not withhold necessary defence costs under a policy, but ultimately rang the death-knell for section 6 – paving the way for its replacement by the *Civil Liability (Third Party Claims Against Insurers) Act 2017* (NSW), which resolved any residual uncertainty for claimants seeking to recover from insurers.

INSURANCE ISSUES CONSIDERED BY THE COURT

- What is the scope and proper construction of the (now repealed) section 6 of the Reform Act; particularly in respect of 'claims-made' D&O and PI policies?
- Can a statutory charge in favour of third-party claimants over insurance monies alter the right of a policy holder to have defence costs paid under their policy – even if this results in the policy limit being eroded?

Facts

- Directors of GSL and its subsidiaries (the **Insured**) held Directors & Officers (**D&O**) and Professional Indemnity (**PI**) insurance policies (the **Policies**) with various insurers.
- The Policies were each 'claims made and notified' policies, meaning they would only respond to a claim made against the Insured and notified to the Insurer during the policy period (unlike an "occurrence-based" policy, which covers claims that occur during the policy period, regardless of when the insurer is notified). Among the losses covered by the Policies were defence costs, legal representation expenses and other associated costs (**Defence Costs**) incurred by the Insured.
- Plaintiffs from the Great Southern Litigation (the **Claimants**) – facing the real prospect that, even if they were successful, proceeds available for damages or compensation under the Policies would quickly be eroded by the Insurers paying the Insured's defence costs – sought to quarantine the insurance monies.
- In September 2012, in reliance on section 6 of the *Reform Act*, the Claimants notified the Insurers they were invoking a "statutory charge" over the insurance monies – the effect of which would give priority to their third-party claim over the Insured's Defence Costs.
- Section 6(1) of the Reform Act provided that:

> *If any person (hereinafter in this Part referred to as the insured) has, whether before or after the commencement of this Act, entered into a contract of insurance by which the person is indemnified against liability to pay any damages or compensation, the amount of the person's liability shall on the happening of the event giving rise to the claim for damages or compensation, and notwithstanding that the amount of such liability may not then have been determined, be a charge on all insurance moneys that are or may become payable in respect of that liability.*

- In 2013, the New South Wales Court of Appeal was asked by the Insurers to consider whether the Insured were entitled to have their defence costs paid under the Policies that may otherwise have been subject to the statutory charge asserted by the Claimants.
- Among the questions referred to the Court of Appeal, were three main issues concerning the proper construction of section 6:

1. Was section 6 limited in its application to "occurrence based" policies, or did it apply to "claims made" policies;
2. Did section 6 apply to a claim for damages or compensation if the event giving rise to the claim occurred *before* the relevant policy came into effect; and
3. To the extent section 6 did impose a charge on insurance monies payable under the

Policies, were the Insured first entitled to be advanced their Defence Costs?

Analysis by the Court

Issue 1 – Claims Made Policies

- The Insurers contended that a proper construction of section 6(1), being primarily concerned with "*the happening of the event giving rise to the liability…in respect of which the claim is made",* meant that a charge could only apply to contracts of insurance where the "event" triggered the insured's right to indemnity.
- The right to indemnity under a claims made policy, they argued, was not triggered by the event giving rise to liability, but by the making (or notification) of a claim. This was not something that was contemplated by the drafters of section 6.
- The Court rejected the Insurer's arguments, holding that section 6 can apply to claims made policies.[310] In reaching this conclusion, the Court of Appeal made several important findings:
  - Considering the generality of the language used and "reforming" objectives behind it, section 6 should apply to any insurance policy that indemnifies against liability to pay damages or compensation. [311]
  - A claim is not, in and of itself, something against which someone can be indemnified. "*It is only liability to pay damages or compensation in respect of which a claim is made that can be the subject of indemnity*."[312]
  - The words "may become payable" in section 6(1) expressly contemplated that insurance moneys may become payable at a time after a charge arises – such as where an insured subsequently enters an insurance contract that responds to a claim.

Issue 2 – Relevant Event Prior to Policy

- The Court held that section 6 did not apply to claims for damages or compensation in circumstances where the alleged conduct of the insured giving rise to the claim by a third-party claimant happened before the relevant insurance policy had commenced.
- To reach this conclusion, the Court first reviewed two constructions of section 6(1) considered by Lindgren J in the case of *FAI General Insurance v McSweeny* - that the claimant's entitlement arose either:
  - the moment after the contract of insurance is entered into; or
  - at the time of the adjudication of the claim against the insured.[313]
- The first of these constructions had been followed by Hodgson JA in *Walter Construction*.[314] In that case, the Court had concluded a charge under section 6 was *not* available if the policy did not come into existence until after the event triggering the operation of section 6.
- Here, although the Court was not inclined to overturn the decision in *Walter Construction*, it was critical of Hodgson JA's approach (although it did state that Hodgson JA's reasoning was not "*plainly wrong*" and the wording of section 6 "*is at best opaque*".[315])

310 *Chubb Insurance Company of Australia Limited v Moore* (2013) 302 ALR 101; [2013] NSWCA 212 [82] ('***Chubb***').
311 *Chubb* [83] – [84].
312 *Chubb* [86].
313 *FAI General Insurance v McSweeny* [1997] FCA 152; (1997) 73 FCR 379 at 415.
314 [2007] NSWCA 124; (2007) 14 ANZ-Ins Cas 61-734.
315 *Chubb* [99].

Issue 3 – Defence Costs

- On the question of whether the statutory charge attaches to defence costs, the Claimants contended that:
  - the reference in section 6(1) to "*all insurance moneys that are or may become payable in respect of that liability*" meant that any amounts available under the policy that could respond to their claim were subject to the charge;
  - by the operation of section 6(6),[316] upon receipt of actual notice of the charge, no payment made under the Policies will be a valid discharge by the Insurers;[317]
  - the words "any payment" in section 6(6) had a meaning that would include any payment encompassing defence costs and other like costs or expenses.
- Receipt by the Insurers of actual notice of the charge, the Claimants argued, was *"the happening of an event giving rise to liability".* From that time, any payment made under the policy which eroded the policy's limit of liability would be an invalid discharge by the Insurer. This meaning, they said, was consistent with the statutory purpose of the section – to ensure "*insurance moneys are not to be depleted to the prejudice of the third-party claimant*".[318]
- The Court held that any statutory charge created by section 6 cannot apply to defence costs, legal representation expenses or other related costs and expenses. Despite an acknowledgment that the charge under section 6(1) comes into existence on "the happening of an event giving rise to liability", it must **at that time,** attach to all insurance moneys that are or may become payable in respect of the insured's liability for damages or compensation.[319]
- Recognising that section 6 does not alter the contractual relationship between insurer and insured, the Court stated that the charge is concerned with monies payable in respect of a liability of the insured to pay damages or compensation to the claimant, not other monies payable under the contract of insurance, such as defence costs.[320] Relevantly, each insured had a contractual right under the terms of the policy to advance defence costs within 30 days of an invoice from defence counsel.[321] If section 6 had been intended to alter the contractual relationship between insurer and insured in such a radical way (such as to potentially leave the insured with insufficient resources to defend major claims), it would have done so in express terms.[322]

316 which states that any payment made by the insurer under the contract of insurance without actual notice of the existence of any such charge shall to the extent of that payment be a valid discharge to the insurer, notwithstanding anything in this Part contained.
317 *Chubb* [111].
318 *Chubb* [109].
319 *Chubb* [118] - [119].
320 *Chubb* [120]
321 *Chubb* [122].
322 *Chubb* [124].

Result

- The NSWCA held there was no basis for restricting section 6 to 'occurrence based' insurance policies and that any statutory charge did not restrict the Insurers from advancing defence costs to the Insured.

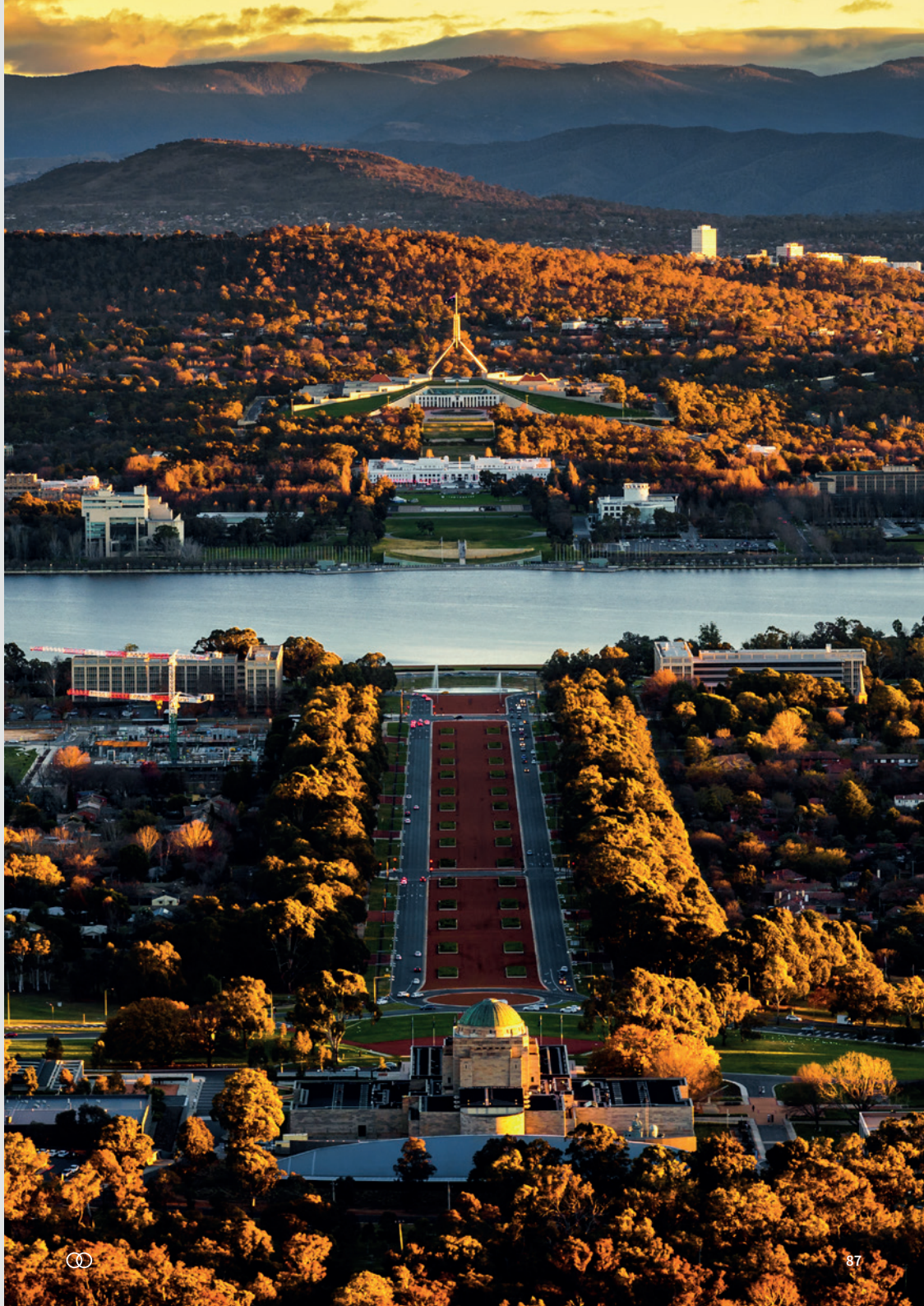
Significance

- The Court in this case also noted that '*Section 6 should be repealed altogether or completely redrafted in intelligible form, so as to achieve the objects for which it was enacted*'.[323]

- Following this and further calls for legislative change to "fix" the contract law issues arising out of this case and other similar cases, section 6 of the *Reform Act* was finally repealed in 2017 and replaced by the *Civil Liability (Third Party Claims Against Insurers) Act 2017* (NSW).

- With its primary function being 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, the *Third Party Claims Act* resolved the inherent uncertainty and ambiguity created by section 6 of the *Reform Act*. For more information about the *Third Party Claims Act*, along with three case examples, please check out the 2022 Edition of our Insurance Pocketbook.[324]

323 *Chubb* [55].
324 <https://www.kwm.com/au/en/insights/latest-thinking/kwm-insurance-pocketbook-2022.html>.



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