Annual Review of Insurance & Reinsurance Law 2003

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

SYDNEY
Andrew Martignoni, Editor
Ph: +61 2 9230 4485
Andrew.Martignoni@aar.com.au

Oscar Shub
Ph: +61 2 9230 4305
Oscar.Shub@aar.com.au

Michael Quinlan
Ph: +61 2 9230 4411
Michael.Quinlan@aar.com.au

Dean Carrigan
Ph: +61 2 9230 4869
Dean.Carrigan@aar.com.au

Michael Ball
Ph: +61 2 9230 4973
Michael.Ball@aar.com.au

John Morgan
Ph: +61 2 9230 4953
John.Morgan@aar.com.au

John Warde
Ph: +61 2 9230 4892
John.Warde@aar.com.au

BRISBANE
John Baartz
Ph: +61 7 3334 3254
John.Baartz@aar.com.au

Andrew Buchanan
Ph: +61 7 3334 3244
Andrew.Buchanan@aar.com.au

MELBOURNE
Louise Jenkins
Ph: +61 3 9613 8785
Louise.Jenkins@aar.com.au

Prue Campton
Ph: +61 3 9613 8741
Prue.Campton@aar.com.au

PERTH
Jenny Thornton
Ph: +61 8 9488 3805
Jenny.Thornton@aar.com.au

HONG KONG
Matthew Barnard
Ph: +852 2840 1202
Matthew.Barnard@aar.com.au

Simon McConnell
Ph: +852 2840 1202
Simon.McConnell@aar.com.au

SINGAPORE
Adam Lunn
Ph: +662 679 1333
Adam.Lunn@aar.com.au

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

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

We would very much like your feedback on this Review.

If you would like further information about our regular Forums on Insurance & Reinsurance Law, please contact Natasha Scott on +61 2 9230 4426.
ANNUAL REVIEW OF INSURANCE & REINSURANCE LAW 2003

Also available online at:
PREFACE


This year’s Review is considerably more voluminous than any previous year. In part, this is due to the unprecedented number of significant developments. It is also due to the inclusion for the first time of an Asia section. This reflects the increasing significance of Asia in AAR's practice, and a recognition of the importance of being able to service clients in the insurance industry throughout Asia, as well as in Australia. I am indebted to Simon McConnell, AAR's Insurance Partner in Hong Kong, who reviewed and edited the Asia section of the Review.

In the area of insurance law, many of the most significant court decisions in 2003 concern the construction of insurance policies. Several decisions relating to aggregation of claims illustrate the importance of careful consideration of the wording of insuring clauses and aggregation clauses in light of the types of claims that may arise from the activities carried out by insureds. These decisions are of great interest to insureds and their brokers, insurers, and, in particular, reinsurers.

We have reported on a number of decisions from the United Kingdom. Although not binding on Australian courts, they are likely to constitute persuasive authorities. In Australia, the decision in *Silbermann v CGU Insurance Ltd* means that ‘up front’ cover for defence costs may not be available for directors where fraud is alleged, even if not yet proved.

In the area of claims, the developments in 2003 that are likely to have the greatest impact are the continuing legislative reforms to civil liability, and the proposals for reform of the *Insurance Contracts Act*. In December 2003, the Commonwealth introduced a long-promised proposal for amending the *Trade Practices Act*. The proposal is aimed at ensuring that civil liability reforms in the states and territories (most significantly those relating to duty of care and the introduction of proportionate liability) are not able to be undermined by plaintiffs lodging claims at the Commonwealth level.

In addition, the inquiry that has been set up to consider reform of the *Insurance Contracts Act* is likely to lead to reforms that will alleviate the impact on insurers of the 2001 High Court decision in *Australian Hospital Care*. The consequence will be that ‘claims made and notified’ policies will operate in a manner more closely resembling their intent. This will come as a great relief to overseas insurers, particularly those in the Lloyd’s market, who are writing an increasing level of Australian primary insurance business.

It has been pleasing to see the continuing interest being generated by the Review, both internally and externally. The number of contributors to this year’s publication is unprecedented and too long for me to list. I hope the Review continues to generate interest, as well as provide a valuable reference tool for its readers. I encourage all readers to provide any feedback that may help us to improve the Review and ensure that it continues to be useful to its readers.

Andrea Martignoni
Editor
Allens Arthur Robinson (AAR) has been servicing clients in Australia for 180 years and in the Asia Pacific region for the past three decades. AAR is one of the largest law firms in the Asia-Pacific region, with 200 partners and more than 600 other legal staff.

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

An increasingly complex, competitive and volatile insurance environment demands legal advisers who recognise the critical issues and expectations arising in the Australian and global markets.

Known for our commonsense approach, we’re both results-driven and focused on our clients’ commercial needs. We’re known for our expertise in all aspects of insurance and reinsurance law, whether corporate, regulatory or contentious.

We are well-equipped to advise on a range of issues, from complex and sensitive, litigation to interpretation in policy coverage disputes and policy drafting, claims assessment, statutory and compliance issues, and mergers and acquisitions.

In litigation, we fight vigorously those cases that have to be fought; but, from the outset, we provide strategic case management and focus on whether alternative methods of dispute resolution will save our clients both time and money.

National Practice Leader

Oscar Shub
Partner, Sydney
Ph: +61 2 9230 4305
Oscar.Shub@aar.com.au
<table>
<thead>
<tr>
<th>Partner, Brisbane</th>
<th>Partner, Sydney</th>
<th>Partner, Sydney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ph: +61 7 3334 3254</td>
<td><a href="mailto:John.Baartz@aar.com.au">John.Baartz@aar.com.au</a></td>
<td>Ph: +61 2 9230 4973</td>
</tr>
<tr>
<td>John Baartz</td>
<td></td>
<td><a href="mailto:Michael.Ball@aar.com.au">Michael.Ball@aar.com.au</a></td>
</tr>
<tr>
<td></td>
<td>Andrew Buchanan</td>
<td></td>
</tr>
<tr>
<td>Ph: +61 7 3334 3244</td>
<td><a href="mailto:Andrew.Buchanan@aar.com.au">Andrew.Buchanan@aar.com.au</a></td>
<td>Ph: +61 2 9230 4869</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Dean.Carrigan@aar.com.au">Dean.Carrigan@aar.com.au</a></td>
</tr>
<tr>
<td></td>
<td>Louise Jenkins</td>
<td></td>
</tr>
<tr>
<td>Ph: +61 3 9613 8785</td>
<td><a href="mailto:Louise.Jenkins@aar.com.au">Louise.Jenkins@aar.com.au</a></td>
<td>Ph: +662 679 1333</td>
</tr>
<tr>
<td>Louise Jenkins</td>
<td></td>
<td><a href="mailto:Adam.Lunn@aar.com.au">Adam.Lunn@aar.com.au</a></td>
</tr>
<tr>
<td></td>
<td>Andrea Martignoni</td>
<td></td>
</tr>
<tr>
<td>Ph: +61 2 9230 4485</td>
<td><a href="mailto:Andrea.Martignoni@aar.com.au">Andrea.Martignoni@aar.com.au</a></td>
<td>Ph: +852 2840 1202</td>
</tr>
<tr>
<td>Andrea Martignoni</td>
<td></td>
<td><a href="mailto:Simon.McConnell@aar.com.au">Simon.McConnell@aar.com.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partner, Hong Kong</td>
</tr>
<tr>
<td></td>
<td>John Morgan</td>
<td>Ph: +61 2 9230 4953</td>
</tr>
<tr>
<td>Ph: +61 2 9230 4953</td>
<td><a href="mailto:John.Morgan@aar.com.au">John.Morgan@aar.com.au</a></td>
<td>Ph: +61 2 9230 4411</td>
</tr>
<tr>
<td>John Morgan</td>
<td></td>
<td><a href="mailto:Michael.Quinlan@aar.com.au">Michael.Quinlan@aar.com.au</a></td>
</tr>
<tr>
<td></td>
<td>Jenny Thornton</td>
<td></td>
</tr>
<tr>
<td>Ph: +61 8 9488 3805</td>
<td><a href="mailto:Jenny.Thornton@aar.com.au">Jenny.Thornton@aar.com.au</a></td>
<td>Ph: +61 2 9230 4892</td>
</tr>
<tr>
<td>Jenny Thornton</td>
<td></td>
<td><a href="mailto:John.Warde@aar.com.au">John.Warde@aar.com.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CONTENTS

General insurance law

1. Third party unable to rely on section 54
   Tzaidas (by his tutor Tzaidas) v Child; Tzaidas v Child 13

2. Scope of cover for third parties specified or referred to in the policy
   General Motors Acceptance Corp Aust v RACQ Insurance Ltd 15

3. Third party claims: when does an ‘event giving rise to the claim’ occur?
   QBE Insurance Ltd & Suncorp Metway Insurance Ltd v Aulich & Ors 17

4. Insured ‘clearly informed’ of flood exclusion by being provided with policy wording
   Marsh v CGU Insurance Limited trading as Commercial Union Insurance 18

5. Maritime insurance: has the tide turned?
   Gibbs v Mercantile Mutual Insurance (Australia) Ltd 21

6. What is the scope of an implied warranty relating to a vessel in a marine insurance contract?
   Solway v Lumley General Insurance Limited 24

7. Total and permanent disability benefits
   Cameron v Board of Trustees of the State Public Sector Superannuation Scheme 26

8. Employer unable to claim indemnity against a motor vehicle third-party insurer for workers’ compensation payments following motor vehicle injury
   State Rail Authority of NSW v Sun Alliance & Royal Insurance Australia Ltd 28

9. Stamp duty on premiums: inclusive or exclusive of GST?
   Commissioner of State Revenue v Royal and Sun Alliance Insurance Australia Ltd 30

10. Insurance agent liable to insurer for lost opportunity
    Dickinson v National Mutual Life Association of Australasia Ltd (trading as AXA Australia) 32

11. Shifting burdens of proof: when must the insured prove a negative?
    Ocean Harvester Holdings Pty Ltd v MMI General Insurance Ltd 34

12. Appeal Court reluctant to revisit facts
    Suncorp Metway Insurance Limited v Scarf 35

13. Company subject to deed of company arrangement ordered to produce insurance policy to a prospective claimant
    Glaister v Banwell Pty Ltd (ACN 009 394 585) (subject to a deed of company arrangement) 37

Duty of disclosure and misrepresentation

14. What is the scope of an insured’s duty of disclosure under s21 of the Insurance Contracts Act?
    Permanent Trustee Australia Limited v FAI General Insurance Company Limited (in liquidation) 39

15. When will an insurer be unable to avoid in cases of fraudulent non-disclosure?
    FAI General Insurance Co Ltd (in liquidation) v Sherry 42
16. Duty to disclose considered in cases of progressive illness
McCabe v Royal & Sun Alliance Life Assurance Australia Ltd

17. Insurer fails to provide disclosure that would have resulted in denial of cover
Schaffer v Royal & Sun Alliance Life Assurance Australia Ltd

18. Contracting out of the duty of disclosure
HIH Casualty and General Insurance Limited & Ors v Chase Manhattan Bank & Ors

Construction of policies

Aggregation clauses and identifying the cause of loss

19. Many claims or a single claim: the importance of aggregation clauses
Lloyds TSB General Insurance Holdings & Ors v Lloyds Bank Group Insurance Company Limited

20. Building defects: when will several claims form a ‘series of claims arising from one event’?
QBE Insurance Ltd v MGM Plumbing Pty Ltd

21. September 11: one occurrence?
World Trade Center Properties LLC & Ors v Hartford Fire Insurance Company & Ors; SR International Business Insurance Co Ltd & Ors v Travelers Insurance Company & Ors

22. Identifying which event caused loss, when multiple losses follow the outbreak of war
Murray Arnold Campbell Scott (for and on behalf of all Underwriting Members of Syndicates 401 and 857 at Lloyd's) v The Copenhagen Reinsurance Company (UK) Ltd

23. Aggregation: what amounts to a ‘single claim’ where there is no aggregation clause
Mabey and Johnson Ltd v Ecclesiastical Insurance Office Plc & Ors

24. Determining the relevant ‘event’ that causes the loss when a train goes off the rails
Midland Mainline Ltd v Commercial Union Assurance Company Ltd

Insuring clauses

25. Liability insurance: joint venture clause limited to liability of named insured only
Egis Consulting Australia Pty Ltd v Kvaerner Oil & Gas Australia Pty Ltd & Anor

26. Cover denied where the intention is not carried into the express words of a policy
Manren Limited v Royal and Sun Alliance Insurance Australia Limited

Exclusion clauses

27. D & O insurance: insurer seeking to rely on fraud exclusion not liable to pay defence costs upfront
Silbermann v CGU Insurance Ltd; Rich v CGU Insurance Ltd; Greaves v CGU Insurance Ltd

28. Fraud exclusions: what is the boundary between gross negligence and dishonesty?
Harle v Legal Practitioners Liability Committee

29. Exclusion clauses, cross-liability clauses and election
National Vulcan & Ors v Transfield; National Vulcan & Ors v Connell Wagner; National Vulcan & Ors v Coffey Partners International
30. Construction of an exclusion clause, knowledge of a broker and the duty of disclosure
QBE Mercantile Mutual Ltd v Hammer Waste Pty Ltd and Anor

31. When is a vehicle not a vehicle?
Palframan v Jackson’s House Removals (a firm) & Ors

32. Insurer not liable where an excluded event contributed to loss, even if not the sole cause of loss
Prosser & Anor v AMP General Insurance Ltd

Miscellaneous issues relevant to policy construction

33. Recovery of business interruption losses following September 11 terrorist attacks
If P&C Insurance Limited (Publ) v Silversea Cruises Limited & Ors

34. How significant are credit limits when ascertaining amounts recoverable under a policy-of-credit insurance?
Moore Large & Co Ltd v Hermes Credit & Guarantee Plc (sued as Credit and Guarantee Insurance Co Plc)

35. Life insurance: representation that an existing policy would be cancelled held to have no contractual effect
Paul Raymond Stone v Tower Australia Ltd

Reinsurance

36. Distribution of the assets of an insolvent reinsurer
New Cap Re v Faraday Underwriting

37. Reinsurance policy: extent of cover under ‘aggregate loss protection’ clause
Allianz Australia Insurance Ltd v General Cologne Re Australia Ltd

38. Multi-year contracts: pitfalls facing reinsurers seeking to invoke review clauses
Charman v New Cap Reinsurance Corporation Limited (in liquidation)

39. Film finance insurance: reinsurer able to rely on breach of warranty not contained in insurance contracts
GE Reinsurance Corporation & Ors v New Hampshire Insurance Co & Anor

40. ‘Follow the settlements’ clauses in contracts of reinsurance: when will a reinsurer be bound to follow a settlement made?
Assicurazioni Generali SpA v CGU International Insurance PLC & Ors

41. Avoiding contracts of reinsurance for misrepresentation
Assicurazioni Generali SpA v Arab Insurance Group (BSC)

Duty of care, trade practices and common law liability

42. The latest word on economic loss claims
Johnson Tiles Pty Ltd v Esso Australia Pty Ltd

43. Occupier’s liability: High Court on duty to warn
Hoyts Pty Ltd v Burns

44. New South Wales Court of Appeal overturns jury negligence verdict based on failure to warn
Waverley Municipal Council v Swain

45. No duty to provide pool fencing when risk of injury is obvious
Waterways Authority & Anor v Mathews
46. Sandbar in a tidal creek is an inherent risk and an obvious danger
   Mulligan v Coffs Harbour City Council & Ors

47. Negligence: whether the defendant’s negligence caused the plaintiff’s severe psychiatric condition
   Shorey v PT Limited

48. Was a legislative declaration of plants as ‘prohibited’ reasonably foreseeable?
   Dovuro Pty Limited v Robert John Wilkins & Ors

49. When is a hotel liable for the injury of an inebriated patron?
   Parrington v Hotelcorp Pty Ltd & Ors

50. The contributory negligence of an intoxicated passenger
   Joslyn v Berryman, Wentworth Shire Council v Berryman

51. Salmonella outbreak from contaminated orange juice: supplier liable, despite absence of negligence
   Dowdell v Knispel Fruit Juices Pty Ltd

52. Medical negligence: damages available for costs of maintaining an unintended child
   Cattanach v Melchior

53. Medical negligence: no extension to Griffiths v Kerkemeyer damages
   Diamond v Simpson (No 1)

54. Negligence and medical practitioners: what duty does a doctor owe to a patient whose partner tests positive for HIV?
   PD v Dr Nicholas Harvey

55. Sexual abuse of pupils by teachers: who compensates the victims?
   New South Wales v Lepore; Samin v Queensland; Rich v Queensland

56. Broker’s duty to advise insured about its insurance requirements
   Katherine Electronic Services Pty Ltd v CGU Insurance Limited trading as Commercial Union Insurance and Nonpareil Pty Ltd trading as Pfitzner & Partners Insurance Brokers

Legislative and regulatory developments

57. Review of the Insurance Contracts Act

58. Tort law reform

59. Financial services reform

60. Medical indemnity reform

61. Terrorism Insurance Act 2003

62. Review of discretionary mutual funds & direct offshore foreign insurers

63. Prudential supervision of general insurance: APRA stage two reforms

64. Summary of the Age Discrimination Bill 2003
Asia Review

65. Hong Kong 184

Insurance legal framework and industry background in Hong Kong

2003 case summaries

(i) Obligation to notify insurers of relevant events connected to claims
Harbourfield Engineering Co. Limited v Falcon Insurance Co. (Hong Kong) Limited

(ii) Can an insurer withhold an extension of time unreasonably?
Fong Wing Shing Construction Co Ltd v Assurances Generales de France (HK) Ltd

(iii) Insurer cannot avoid cargo insurance policy on grounds of material non-disclosure, breach of warranty and lack of insurable interest
Hong Kong Enterprises Ltd & Ors v QBE Insurance (Hong Kong) Ltd

(iv) Marine insurance and ambiguous terms
BC Enterprise Sdn Bhd Nagasaki International Limited Cofco International Trading Co Ltd v Bank of China Group Insurance Company Limited

Professional and civil liability

(v) Duty of care of solicitors not acting in a professional capacity
Yiu & Ors v Chow

(vi) When is a financial advisor liable for losses suffered by a client?
Field v Barber Asia Ltd

(vii) Vicarious liability: what amounts to a sufficiently close connection with employment?
The Ming An Insurance Company (HK) Limited v The Ritz-Carlton Limited

(viii) Tour operator found to have a non-delegable duty of care
Au Ka Ying & Ors v Guandong (HK) Tours Company Limited

66. Singapore 201

Insurance legal framework and industry background in Singapore

2003 case summaries

(ix) A case of rushed cover: a lack of detailed instructions from the insured led to a lack of coverage
Wan Teck Chian Machinery (PTE) Ltd v CGU International Insurance PLC (formerly known as Commercial Union Assurance Co PLC)

67. China 209

Insurance legal framework and industry background in China

68. Thailand 216

Insurance legal framework and industry background in Thailand

69. Papua New Guinea 221

Insurance legal framework and industry background in Papua New Guinea
In New South Wales, a court can allow a third party to sue an insurer directly, unless the insurer has a right to disclaim liability under the insurance policy. Does Commonwealth legislation on the effectiveness of disclaimers affect a court’s ability to refuse an application to bring a direct claim?

Factual background
The plaintiffs, a mother, father and child, claimed against a number of defendants for professional negligence in relation to the boy’s birth. The first defendant, Dr Robert Peter Child, was an obstetrician, the second defendant was the Hurstville Community Co-operative Hospital Ltd (the hospital), and the third defendant, Dr Charles M. Scarf, was a paediatrician.

The hospital held an insurance policy with CGU Insurance Ltd (the insurer) of a type commonly known as a ‘claims made and notified’ policy. The effect of such a policy is that an insured can claim against the policy after its expiration, provided that the insured notified the insurer during the period of insurance of any fact, situation or circumstance of which it became aware during that period that could give rise to the claim.

The proceedings
The plaintiffs sought leave to commence proceedings against the insurer under section 6 of the Law Reform (Miscellaneous Provisions) Act 1946 (NSW) (the Law Reform Act). This provision creates a charge on insurance monies that can be enforced by a third party as if the action were an action to recover damages or compensation from the insured. The court cannot grant leave to bring this kind of action if it is satisfied that the insurer is entitled ‘under the terms of the contract of insurance’ to disclaim liability.

Was the insured entitled to disclaim liability?
The question before Justice Grove was whether the hospital would have been entitled to make a claim under its policy with the insurer. The plaintiffs asserted that the hospital should have been aware that it had been notified by the plaintiffs’ solicitors for copies of clinical notes setting out the nature and conditions of the plaintiff child’s injuries, treatment and prognosis. The solicitors also requested a statement of fees incurred for that treatment.
The insurer argued that the plaintiffs should be refused leave to bring an action against it under the Law Reform Act. Its primary submission was that it was entitled to rely on the proviso in s6(4) because the hospital had not notified it of relevant circumstances during the period of the policy and the insurer was therefore entitled to disclaim liability.

The insurer noted, however, the possibility that s54 of the Insurance Contracts Act 1984 (Cth) may deprive s6(4) of the Law Reform Act of its proviso. Section 54 of the Insurance Contracts Act provides that, where the effect of a contract of insurance would be that the insurer may refuse to pay a claim by reason of some act of the insured or of some other person that occurred after the contract was entered into, the insurer may not refuse to pay the claim by reason only of that act. Rather, the insurer's liability for the claim will be reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.

Justice Grove found that the hospital was aware of circumstances that might give rise to a claim against it. This finding may be contrasted with that of FAI Insurance v Australian Hospital Care (2001) 204 CLR 641.

Justice Grove accepted the insurer's submission that, in the absence of notification by the hospital, the insurer was entitled to disclaim liability. He also held that s54 is irrelevant to the question of whether leave to commence proceedings ought to be given according to the Law Reform Act. This was because he considered that the Law Reform Act is directed only to the effect of the contract of insurance, and whether that justified a denial of indemnity. He contrasted this to the Insurance Contracts Act, which is directed to the determination at trial of the extent of prejudice to the insurer and whether the act or omission of the insured which would otherwise have provided a disclaimer should be permitted to provide a defence in whole or in part to the claim already made by the insured.

It should be noted that Justice Grove expressed reservation about this viewpoint, but felt bound by the decision of Justice Powell in FAI General Insurance v Jarvis (1999) NSWLR 1 to adopt it.

This case supports the proposition that s54 of the Commonwealth Act is irrelevant to third party actions against insurers in New South Wales. In this case, the plaintiffs’ leave to commence proceedings was refused. It will be interesting to see whether this decision survives any appellate decision on the issue. By placing third parties in a worse position than an insured, this approach produces a result that is arguably contrary to the broader purpose of the Law Reform Act.
The case considers whether a financier whose interest is noted on the policy can successfully claim under a borrower's insurance policy under s48(1) **Insurance Contracts Act 1984** (Cth), in circumstances where the borrower's conduct would preclude it from recovering.

**The facts**

General Motors Acceptance Corporation Australia (the **applicant**) financed the insured's purchase of a vehicle, which was insured with RACQ Insurance Limited (the **respondent**). As is common practice, the applicant's interest in the vehicle was noted on the insurance policy.

The insured made a fraudulent claim on the policy after the vehicle was deliberately destroyed. The applicant sought to recover under the policy, according to s48(1) **Insurance Contracts Act 1984** (Cth), which provides

(1) Where a person who is not a party to a contract of general insurance is specified or referred to in the contract, whether by name or otherwise, as a person to whom the insurance cover provided by the contract extends, that person has a right to recover the amount of the person's loss from the insurer in accordance with the contract notwithstanding that the person is not a party to the contract.

... (3) The insurer has the same defences to an action under this section as the insurer would have in an action by the insured.

The question of whether the financier could recover under the policy was determined as a preliminary issue on an agreed statement of facts, under rule 483(1) **Uniform Civil Procedure Rules** (Qld).

**The decision**

Justice Muir found against the applicant's contended construction of certain clauses of the insurance policy. In particular, he held that:

- the policy's provision that ‘Your policy covers you only when the insured vehicle is being used [for particular purposes]’ refers to the insured's use of the vehicle, even for the purposes of the applicant’s claim. It precludes recovery where the vehicle was used to be deliberately destroyed; and
- where cover is limited to 'damage to your vehicle... caused by an accident’, the definition of accident as ‘an event that is unexpected and unintended from your point of view' refers to the insured's point of view, not the applicant’s, for the purposes of the applicant’s claim.
Justice Muir found that:

To reach a conclusion contrary to that expressed above would be to alter fundamentally the nature of the risks insured against under the policy… such a result would be rather improbable and ought not be arrived at readily.

Seeking to avoid the policy’s restricted scope, the applicant argued, relying on *VL Credits Pty Ltd v Switzerland General Insurance Co [1990] VR 938*, that the effect of section 48(3) is not that the insurer can resist paying a third party under the policy in all circumstances where it can resist making payment to the insured, but rather that it can resist paying a third party where facts that would enable it to resist payment to the insured exist *in respect of the third party.*

However, Justice Muir held that the applicant’s right of recovery under s48(1) ‘is a right to recover “in accordance with the contract”.’ For the applicant to be able to recover its loss under the policy, the loss had to be within the scope of the policy: ie, to arise out of an *accident*, and to have been caused when the vehicle was being used for a specified purpose. He reasoned:

Clause 48(1) does not operate to extend the scope of cover provided by the policy and a person in the position of the applicant must take the policy as he finds it.

Justice Muir additionally held that, even accepting the applicant’s contention that the word ‘your’ in the policy should at times be read as referring to the applicant, the provision of that cover does not extend to accident, loss or damage arising out of ‘the intentional acts of a person in control of your vehicle with your permission’. This, he said, precluded the applicant from recovering its loss where it left the insured and any nominated driver in control of the vehicle, and where damage was caused intentionally by such person.

This case demonstrates that a person noted on an insurance policy, while able to claim under the policy by virtue of s48(1) *Insurance Contracts Act*, is nonetheless subject to the restrictions on cover applicable to the insured under the policy. Persons such as financiers need to be alert to the fact that an insurance policy taken out by their borrower may not protect their interest in all circumstances, and additional, independent, cover may be necessary.
Third party claims: when does an 'event giving rise to the claim' occur?

Two insurers have failed to convince the Australian Capital Territory Court of Appeal that a group of claimants should be prevented from bringing a statutory claim directly against them, rather than against the allegedly negligent insured.

This case concerned an application for leave to appeal arising out of an application on behalf of 176 plaintiffs (respondents to this application) for leave to enforce an insurance policy directly against the insurers. The insured, Taxinvest, was a financial adviser that allegedly gave negligent advice to the respondents. The respondents brought a statutory claim directly against the insurers under the Law Reform (Miscellaneous Provisions) Act 1955 (ACT) (the Act) on the basis that there was a ‘real likelihood’ that Taxinvest would be unable to satisfy the claims. Similar legislation exists in other states and territories.

The insurers argued that the claim could not be brought against them, because the ‘event giving rise to the claim’ within the meaning of section 25(1) of the Act happened before the ‘claims made and notified’ policy commenced. The insurers contended that the ‘event’ was the conduct of Taxinvest in giving negligent advice. Chief Justice Miles rejected this contention, accepting the plaintiffs’ argument that the ‘event’ only happened when the cause of action was complete, ie when the consequential loss was suffered. As the loss happened within the policy period, the application for leave was granted. The decision was based on the proposition that the court had power to grant leave once the plaintiffs had demonstrated an ‘arguable case’.

On an application for leave to appeal, the insurers suggested that it was not in the interests of justice for leave to be granted. Citing earlier decisions, the court confirmed that if there is an argument in the applicant’s favour that could be seriously put, leave should be granted. As there was no apparent authority supporting the insurers’ argument that ‘the event’ referred to in the Act was the giving of negligent advice rather than the suffering of loss, the court concluded that Chief Justice Miles was correct in granting leave to the plaintiffs. The insurers’ application was accordingly dismissed.

This case confirms that an ‘event’ giving rise to a damages claim within the meaning of the legislation conferring rights on third parties against insurers only happens once all of the elements of the cause of action, including the suffering of loss, are complete. Insurers cannot escape liability by claiming that the ‘event’ was the conduct of the insured and that it happened before the policy period, if the cause of action only became complete during the policy period.
Insured ‘clearly informed’ of flood exclusion by being provided with policy wording

Case Name: Marsh v CGU Insurance Limited trading as Commercial Union Insurance

Citation: [2003] NTSC 71, Supreme Court of the Northern Territory per Angel J

Date of Judgment: 20 June 2003

Issues:
- Section 35 of the Insurance Contracts Act 1984 (Cth)
- Whether the requirement under s35(2) is satisfied by the supply to the insured of a document containing the relevant policy provisions

Does a policy document sent by an insurer to an insured ‘clearly inform’ the insured of relevant exclusions in the insured’s policy, so that the insurer is within the application of section 35(2) of the Insurance Contracts Act? The Supreme Court of the Northern Territory held that it does.

The facts
Merilyn Marsh was the owner-occupier of a house in Katherine, which was damaged by flood waters from the nearby Katherine River in the well-known floods of January 1998. Mrs Marsh was insured by the defendant company, CGU Insurance Limited, trading as Commercial Union Insurance (CGU). Mrs Marsh had maintained home contents insurance with CGU since 1983.

CGU denied liability on the ground that the relevant insurance policy excluded indemnity for damage caused by flood.

Mrs Marsh began action against CGU for her loss, relying on s35 of the Insurance Contracts Act 1984 (Cth) (the Act), plus interest under s57 of the Act.

Under regulation 13 of the Insurance Contracts Regulations 1985 (Cth) (the Regulations), home contents insurance is a prescribed contract under s35 and, under regulation 14, flood is a prescribed event under s35. It follows that, subject to s35(2), the policy gave rise to liability by CGU to indemnify Mrs Marsh against flood damage.

The decision
CGU accepted that it bore the onus of bringing itself within s35(2) of the Act. CGU did not suggest that Mrs Marsh knew that she had no flood cover or that a reasonable person in the circumstances could be expected to have known that she had no flood cover. Instead, CGU argued that it ‘clearly informed’ Mrs Marsh in writing that she had no flood cover through a succession of policy documents each time Mrs Marsh renewed the policy and each time the policy conditions were altered.

Having reviewed the policy wordings of home and contents insurance policies issued by CGU over the years, Justice Angel was satisfied that the policy wordings, each time they were issued or revised, had referred to the fact that damage arising from flood was not covered.
Mrs Marsh gave evidence that she did not recall ever receiving the policy documents and each year she simply paid her premium and retained her renewal notice and receipt. In addition, counsel for Mrs Marsh submitted that the policy documents in question were ‘in a format not conducive to reading the whole’, ‘overloaded with information’, and not ‘user friendly’. However, Justice Angel held that:

…the policy clearly told anybody who read it that flood damage was not covered by the policy. The document has an index which includes an entry “flood”. The reader is referred to pages 13, 15 and 36. At the top of page 13 appear the words: “We do not provide cover for damage by flood”. The document has a “Table of Contents” which includes an entry in bold type: “What Section 1 and Section 2 of the policy do NOT cover”, referring to page 36. At page 36 below a bold heading “What Section 1 and Section 2 of the policy do NOT cover” appear the words: “We will not pay claims arising from:” followed by a list of matters including flood. In my view the policy document of itself, if sent to the plaintiff, “clearly informed” her that the policy did not provide insurance coverage for damage by flood.

In arriving at this conclusion, Justice Angel referred to Justice Einstein’s comments in *Hams & Anor v CGU Insurance Limited* (2002) 12 ANZ Insurance Cases 61-525 at paragraph 243:

…I accept as correct the proposition that the words [(whether by providing the insured with a document containing the provisions, or the relevant provisions, of the proposed contract or otherwise)] in s35(2) of the Act… mean that providing a document containing the provisions is one of a number of mechanisms by which an insurer may clearly inform the insured. In each case the content of the document and all of the circumstances of its provision would need to be considered in order to determine if the insurer had effectively informed the insured of the limitation.

Justice Angel went on to conclude that the term ‘informed’, in the context of s35, means simply no more than ‘told’.

Justice Angel then held that, on the balance of probabilities, CGU established that Mrs Marsh was sent the relevant policy document, given the evidence of its system in place and the practice of its Darwin branch in enclosing policy wordings with renewal notices to insureds whenever a material change was made to the relevant policy wording, and from 1996 attaching new policy wordings to all domestic insurance renewals.

Justice Angel dismissed Mrs Marsh’s claim and concluded that:

- the policy document of itself ‘clearly informed’ her that her policy did not provide insurance cover for damage by flood; and
- it was more probable than not that she did receive the relevant policy document.
This case confirms that the requirement in s35(2) to ‘clearly inform’ the insured of relevant exclusions can be satisfied by sending the policy wording to the insured, irrespective of whether or not the insured reads it. However, an insurer must ensure that its policy wordings are in plain English and contain clear references to all exclusions. Even when the policy documents are large and somewhat complex, an index and a table of contents that refers the insured to information about exclusions can achieve the aim of ‘clearly informing’ the insured about those exclusions.
Maritime insurance: has the tide turned?

Case Name: Gibbs v Mercantile Mutual Insurance (Australia) Ltd

Citation: [2003] HCA 39, High Court of Australia per Gleeson CJ, McHugh, Kirby, Hayne and Callinan JJ

Date of Judgment: 5 August 2003

Issues:
- What should be classified as 'marine insurance'?
- What is 'the sea' for the purposes of the Marine Insurance Act 1909 (Cth)?

This case considers when insurance is ‘marine insurance’ and demonstrates a division in the High Court as to what constitutes ‘maritime perils’ under modern Australian law.

The facts

Mr Gibbs and his partner operated a parasailing business where customers were towed behind a speedboat while attached to a parachute by a harness. The rides took place on the estuary of Perth’s Swan River, where the waters of the river and the Indian Ocean mix.

In 1986, Mr Gibbs took out an insurance policy with Mercantile Mutual (Australia) Ltd for the speedboat and trailer and third-party liability insurance covering risks related to their commercial parasailing operation. A warranty that the boat would only be operated in the ‘Protected Waters of WA’ was attached to the policy. Mr Gibbs later admitted he had failed to disclose some information associated with obtaining the insurance. The policy was renewed in 1988, but insurance for the boat and trailer was deleted, leaving only the third-party liability cover.

In 1989, a customer was seriously injured during a parasailing landing. Mr Gibbs failed to give Mercantile the notice required by the policy within the specified time and Mercantile refused the claim. Mr Gibbs sued Mercantile. The District Court found the insurance was not marine insurance. On appeal, this finding was reversed. Mr Gibbs appealed to the High Court.

The legal background

Under the Insurance Contracts Act 1984 (Cth) (the ICA), Mr Gibbs’ failures to disclose and notify Mercantile in time was not an absolute bar to the claim. However, Mercantile claimed the contract was a ‘marine insurance contract’ and so the relevant law was the Marine Insurance Act 1909 (Cth) (the MIA). The ICA specifically states that it does not apply to contracts covered by the MIA. The MIA requires strict compliance with a contract’s terms and it was agreed by both parties that if the MIA applied, then Mr Gibbs’ claim failed.

Under the MIA, every lawful ‘marine adventure’ may be the subject of a contract of marine insurance’, and a ‘marine adventure’ includes a case where a third-party liability arises, so long as it arises from ‘maritime perils’. Under the MIA, ‘maritime perils’ means ‘the perils consequent on, or incidental to, the navigation of the sea, that is to say, perils of the seas’.
The decision

The central issue of the case was whether the Gibbs’ speedboat had faced ‘maritime perils’, as required to fall within the terms of the MIA. By a bare majority, the High Court found that it had.

Chief Justice Gleeson and Justices Hayne and Callinan formed the majority dismissing the appeal. Chief Justice Gleeson held that, where the parties to an insurance contract have in mind a maritime activity, such as operating a commercial vessel carrying passengers engaging in water sports, liability to a passenger arising from navigation of that vessel is a maritime peril. He considered that it was an error to assume that marine insurance only involved ‘great ships on the high seas’, and, while not removing a requirement relating to where the vessel operates, he indicated that he was inclined to a definition of the sea that extended ‘beyond the open ocean’, and included an estuary where ocean waters ebb and flow.

In a significant decision, Justices Hayne and Callinan held that ‘perils of the seas’ were only one class of a genus of perils known as ‘maritime perils’. They considered that, although events occurring when a boat is not at sea may not be caused by ‘perils of the seas’, it does not mean they are not events consequent on exposure to maritime perils. The important issue is the types of risk that the insurer indemnifies against, rather than where the liability-causing event happens. If the type of risk insured against is maritime perils, where that peril occurs is not important.

As a result, their Honours did not need to consider whether the Swan River estuary was the sea or not. It was clear to them that the careless operation of the boat, causing injury to a person being towed, was a peril of a kind consequent on, or incidental to, navigation of the sea. In other words, it was a maritime peril.

In dissent, Justices McHugh and Kirby delivered separate judgments but both held that a vital part of facing a maritime peril was that it be faced at sea. Justice McHugh considered that a vessel cannot be involved in a ‘marine adventure’ unless it is ‘used for voyages that involve traversing the open sea’. Reviewing the history of maritime insurance, he considered it was clear that the MIA was not intended to apply to vessels operating on inland waters unless the inland operation was incidental to, or consequent upon, a sea voyage. Since Mr Gibbs’ speedboat was never to leave the river, it did not take part in ‘marine adventures’.

Justice Kirby looked beyond the form of the insurance policy, to the substance of what was insured against, and found that the policy was, in reality, a commercial, third-party liability policy, to which the ICA should apply. The fact that the policy applied to a speedboat did not make it marine insurance. However, assuming he was wrong on that point, Justice Kirby went on to hold that, in order to be governed by the MIA, a vessel must face perils consequent on, or incidental to, the navigation of the sea. In determining what was the ambit of the sea, he adopted a commonsense approach and concluded that no resident or visitor sitting on the banks of the Swan near central Perth would believe they were at the seaside.
The High Court’s reasoning in this case implies that many insurance contracts relating to boats and water might now be classified as ‘marine insurance’. However, the outcome here may be related to the particular facts of the case. Had the accident occurred further inland, the result may well have been different. Since the time of the accident, the ICA has been amended to cover policies relating to pleasure craft (section 9A), although commercial policies, such as the one in this case, remain excluded.
What is the scope of an implied warranty relating to a vessel in a marine insurance contract?

This case considers the circumstances in which an insured has a ‘reasonable excuse’ for breaching an implied warranty within a contract for marine insurance.

**Case Name:**
Solway v Lumley General Insurance Limited

**Citation:**
[2003] QCA 136, Queensland Court of Appeal per Davies, Williams JJA and Atkinson J

**Date of Judgment:**
28 March 2003

**Issues:**
- Marine insurance
- Whether the insured had a ‘reasonable excuse’ for not complying with an implied warranty in the insurance contract

The respondent argued that there was an implied warranty in the insurance contract providing that the adventure insured must be a lawful one, and that, so far as the insured can control the matter, the adventure must be carried out in a lawful manner. The respondent also relied upon section 39(3) of the Marine Insurance Act 1909 (Cth), which provides that such a warranty ‘is a condition which must be exactly complied with, whether it be material to the risk or not’.

At first instance, the respondent successfully claimed that the vessel was not registered according to the Transport Operations (Marine Safety) Act 1994 (Qld) provisions and that this breached the implied warranty. Regulation 38 of the regulations under the Act requires the owner of a vessel whose place of residence is in Queensland and whose vessel is operating in Queensland waters to register the ship, ‘unless the owner has a reasonable excuse’.

On appeal, the appellant argued that the vessel was registered in the ships register, as required under the Commonwealth Shipping Registration Act 1991, and that at all material times the vessel was under survey with the Maritime Services Board of NSW and was registered in NSW. The appellant also provided evidence that officers from Queensland Boat Patrol and Queensland Transport would regularly inspect the vessel. Each time the appellant showed the officers his NSW permit, they indicated to him that they were satisfied that the boat complied with Queensland regulations. This, the appellant argued, provided him with a reasonable excuse for not registering the vessel.

**The decision**
The Court of Appeal considered the real issue in the proceedings to be whether or not the appellant had a ‘reasonable excuse’ for not registering the vessel, since the implied warranty was only a warranty to do what was lawfully required to be done. The judges considered the definition given to ‘reasonable excuse’ by the High Court in Taikato v The Queen [1996] 186 CLR 454 and, in light of this definition, found that the principal objective of the Transport Operations (Marine Safety) Act 1994 was to ensure marine safety. The Queensland Boat Patrol inspectors, on
sighting documentation from NSW, considered that the vessel satisfied all safety requirements under Queensland legislation. In other words, the Queensland Boat Patrol inspectors had made a representation that the appellant complied with all relevant requirements of the Queensland Act. Consequently, the appellant reasonably believed that he did not have to register in Queensland in order to comply with the Queensland legislation. He therefore had a ‘reasonable excuse’ for not registering the vessel and had complied with his implied warranty.

The appeal was upheld, with the judgment in favour of the respondent set aside.

This case illustrates that the implied warranty applying to vessels in marine insurance contracts requires the insured to do no more than what is required under relevant legislation. If the legislation provides relief for any technical breaches available to the insured, there will be no breach of the implied warranty.
Total and permanent disability benefits

Case Name:
Cameron v Board of Trustees of the State Public Sector Superannuation Scheme

Citation:
[2003] FCAFC 214, Federal Court of Australia, per Whitlam, Kiefel and Dowsett JJ

Date of Judgment:
5 September 2003

Issues:
- The nature and function of the Superannuation Complaints Tribunal in reviewing a decision of a trustee
- The extent to which a medical specialist’s view will be relevant

This case is one of many recent examples of Total and Permanent Disability (TPD) claims being aggressively (yet unsuccessfully) pursued, despite consistent medical evidence to the contrary.

Mr Cameron was awarded a Permanent and Partial Disablement benefit after retiring from his work as a teacher because of a voice disorder. Mr Cameron appealed to the Superannuation Complaints Tribunal (the SCT) under s14 of the Superannuation (Resolution of Complaints) Act 1993 (Cth) (the SRCA), claiming that he was entitled to be paid a TPD benefit. Mr Cameron relied mainly on one doctor’s report in which the doctor had found Mr Cameron to be totally and permanently disabled, based on an interpretation of the meaning of TPD given by the doctor. There was other consistent medical evidence to the contrary. The SCT found the decision to be fair and reasonable.

Mr Cameron then appealed to the Federal Court of Australia under s46 of the SRCA. Justice Spender dismissed the appeal with costs.

Mr Cameron then appealed to the Full Federal Court of Australia, which also dismissed the appeal with costs. Key points from the judgment include the following:

(a) The nature and function of the SCT in reviewing a decision under s37 of the SRCA is to consider whether the decision complained of was fair and reasonable in the circumstances, not to consider whether the respondent was totally and permanently disabled.

(b) Just because the SCT is not persuaded by a particular report does not mean that the report was not before it, or that it failed to take it into account as a relevant consideration.

(c) Any opinion expressed by an occupational physician about the ability of the applicant to perform a specified job is highly relevant. However, such a medical specialist’s views about other possibly relevant matters, such as university syllabuses and grades and the true meaning of a statutory definition, would be likely to command little attention from a body like the Board of Trustees of the State Public Sector Superannuation Scheme, which is composed of employer and employee representatives from the public sector.

(d) Factors that a decision-maker is bound to consider in making a decision are determined by construction of the statute conferring the power to make that decision, not by the pieces of evidence submitted to the decision-maker by a person affected by the decision.
This case confirms the well-settled principle that when a trustee decision to reject a TPD benefit is reviewed, the SCT is to consider whether the decision complained of was fair and reasonable in the circumstances. In reviewing the trustee’s decision, the SCT is not obliged to accept medical specialist’s views about non-medical matters, even though such matters might be relevant.
This case holds that an employer cannot claim indemnity for workers’ compensation payments from a motor vehicle third-party policy issuer under section 151Z(1)(d) of the Workers Compensation Act 1987 (NSW), given that the only trigger for the right conferred by that section is a liability to pay damages for an injury that also happens to be compensatable under the Act and not a liability to indemnify.

Facts

Mr Harbour was injured while employed by the State Rail Authority of NSW (SRA), due to the negligence of a fellow employee, Mr Robinson, who was operating a mobile crane belonging to SRA. The crane was insured by Sun Alliance & Royal Insurance Australia Ltd (Sun) under a motor vehicle third-party policy, providing both the SRA and Mr Robinson with a statutory right of indemnity.

Although Mr Harbour commenced action against Mr Robinson, those proceedings were discontinued. SRA, a self-insurer for workers’ compensation purposes, began paying compensation to Mr Harbour and, in September 1999, it paid compensation to Mr Harbour in the sum of $138,850.48 plus costs, in commutation of Mr Harbour’s entitlements, approved by the Compensation Court.

In 2000, SRA commenced proceedings against Sun, seeking indemnity under the policy in relation to the monies paid to Mr Harbour and, in September 1999, it paid compensation to Mr Harbour in the sum of $138,850.48 plus costs, in commutation of Mr Harbour’s entitlements, approved by the Compensation Court.

Sun obtained a summary dismissal, Judge Rolfe holding that the principles of double insurance did not apply and that the policy in its terms did not cover the workers’ compensation payments made by the SRA. He also rejected a claim under s151Z(1)(d) of the Workers Compensation Act 1987 (NSW) (the Act), holding that the provision did not apply because s3 of the Employees Liability Act 1991 (NSW) had removed any liability of Mr Robinson to pay damages to his employer in the circumstances.

Fresh proceedings were started by SRA in 2001, again claiming indemnity and/or contribution from Sun. The insurer again obtained an order for summary dismissal, and Judge Woods agreed with the reasoning of Judge Rolfe. SRA appealed the decision but only pressed the claim under s151Z(1)(d).

Section 151Z(1)(d) provides that if a person other than the worker’s employer is liable to pay damages for a worker’s injury, then the person paying workers’ compensation under the Act is entitled to be indemnified by that other person.
The judgment

Sun submitted that s151Z(1)(d) cannot confer a right of indemnity against it, because Sun had no liability to Mr Harbour to pay damages for his injury. A right of indemnity under an insurance policy was not a right to claim damages.

SRA submitted that s151Z(1)(d) extends to a person liable to indemnify any person liable to pay damages for the worker’s injury.

The court, constituted by President Mason and Justices Sheller and Foster, rejected the argument put forward by SRA and held that nothing in s151Z(1)(d) supports such an argument, noting that none of the provisions of s151Z are capable of referring to the insurer who may be standing behind a person in whom any of those rights or obligations are vested.

The court held that s151Z clearly recognises the distinction between a primary liability to pay damages and a secondary liability to indemnify for those damages. Section 151Z(d) was only triggered against a party who had a primary liability to pay damages, ie Mr Robinson (and his employer SRA).

This case provides comfort to the issuers of motor vehicle third-party policies. It suggests that claims cannot be made against them under s151Z of the Workers Compensation Act 1987 (NSW), in respect of workers’ compensation payments made by the insured for injuries arising from negligent use of the motor vehicle.
Are insurers liable to pay stamp duty on the GST component of premium revenue collected or only on the actuarially established premiums for the risks they assume? The Victorian Court of Appeal found that the terms ‘premiums’ and ‘gross premiums’ used in the Victorian Stamp Duties Act 1958 (the Act) include the GST component and that stamp duty is therefore payable on the entire sums collected by insurers.

The Commissioner of State Revenue (the Commissioner) issued Royal and Sun Alliance (the insurer) with a notice of assessment for stamp duty payable under the Act. The Commissioner assessed the stamp duty payable on the insurance premiums collected by the insurer, including the amounts of GST payable by the insurer within the definition of premiums. The insurer objected to this assessment and requested the Commissioner to treat the objection as an appeal to the Supreme Court.

At first instance, Justice Byrne found that there was no accepted industry meaning of ‘premiums’ or ‘gross premiums’. His Honour therefore rejected the insurer’s submission that the proper construction of these terms necessarily excluded any GST collected. However, the insurer had, on certain policies and renewals, separately designated the GST payable. Justice Byrne was therefore persuaded that, in this case, the GST component was not part of the gross premiums and accordingly not subject to stamp duty.

On appeal by the Commissioner, Justice Ormiston (with whom Justices Batt and Chernov agreed) upheld the trial judge’s finding that there was no accepted industry meaning of ‘premiums’ or ‘gross premiums’ and that the proper construction of the terms did not exclude GST collected by the insurer. Further, the Court of Appeal overturned Justice Byrne’s original finding that the separate designation of GST payable by the insured was relevant to calculating the premium or gross premium assessable to the insurer. Accordingly, the Court of Appeal disposed of the insurer’s objection, ordering that the whole sum received or receivable by the insurer was liable to stamp duty.
This decision makes it clear that insurers will be liable to stamp duty assessable on the entire sum of premiums they receive, including any components collected to cover GST. Insurers should therefore be careful to provide for the collection of adequate premium income to cover any increased liability to stamp duty. Interestingly, while the court was considering its decision, the Victorian Parliament enacted legislation operating retrospectively (except in relation to this appeal) to the same effect as this judgment.
An insurer has successfully claimed against its agent for the loss of an opportunity to impose an exclusion clause that would have exonerated it from liability.

In April 1999, the plaintiff took out a Risk Protection Package with AXA through its agent. The package covered total and permanent disablement, business expenses and professional income loss. In July 1999, the plaintiff suffered a disc prolapse and made a claim for income protection and business expenses under the package. The claim was accepted by the insurer.

In 2001, after the package had been renewed, the plaintiff made a claim for total and permanent disablement. The insurer rejected the claim, alleging fraudulent non-disclosure of a CT scan and an x-ray the plaintiff had undergone in 1996 and 1997, respectively. The plaintiff claimed that the procedures had been performed as precautionary measures. The results did not indicate any serious problems so the plaintiff had not thought it necessary to raise them with the agent.

The insurer ultimately dropped the allegations of fraudulent non-disclosure, settled the claim with the plaintiff and issued proceedings against the agent.

The agent had not taken the plaintiff through the detailed questions in the proposals and had asked very broad questions about whether he had changed his health cover in the previous two years or had received any medical treatment in that time. He was not asked any questions about his prior medical history, nor, in particular, about CT scans, x-rays or medical treatments.

The court found that the agent had breached its duties to the insurer by failing to ask the plaintiff questions in the proposals that would have elicited information about the CT scan and x-ray. The insurer claimed that, had it been aware of the CT scan and x-ray, it would have imposed a ‘full back’ exclusion when the package was renewed, thereby avoiding liability for the claim. The court rejected this on the balance of probabilities, finding that further investigation would have revealed that there was no injury to the spine at the time of the examinations. Nonetheless, the court held that there was still a 20 per cent chance that such an exclusion clause would have been imposed if the insurer had known about the examinations. The insurer was therefore entitled to recover for loss of that opportunity.
Although the insurer could not establish that it would have imposed an exclusion clause of the kind suggested ‘on the balance of probabilities’, the court allowed the insurer to recover on the basis of the prospect that it would have excluded cover. The correctness of this decision is doubtful. Justice Smith relied on the High Court decision in Sellars v Adelaide Petroleum NL (1992) 179 CLR 332. However, in that case it was clear that on the balance of probabilities an opportunity had been lost, and a percentage was applied in assessing its value. On the facts of this case, on the balance of probabilities, the insurer had suffered no loss. Accordingly, there appears to be no basis for any award of damages against its agent.
Shifting burdens of proof: when must the insured prove a negative?

Case Name:
Ocean Harvester Holdings Pty Ltd v MMI General Insurance Ltd

Citation:
[2003] QSC 262, Supreme Court of Queensland per Cullinane J

Date of Judgment:
15 August 2003

Issues:
- Conflicting evidence on cause of vessel sinking
- Defendant alleges – but is unable to positively prove – scuttling
- Scuttling evidence relevant to whether loss caused by ‘accident’

This case confirms that, even where an insurer is unable to positively prove scuttling, the court may have regard to evidence of scuttling in deciding whether the insured has discharged its burden of proving that the loss falls within the policy.

On 3 September 2000, the plaintiff’s trawling vessel, Ocean Harvester, sank. The vessel was insured under a policy that covered ‘loss by accident’. ‘Accident’ was defined as ‘an unforeseen and unintended happening which caused loss or damage’. The defendant alleged that the vessel had been scuttled.

While the plaintiff claimed the sinking was an accident, the deckhand of a vessel called in for help testified that it was deliberate. Owing to the unsatisfactory state of the evidence, Justice Cullinane resorted to resolving the matter on burden of proof.

It was not disputed that the insured carried the onus of proving that the loss came within the policy. Nor was it disputed that the insurer carried the onus of proof in relation to the allegation of scuttling. However, the issue was whether the court could have regard to evidence raised by the insurer to determine whether the plaintiff had discharged its onus.

The insurer referred to a line of cases that answered this question in the affirmative. The insured attempted to distinguish this case from the earlier authorities on the basis that they concerned policies requiring the insured to show that the loss was caused by a ‘peril of the seas’, as distinct from an ‘accident’. However, Justice Cullinane rejected the insured’s contention that there was any significant difference, holding that ‘the present policy might be said to express in a more common parlance what is covered by a perils of the sea policy’.

Having established this, Justice Cullinane considered the deckhand’s evidence. Although stopping short of a positive finding of scuttling, he concluded that the evidence must stand as a bar to the insured succeeding in its action, as it left him ‘unable to be satisfied that it is more probable than not that the vessel was not scuttled’. Therefore, the insured had failed to discharge its onus of proving that the loss was caused by accident.

This case illustrates how, as a practical matter, the requirement that an insured prove its loss from ‘perils of the sea’ or ‘by accident’ may place a positive burden on the insured to rebut any evidence of other causes raised by the insurer.
Appeal Court reluctant to revisit facts

Case Name: Suncorp Metway Insurance Limited v Scarf

Citation: [2003] NSW CA 185, New South Wales Court of Appeal per Palmer J, Handley and McColl JJA

Date of Judgment: 3 July 2003

Issues:
- Assessing expert evidence
- Appellate intervention

In this case, the New South Wales Court of Appeal considers appellate intervention where there is competing expert evidence and the trial judge made a finding of fact in favour of a party to whom the burden of proof does not apply.

The facts
This insurance claim followed an accident involving a 1999 Porsche Carrera motor vehicle, in which the car was destroyed, on 13 August 2000 in Bellevue Hills, Sydney.

Suncorp Metway Insurance Limited (the appellant) had insured Mr Charles Alexander Scarf (the respondent) against loss or damage to that vehicle.

At trial
In the District Court, the appellant argued that the policy entitled it to refuse indemnity on the basis that at the time of the event, the car was being driven by a person whose faculties were impaired or was under the influence of alcohol. It was common ground that at the time of the accident the respondent’s son was under the influence of alcohol.

The trial judge, Justice Boyd Boland, had to consider whether or not the respondent’s son was driving the motor vehicle at the time the accident occurred. Mr Milicic gave evidence that he, and not the respondent’s son, was driving the vehicle at the time of the accident. This was inconsistent with expert evidence sought, concerning, among other matters, the pattern of glass distribution within the motor vehicle.

The appellant argued that the fact that there were no glass fragments on the clothes of Mr Milicic was inconsistent with the fact of him being in the vehicle at the time of the accident. The trial judge preferred the evidence of the respondent’s expert Mr Johnson, on the basic questions associated with the distribution of glass and found, on the balance of probability, that Mr Milicic was the driver of the vehicle at the relevant time.

The issues
The appellant sought to challenge the process of reasoning that led to the trial judge’s conclusion.
In response to this challenge, Justice McColl stated, ‘In this respect it is worth reminding those who appear before us of the observations of Griffith CJ in *Derman v Derman*¹, where the Chief Justice said:

If the tribunal of first instance having seen and heard the witnesses comes to a conclusion in favour of the party upon whom the burden of proof does not lie it is almost hopeless to try to induce the Court of Appeal to interfere without finding unless it is clearly produced upon a wrong principle. That is a general rule of law which prevails in Courts of Appeal.

**The decision**

The court held that the appellant had not demonstrated any appealable error in the trial judge’s reasoning that led to the conclusion of the identity of the driver at the time of the accident.

The court dismissed the appeal with costs.

This case demonstrates that appellate courts are reticent to intervene where the basis of an appeal requires the court to revisit the facts, and the question is what could reasonably be inferred from the facts.

¹ (1908) 7 CLR 549 at 553.
Company subject to deed of company arrangement ordered to produce insurance policy to a prospective claimant

Case Name:
Glaister v Banwell Pty Ltd (ACN 009 394 585) (subject to a deed of company arrangement)

Citation:
[2003] WASC 101, Western Australian Supreme Court – Chambers per Sanderson M

Date of Judgment:
27 May 2003

Issues:
- Section 444E(3) Corporations Act 2001 (Cth)
- Whether leave should be granted to proceed against a company subject to a deed of company arrangement
- Whether the court should order discovery of any relevant insurance policy

On an application under section 444E(3) of the Corporations Act 2001 (Cth) (CA) for leave to proceed against a company subject to a deed of company arrangement (DOCA), the Supreme Court of Western Australia ordered the company to produce any insurance policy relevant to the plaintiff’s claim. This was because the company’s entitlement to be indemnified by an insurer was a relevant consideration in deciding whether leave should be granted to proceed against it.

Banwell Pty Ltd owned and operated several commercial sea vessels. Mr Glaister allegedly suffered personal injuries after falling from a ramp while disembarking from the SeaFlyte (a vessel owned by Banwell) at the Rottnest Island jetty on 3 March 2000. He began WA District Court proceedings against Banwell on 27 October 2000 and the action was entered for trial on 17 December 2001.

On 30 May 2002, administrators were appointed to Banwell. On 25 September 2002, Mr Glaister’s solicitors requested the administrators’ consent under section 440D(1)(a) CA to proceed with the action against Banwell. After some delay, the administrators refused that request in a letter dated 9 December 2002. Banwell executed a DOCA on 13 December 2002, and its administrators then became the deed administrators under the DOCA. The DOCA was stated to bind creditors whose debts or claims arose before the appointment of the administrators on 30 May 2002.

On 25 September 2002, Mr Glaister’s solicitors asked Banwell’s then administrators whether the company held any insurance policy that entitled it to be indemnified against any liability to Mr Glaister. However, the deed administrators indicated on 16 April 2003 that they were not prepared to disclose the insurer’s name. Mr Glaister then applied under s444E(3) CA for leave to proceed with the District Court action, and also for production of any relevant insurance policy.

Master Sanderson accepted that any public liability insurance policy would not be discoverable by Banwell in the ordinary course of the District Court proceeding, because it did not relate to a matter in issue between the parties. However, he thought that this case was somewhat different.

Following an earlier Federal Court authority, Master Sanderson held that, in considering an application for leave under s444E(3) CA (for leave to proceed against a company subject to a DOCA), the court will generally have regard to the principles relevant to an application under s471B CA for leave to proceed against a company in liquidation. The Master expressly rejected the company’s argument that its position was similar to that of a company under administration.
Master Sanderson referred to the eight broad principles relevant to an application for leave to proceed against a company in liquidation (a s471B application), as set out in the well-known case of *Re Gordon Grant & Grant Pty Ltd* (1982) 1 ACLC 196 at 199. In particular, the fifth principle is that leave is more likely to be granted where an insurer stands behind the company to pay any judgment that the plaintiff might obtain against it. This is because it would then be unlikely for company creditors to be prejudiced by the grant of leave to proceed and, further, because the insolvency legislation was not designed to protect insurers. On this basis, Master Sanderson was prepared to grant Mr Glaister leave to proceed against Banwell in the District Court.

The Master also made an order requiring the disclosure of any insurance policy. Master Sanderson held that, on an application for leave to proceed under s444E(3), the plaintiff would be entitled to discovery of any relevant insurance policy, since the company’s entitlement to be indemnified by an insurer is a relevant consideration on such an application. Accordingly, the Master found that an order requiring production of the insurance policy to Mr Glaister was necessary for the proper disposition of the originating process in this case (although he noted that Mr Glaister could not move to execution on any judgment he may obtain in the District Court without further leave of the Supreme Court).

This case illustrates that, on an application under s444E(3) CA for leave to proceed against a company subject to a DOCA, the court may order production of any insurance policy held by the company, even though the plaintiff would not be entitled to discovery of the policy in ordinary civil litigation. The case suggests that the court may also order production of an insurance policy on an application for leave to proceed against a company in liquidation. However, as confirmed by the related decision in *Godden v Banwell* [2003] WASC 217 (4 November 2003), the position may be different where the claimant had brought proceedings before the appointment of the administrator (or liquidator). In those circumstances, the grant of leave is a mere formality and the existence or otherwise of an insurance policy would not be relevant.
What is the scope of an insured’s duty of disclosure under s21 of the Insurance Contracts Act?

Case Name:
Permanent Trustee Australia Limited v FAI General Insurance Company Limited (in liquidation)

Citation:
[2003] HCA 25, High Court of Australia per McHugh, Kirby, Callinan, Gummow and Hayne JJ

Date of Judgment:
8 May 2003

Issues:
- Insured’s duty of disclosure under s21 of the Insurance Contracts Act 1984 (Cth)
- Whether the insured’s duty extends to disclosing matters that do not affect the insured risk

An insured’s duty of disclosure under section 21(1) of the Insurance Contracts Act 1984 (Cth) (the Act) is limited to disclosing matters that affect the insurer’s assessment of the risk of the proposed insurance and does not extend to disclosing every matter relevant to the insurer’s decision to enter into the contract of insurance.

The facts
In 1991, Permanent Trustee Australia Limited and Permanent Trustee Company Limited (the appellants) were looking to obtain insurance for the following year. Their existing insurance cover was provided by a number of insurers, one of which was FAI General Insurance Company Limited (FAI). The appellants had decided not to obtain any of their insurance from FAI in the following year, subject to obtaining satisfactory quotations from alternative insurers.

In the course of obtaining the new cover, the appellants were granted a short extension of their existing cover. All of the appellants’ insurers agreed to the extension, including FAI, which was paid a standard commercial rate for the extension. When the appellants’ broker obtained FAI’s agreement to the extension of time, it did not disclose to FAI the intention of the appellants not to renew their insurance with FAI (subject to obtaining satisfactory quotations from other sources).

FAI claimed – and the trial judge found – that had FAI known that it might not be invited to participate in the renewal of the insurance, it would not have provided the extension of time (for commercial and emotional reasons unrelated to the risk of granting the extension). On this basis, FAI refused to indemnify the appellants for a claim notified during the period of the extension.

The appellants brought an action claiming that FAI was obliged to indemnify them. FAI argued, inter alia, that it was not obliged to indemnify the appellants because the latter, by failing to disclose their intention not to renew their insurance with FAI, had breached their duty of disclosure under s21 of the Act, which materially provides:

(1) Subject to this Act, an insured has a duty to disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known to the insured, being a matter that:

(a) the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms; or

(b) a reasonable person in the circumstances could be expected to know to be a matter so relevant.
Section 21(2) lists certain matters that do not need to be disclosed, including matters that diminish the risk or are of common knowledge. FAI’s argument was successful before the primary judge and the NSW Court of Appeal (ie these courts accepted that the appellants’ intention not to renew their insurance with FAI was a ’matter relevant to the decision of [FAI] whether to accept the risk and, if so, on what terms’).

The appellants appealed the matter to the High Court where Justices McHugh, Kirby and Callinan jointly delivered the majority judgment in favour of the appellants. Justices Gummow and Hayne delivered a joint dissenting judgment.

The decision
Justices McHugh, Kirby and Callinan held that the issue of whether the appellants did or did not intend to renew their policy was not a matter relevant to FAI’s decision as to whether to accept the risk of the extension or the terms on which the decision to accept the risk would be made. Therefore, the appellants were not guilty of any relevant non-disclosure and were entitled to be indemnified for the claim notified during the period of the extension.

Their decision was based on the following two key findings:

- The wording of s21 (in particular, the use of the expression ’accept the risk’ rather than, for example, ’enter the insurance contract’ and the exception, in s21(2), for matters diminishing the risk), considered in light of relevant parliamentary materials, showed that the focus of the Act was on the particular risk of the proposed insurance rather the ’broader question of the commercial willingness of the insurer to accept the risk, still less emotional or individual reactions to that question’.
- If the duty of disclosure extended beyond matters material to the risk, the insured would be under an extraordinarily high burden, which could not have been intended by the legislature.

The majority’s interpretation of the expression ‘matter relevant to the decision of the insurer whether to accept the risk...’ also applies to s26(2) of the Act (which limits the range of statements that can be classified as misrepresentations by reference to the relevance of the statement to the decision of the insurer to accept the risk).

Justices Gummow and Hayne dissented on the basis that the Act does not distinguish – and it would be difficult to distinguish – between matters relevant to an insurer’s decision to accept a risk and matters that do not bear upon the risk but are relevant to whether a contract of insurance should be made. In contrast to the majority, Justices Gummow and Hayne considered that:

- the concept of ‘accepting the risk’ (as opposed to assessing the risk) should be regarded as synonymous with – rather than contrasted with – entering the contract of insurance; and
- to require an insured to disclose matters beyond those affecting the risk of the proposed insurance would not impose an unreasonable burden on an insured, having regard to the requirements and limitations in s21 of the Act.
Justices Gummow and Hayne also held that, because the appellants had wholly delegated to their brokers the performance of their duty of disclosure, the broker’s knowledge was to be imputed to the appellants for the purpose of s21. The majority judges did not need to decide this point but indicated that, in their view, it may not be acceptable to make such an imputation for the purposes of s21.

The court has now confirmed that commercial matters that may be relevant to the decision of the insurer about whether or not to issue the policy, but which do not have a bearing on the assessment of the risk, do not have to be disclosed. Some insurers might consider somewhat arbitrary the distinction between (a) matters relevant to accepting the risk, and (b) matters relevant to making a decision on whether or not to accept the contract.
When will an insurer be unable to avoid in cases of fraudulent non-disclosure?

Case Name:  
FAI General Insurance Co Ltd (in liquidation) v Sherry

Citation:  
[2002] SASC 431, Supreme Court of South Australia per Doyle CJ, Bleby and Besanko JJ

Date of Judgment:  
23 December 2002

Issues:  
- Professional indemnity insurance
- Extension for deliberate and dishonest acts
- Duty of disclosure

In this decision, the Full Court considers the circumstances in which an insurer can deny indemnity to a dishonest insured. For instance, does public policy preclude an insurer from covering dishonest and deliberate acts? Also, how does fraudulent non-disclosure in the insurance proposal affect an insured’s entitlement to claim against a policy?

The policy

The insurer issued a professional indemnity policy to a partnership of accountants and an associated company called Amjex Pty Ltd. The policy contained an extension for fraudulent conduct (the extension) as follows:

The Insured shall be protected... for any claim upon which suit may be brought by reason of any alleged dishonesty, mis-statement or fraud on the part of the Insured or its partners or its employees, unless a judgment or other final adjudication thereof adverse to the Insured shall establish that acts of active and deliberate fraud or dishonesty committed by any partner or partners of the Insured with actual fraudulent or dishonest purpose and intent were material to the cause of action so adjudicated... in which event this Certificate shall only pay in excess of the full extent of such Partner's or Partners’ assets in the firm. Any other personal assets of such Partner or Partners recovered by the Insured shall inure, to the extent of the amount paid by this Certificate, to the benefit of the Company.

The ‘Insured’ was defined in the policy to include the partnership of accountants, each partner, Amjex and the directors of Amjex.

An accountant, who was also a partner in the accounting firm and an Amjex director, dishonestly misappropriated substantial sums of money from two clients. The accountant was later convicted of criminal offences for these misappropriations. The clients successfully sued the accountant and Amjex for more than $5 million. The litigation bankrupted the accountant, and Amjex went into liquidation. The clients then took an assignment of any benefits that the accountant and Amjex had under the professional indemnity policy.

The clients claimed indemnity on behalf of the accountant and Amjex on the basis of the extension contained in the policy. The insurer denied that the accountant and Amjex were entitled to indemnity because:

- the policy was not intended to provide cover for intended loss arising from an unlawful and deliberate act (ie the accountant’s conduct);
- as a matter of public policy, an intended loss resulting from an unlawful and deliberate act cannot be the subject of a claim, even if covered under the wording of the insurance policy; and
• the insurer was entitled to avoid the policy because the accountant had not disclosed any wrongdoing in the proposal, even though his dishonest misappropriation took place both before and after the signing of the proposal.

**Did the policy cover loss arising from an unlawful and deliberate act?**

The court held that the policy was intended to provide protection to innocent partners and directors against claims arising from the dishonesty of their partners, fellow directors or employees. The court took this view because partners in a firm are not necessarily aware of the acts or omissions of their fellow partners. It is therefore desirable to have cover for:

• claims arising from an intentional criminal act committed by a fellow partner; and

• the possibility that the partner who completes the proposal has, unknown to the other partners, acted dishonestly or fraudulently, and completes the proposal dishonestly.

However, the court held that indemnity will not be given to a dishonest person in respect of deliberately caused loss unless there is a clearly expressed intention to do so. On its face, the indemnity in question did not extend to dishonest partners or directors. Thus, the accountant was not covered by the policy.

**Would public policy enable an insurer to deny liability for dishonest and deliberate acts?**

Although the court held that the accountant was not covered by policy, it went on to consider whether, hypothetically, an insurer could deny indemnity for harm arising from deliberate and dishonest acts on the basis of public policy. The court concluded that this would be an insufficient ground of refusal, despite the deliberate, dishonest and criminal nature of the accountant’s conduct. This is because the accountant’s ability to claim would provide protection to members of the public, giving them recourse to the insurance proceeds in respect of any fraud. In addition, the accountant in this case could not himself benefit from the indemnity.

**What impact should fraudulent non-disclosure have on an insured’s ability to claim?**

The policy contained a provision waiving the duty of disclosure. The court considered the hypothetical question of whether the insurer could deny indemnity because of the accountant’s failure to disclose wrongdoing when completing the proposal form. The court said that waiver of the requirement of disclosure was not limited to innocent partners. The clause expressly stated that cover was provided ‘notwithstanding that such acts were not disclosed within the Insured’s proposal for insurance’. This was unqualified and therefore had to be read as also giving protection to the dishonest partner.
What impact did the accountant's conduct have on Amjex?

Finally, the court held that Amjex could not be in any worse position by reason of the non-disclosure of the accountant. Accordingly, Amjex could not be denied indemnity on grounds of non-disclosure or public policy. Ultimately, whether Amjex was in fact entitled to indemnity would depend upon whether Amjex was liable to the plaintiffs. That question depended on a determination of the facts of the case, which the Court of Appeal was not required to make.

This case illustrates the application of some important principles relevant to the construction of dishonesty exclusions. Close attention must be paid to the precise policy wording to determine what impact any claim arising from dishonesty on the part of any insured has on:

(a) that insured;
(b) innocent insureds; and
(c) the duty of disclosure.
Duty to disclose considered in cases of progressive illness

Case Name: McCabe v Royal & Sun Alliance Life Assurance Australia Ltd

Citation: [2003] WASCA 162, Western Australia Court of Appeal per Wallwork, Murray and Anderson JJ

Date of Judgment: 24 July 2003

Issues:
- Life insurance
- Duty of disclosure
  - progressive illness
- Evidence of underwriter to establish insurer’s prejudice

This case is concerned with whether or not the insured had made full disclosure of her illness to her life insurer prior to the insurance contract being made and, if full disclosure had been made, whether the insurer would have accepted the risk.

The facts
Mrs McCabe suffered from systemic lupus erythematos (SLE), a chronic disease. In October 1997, Royal & Sun Alliance Life Assurance Australia Limited (Royal & Sun) invited Mrs McCabe to apply for life insurance. She received a brochure that detailed her duty to disclose any matter material to the formation of the insurance contract. Mrs McCabe applied for the life insurance, and Royal & Sun subsequently sought a medical report from Mrs McCabe’s general practitioner, which did not expressly refer to SLE but was in terms that the trial judge later held complied with the duty to disclose her SLE.

On 26 February 1998, while hospitalised for an exacerbation of her SLE, Mrs McCabe was advised by Royal & Sun that her application had been accepted at a monthly premium increased by 75 per cent of the standard premium. Instead of immediately accepting the contract, Mrs McCabe applied to AMP Life Limited (AMP) for life insurance, disclosing that she suffered from SLE. AMP refused Mrs McCabe’s application. Mrs McCabe then took up cover with Royal & Sun.

Mrs McCabe died on 5 June 1998 from complications arising from her SLE. Her husband, Mr McCabe, made a claim on her life insurance. Royal & Sun denied the claim on the ground that Mrs McCabe had breached her duty of disclosure under section 21(1) of the Insurance Contracts Act 1984 (Cth) (Insurance Contracts Act) because, prior to the insurance contract being made, she failed to disclose that she had:

- been hospitalised for SLE; and
- been refused life insurance by AMP.

As the executor of Mrs McCabe’s estate, Mr McCabe sued Royal & Sun for the insured amount of $100,000, together with interest payable.

The trial judge found that Mrs McCabe had breached her duty of disclosure by not disclosing her hospitalisation and the refusal of life insurance by AMP. The claim was dismissed.
The decision of the Court of Appeal

The questions on appeal were:

- whether Mrs McCabe had a duty to disclose to Royal & Sun that she had been hospitalised, and that her application for insurance by AMP had been rejected (those being matters which she knew and which she knew or ought reasonably to have known, were relevant to Royal & Sun’s decision to accept the risk); and
- whether Royal & Sun would have entered into the insurance contract if it had known the undisclosed facts.

Justice Murray found that Mrs McCabe:

- knew of the nature of her disease;
- knew her disease had worsened so as to require hospitalisation;
- on such basis, ought reasonably to have known that Royal & Sun would have wanted to know that her disease was in such a state so as to create such a crisis;
- knew that AMP’s refusal of her application for insurance was due to her SLE; and
- must have known, or ought reasonably to have known, that such refusal was relevant to Royal & Sun’s decision whether to proceed with its offer of insurance.

Furthermore, Justice Murray held that the timing of Mrs McCabe’s final acceptance of the proposal of Royal & Sun indicated that, rather than advise Royal & Sun of these obviously material alterations to her circumstances, she thought it prudent to take up the offer of insurance, even at the greatly increased premium.

As to whether Royal & Sun would have accepted the risk, Justice Murray was satisfied, on the evidence of Royal & Sun’s consultant underwriter who had assessed Mrs McCabe’s application, that it would not have accepted Mrs McCabe’s application if it had known these facts.

The appeal was dismissed.

This case illustrates circumstances in which a court will find that an insured has failed to disclose material facts when applying for life insurance. It is not enough for the insured to disclose that he or she is suffering from a particular disease or illness, in circumstances where there are specific matters that would indicate concern as to the extent the disease had progressed.
Where an insured has made untrue statements in connection with an insurance contract that amount to misrepresentations, when can the insurer avoid the contract under the Insurance Contracts Act 1984 (Cth) provisions?

The respondent, Ms Schaffer, held a ‘Recovery Insurance Policy’ (the policy) with Royal & Sun Alliance Life Assurance Ltd (Royal & Sun), giving her benefits in the event that she should become totally and permanently disabled. The contract was deemed to be a contract of life insurance under the Insurance Contracts Act 1984 (the Act).

Ms Schaffer claimed on the policy, maintaining that she was totally and permanently disabled from working, due to severe breathlessness caused by stress.

Royal & Sun sought to avoid the policy under s29(3) of the Act, on the grounds that failure to disclose the following facts in answer to relevant questions in the proposal form meant that the answers given were untrue:

(a) Ms Schaffer suffered the breathlessness; and
(b) her last medical consultation took place in December 1997 (rather than June 1997 as she had stated) and that Ms Schaffer attended the consultation to obtain relief for her breathing difficulties and not (as she stated) for a ‘routine check up’.

Under the Act, statements made by an insured prior to entering into a contract of insurance will only be misrepresentations if a reasonable person could be expected to know that the statements would have been relevant to the decision of the insurer to accept the risk and, if so, on what terms (s26). The court held that Ms Schaffer should have known that the statements would have been relevant to Royal & Sun’s decision. The statements were therefore held to be misrepresentations and s26 did not operate to exclude them from being so.

The court observed the wider operation that s26 (misrepresentations) may have, compared with s21 (non-disclosure). The trial judge had found that there was no relevant non-disclosure in this case, and this finding was not disputed on appeal. Ms Schaffer’s shortness of breath was not a matter that a reasonable person in her circumstances could be expected to know was relevant. However, the statements she made in answer to the specific questions in the proposal form were matters that a reasonable person in her circumstances could be expected to know to be relevant.
The court then considered if Royal & Sun could avoid the policy under s29(3) of the Act. To do so, Royal & Sun had to prove that it would not have been prepared to enter into a policy with Ms Schaffer on any terms, had the misrepresentation not been made. The evidence of Royal & Sun’s underwriters was that a further medical report would have been obtained, had Ms Schaffer disclosed the true facts. However, the evidence was inconclusive as to whether that further medical report would have led to Royal & Sun declining the risk.

Royal & Sun failed to discharge the burden of proof by showing that it would not have been prepared to enter into a contract with Ms Schaffer on any terms, had the misrepresentations not been made. The court concluded that, on the evidence led by Royal & Sun, it was possible that Royal & Sun may still have entered into a policy with Ms Schaffer, on the same, or some other, terms.

This case illustrates that, where an insurer seeks to exercise a right to avoid, it is important that it obtains proper evidence to show that it would have declined the cover on any terms. Similar principles apply to contracts of general insurance, and whether the right to avoid is based on a misrepresentation or a non-disclosure.
DUTY OF DISCLOSURE AND MISREPRESENTATION

Contracting out of the duty of disclosure

Case Name:  
HIH Casualty and General  
Insurance Limited & Ors v  
Chase Manhattan Bank & Ors

Citation:  
[2003] UKHL 6, UK House of Lords per Lords Bingham, Steyn, Hoffman, Hobhouse and Scott

Date of Judgment:  
20 February 2003

Issues:  
• The duty of disclosure  
• Fraudulent non-disclosure or misrepresentations  
• An insured’s liability for an agent’s fraud

The House of Lords has held that, although an insurer may waive the duty of disclosure for negligent misrepresentations and/or non-disclosures by both the insured and the insured’s agent, such waiver will not extend to fraudulent misrepresentations by an agent unless the language clearly and unmistakably indicates such an intention.

The facts
Chase Manhattan Bank (Chase) was the leader of a syndicate of banks that provided funding for film production. Insurance cover was obtained from HIH and other insurers to cover the risk that revenues from the films would be insufficient to repay the loans. The policies were arranged by a broker, Heaths North America & Special Risks Ltd (Heaths), and contained a ‘truth of statement’ clause that limited the duty of disclosure.

There were substantial shortfalls in the loans, and Chase claimed under the policies. HIH sought to avoid the policies and to recover damages against Chase, on the grounds of fraudulent or negligent misrepresentations and non-disclosures on the part of the broker, Heaths. Chase argued that the insurers were not entitled to repudiate liability or claim damages because the ‘truth of statement’ clause protected Chase from liability arising from misrepresentations or non-disclosures by its agent.

The truth of statement clause
The House of Lords’ decision ultimately turned on the construction of the ‘truth of statement’ clause in the policies, which read as follows:

[6] the Insured will not have any duty or obligation to make any representation, warranty or disclosure of any nature, express or implied (such duty and obligation being expressly waived by the insurers) and

[7] shall have no liability of any nature to the insurers for any information provided by any other parties and

[8] any such information provided by or non-disclosure by other parties including, but not limited to, Heath North America & Special Risks Ltd (other than Section I of the Questionnaire) shall not be a ground or grounds for avoidance of the insurers’ obligations under the Policy or the cancellation thereof.
It was accepted that the general intention behind the clause was to prevent Chase from losing the benefit of the policies because it had failed to disclose material circumstances that it was deemed to know. Chase was not in the usual position of an insured, because it had no special knowledge of the actual risk over and above that of the insurer.

The decision
The issue for the House of Lords was the extent to which the ‘truth of statement’ clause operated to protect Chase from the consequences of any negligent or fraudulent misrepresentation or non-disclosure by Heaths.

The House of Lords found that clause 6 of the truth of statement clause clearly operated to relieve Chase of its obligations to make any representation, warranty or disclosure. However, that waiver was personal to the insured and did not impinge on Heaths’ duty of disclosure.

The majority of their Lordships held that clause 7 would operate to exempt Chase from liability for negligent misrepresentations or non-disclosures made by Heaths. However, the clause was not sufficient to remove the insurer’s rights arising out of any fraud on the part of Heaths. The House recognised that fraud is ‘a thing apart’ and that a contracting party cannot, as a matter of public policy, exclude liability for his own fraud. Although their Lordships did not actually address whether a party could validly exclude liability for his agent’s fraud, it was agreed that the parties would need to express such an intention in clear and unmistakable language, ‘such as will alert a commercial party to the extraordinary bargain he is invited to make’. Clause 7 contained no such clear wording, and their Lordships did not accept that the parties had ever intended to exclude liability for fraud of an agent.

In his dissent, Lord Scott held that no rule of public policy precluded a party from excluding contractual liability for his agent’s fraud (so long as he is not a party to it), and, in his opinion, the words in the ‘truth of statement’ clause were wide enough to cover such an exclusion.

The majority decision meant that the insurers were entitled to avoid the policies for fraudulent misrepresentations and non-disclosures by Heaths, and were entitled to damages from Chase for the fraudulent misrepresentations, and for the fraudulent non-disclosures that amounted to fraudulent misrepresentations.

The House of Lords has demonstrated a reluctance to exclude an insurer’s right to avoid a policy for fraud of an agent, in the absence of clear and unmistakable language. This case may provide some persuasive authority on the construction of similar policy wording by Australian courts.
Many claims or a single claim: the importance of aggregation clauses

Subtle differences in the wording of aggregation clauses can affect the availability of cover should the company face multiple claims arising from the same or similar circumstances. This decision of the House of Lords went in favour of the insurer, overturning a prior Court of Appeal decision permitting aggregation.

The facts

Following an investigation in 1994 by the UK Securities and Investments Board, the insured was found to have committed widespread breaches of the UK Financial Services Act 1986 (the Act) in marketing and selling personal pension schemes.

The investigation revealed that many individuals had been persuaded to transfer to personal schemes without adequate advice about the risks, advantages and disadvantages. Consequently, the insured had committed various breaches of relevant statutory rules, including failure to 'ensure' that the insured's sales representatives complied with the Code of Conduct referred to in the rules. The Act gave investors a cause of action in respect of these breaches of statutory duty. The insured, then a member of the TSB Group, received about 22,000 claims. Most of the claims were for relatively small amounts. None exceeded £35,000. However, the total amount of the claims was very large. The insured paid out more than £125 million in compensation.

The insured then sought to recover under its insurance policy.

The policy

The insured had a ‘Banker’s Composite Insurance Policy’, which covered it, and other members of its group of companies, against a variety of risks. This included liability to third parties arising from breaches of common law or statutory duties by employees.

The policy provided for a deductible of £1 million ‘for each and every claim’.

The insured sought to rely upon an ‘aggregation clause’ in the following terms:

If a series of third party claims shall result from any single act or omission (or related series of acts or omissions) then, irrespective of the total number of claims, all such third party claims shall be considered to be a single third party claim for the purposes of the application of the deductible.
The decision

Lord Hoffman (with whom each of the other members of the court broadly agreed) accepted that the purpose of an aggregation clause was to enable two or more separate losses covered by the policy to be treated as a single loss for deductible or other purposes when they are linked by a unifying factor of some kind.

He went on to observe that there is a distinction between an ‘event’ and a ‘cause’. An event is something that happens at a particular time, at a particular place, in a particular way. A cause, on the other hand, is less constricted. He noted:

The choice of language by which the parties designate the unifying factor in an aggregation clause is of critical importance and can be expected to be the subject of careful negotiation.

Lord Hoffman observed that on the wording before him, the unifying factor was a common cause, but that cause must be a ‘single act or omission’, or ‘a related series of acts and omissions’.

The policy defined the term ‘act or omission’ to (relevantly) mean a breach ‘in respect of which civil liability arises on the part of the insured’. It followed that the relevant act or omission had to be one that would be sufficient to give rise to liability on the part of the insured.

One of the insured’s arguments was that the absence of a training or monitoring system was a relevant omission, which was the common cause of many of the claims. However, Lord Hoffman observed that even though this was a breach of the rules, no civil liability would arise unless and until the insured’s sales representatives had, in fact, contravened the Act. Likewise, if such a contravention occurs, then the insured will be liable, whether or not there was an adequate training and monitoring system. It followed that the absence of a training or monitoring system was not an act or omission from which the liability arose.

In spite of this, the Court of Appeal had held that the claims arose from a ‘related series of acts or omissions’. It therefore found in favour of the insured.

The House of Lords disagreed, allowing the appeal and finding in favour of the insurer. Their Lordships considered that the wording of the clause required that a related series of acts or omissions would only be relevant if they operated together to result in each of the claims. It was not sufficient that one act should have resulted in one claim and another act in another claim. The House of Lords read the expression ‘related series of acts or omissions’ far more narrowly than the Court of Appeal. It regarded the expression as playing a subordinate role of covering the case in which liability cannot be properly described as arising from a single act or omission but can be attributed to a number of particular acts or omissions acting in combination. That was not the case for the insured. The relevant acts or omissions were contraventions by the salesmen employed by the insured. Different and separate acts or omissions applied to each claim.
This ruling is not binding authority in Australia. However, no Australian authority runs contrary to this decision and it is likely to constitute a persuasive authority before an Australian court. In the past, Australian courts have derived considerable assistance from UK authorities when considering the construction of aggregation clauses.

The decision highlights the need for insureds to pay careful attention to the wording of aggregation clauses in relevant insurance policies, particularly (but not only) to any form of liability policy.
This case concerns an application by QBE Insurance Ltd for declarations against MGM Plumbing Pty Ltd, concerning the respective rights and obligations under their insurance policies.

Glenwood Homes Pty Ltd sued its subcontractor, MGM Plumbing Pty Ltd, alleging that MGM had negligently installed waterproofing membranes in the bathrooms of 47 houses built and/or renovated by Glenwood. Glenwood repaired the defective work at significant cost, and contended that it was likely to incur additional significant costs repairing further premises. MGM argued that it merely adopted the method of waterproofing specified by Glenwood.

MGM lodged a claim with QBE Insurance Ltd. QBE had issued an industrial special-risks and a broad-form liability policy to MGM. The issue in this application was whether, under the terms of its insurance policies, MGM should bear an excess of $300 for each allegedly defective installation, or bear only one excess of $300 in respect of all the defective installations.

The policies covered MGM for claims for property damage arising out of an ‘Occurrence’ (as defined).

The policy defined an ‘Occurrence’ as an event, including continuous or repeated exposure to substantially the same general conditions, resulting in unintended property damage. The policy also contained a clause in the following terms:

Should one or more excess be payable under this policy for any claim or series of claims arising from the one event, such excesses shall not be aggregated and the highest single level of excess only shall apply.

The policies provided that MGM was liable to pay an excess for every ‘Occurrence’ for which MGM lodged a claim.

Quoting at length Justice Stephen in Distillers Co (Bio-Chemicals) (Aust) Pty Ltd v Ajax Insurance Co Ltd (1973-1974), who said that ‘occurrences’ were the mishaps that caused the injury, not what was actually suffered, Justice Ambrose found that the relevant ‘occurrence’ in this case was the ‘unworkmanlike’ waterproofing on each occasion of deficient installation. Justice Muir did not accept the adoption of the unacceptable method of installation as the relevant ‘occurrence’; an approach that would have allowed each deficient installation to be treated as a consequence of that single ‘occurrence’. He reasoned that such a construction departs from the ordinary meaning of an ‘event’ or an ‘occurrence’, being something that has ‘happened at a particular time, at a particular place, in a particular way...’
Accordingly, Justice Muir found MGM obliged to pay the $300 excess to QBE on each and every claim.

This case is an example of how courts will treat the aggregation of claims and interpret the meaning of ‘occurrence’ and ‘event’ as used in insurance policies. The approach taken by Justice Muir is consistent with that of the UK House of Lords in *Lloyds TSB General Insurance Holdings & Ors*, also reported in this Review.
Case Name:
World Trade Center Properties LLC & Ors v Hartford Fire Insurance Company & Ors; SR International Business Insurance Co Ltd & Ors v Travelers Insurance Company & Ors

Citation:
Unreported judgment of the United States Court Of Appeals for the Second Circuit per Walker CJ, Cabranes and Pooler J

Date of Judgment:
26 September 2003

Issues:
- What is the status of a ‘binder’?
- What constitutes an ‘occurrence’ in the context of two separate but coordinated terrorist attacks when a binder is silent on the matter?

Background to the appeals
This case, involving two separate but related appeals by the owners of property interests in the World Trade Center (WTC) in New York, is the latest in a string of litigation flowing from the events of 11 September 2001, which resulted in the complete destruction of the WTC. Just weeks before the attack, a new 99-year lease had been taken out on the WTC and, as a result, layered insurance for the WTC was being renegotiated with 20 separate insurers. At the time of the terrorist attack, only a handful of these insurers had issued final policies. The remainder, who comprised the respondents in these appeals, had signed ‘binders’ obligating them to provide property insurance for the WTC properties.

A binder is a temporary or preliminary form of insurance, designed to protect the insured from the risk of loss during the period after application for insurance but before the final policy is issued. Once the formal policy is issued (or the application is rejected), the binder ceases to operate. Since a binder is not a finalised policy, its terms are often incomplete or informal, but, if properly created, it remains a valid contract.

In this case, the binders insured the appellants (the insured) for roughly US$3.5 billion per ‘occurrence’. However, since each occurrence was subject to a separate excess or deductible, Willis of New York Inc, brokers for the insured, had sought insurance on the basis of their own specific form of insurance (the Wilprop form), which defined occurrence as meaning:

...all losses or damages that are attributable directly or indirectly to one cause or to one series of similar causes. All such losses will be added together... and treated as one occurrence irrespective of the period or time or area over which such losses occur.

This definition was advantageous to the insured if several related events totalling less than $3.5 billion caused damage, since only one excess was payable, but in the event of a catastrophic event such as occurred on 11 September, it limited the liability of the insurers to a single payment of $3.5 billion. In the event, losses on 11 September far exceeded that amount.

All the appellee-insurers entered into binders on the basis of the Wilprop form (the Wilprop insurers) except the Travelers Indemnity Company (Travelers), which insisted on a binder based on its own form of insurance in which ‘occurrence’ remained undefined.

On 14 September 2001, three days after the destruction of the WTC and at the request of the insured, Travelers issued its final policy, which did not include a definition of occurrence.
The appeals
The insured appealed to the court from two judgments of the District Court of New York. First, they appealed against a decision granting summary judgments in favour of three of the Wilprop insurers. The District Court had ruled that, based on the definition in the Wilprop form, the events of 11 September were the result of a single occurrence. The insured claimed that the insurance of the WTC was based on layered insurance and that the lead insurer was Travelers. They claimed that it was industry practice that subsidiary insurers ‘follow the form’ of the lead insurer, namely Travelers. They pointed to email correspondence of negotiations between the parties, which included phrases by the Wilprop insurers to the effect that they would be bound by the policy ‘as ultimately agreed’. The insured claimed that this meant the Travelers policy. As a result, the insured argued that, as of 11 September, the Wilprop insurers were not bound by their binders but by the terms of the Travelers policy issued on 14 September.

Second, the insured appealed against a refusal by the District Court to grant summary judgment in favour of the insured against Travelers. The insured argued before the District Court that since ‘occurrence’ was undefined in the Travelers policy, they were entitled to summary judgment on the basis that under the general law of New York, what occurred on 11 September was two occurrences.

The outcome
The Court of Appeals, in a unanimous decision, dismissed both appeals.

In considering the first, the court held that, although a binder may be incomplete in some regards, the best evidence as to the intentions of the parties when signing the binder was the form of the policy that will form the basis of the negotiation, in this case the Wilprop form. The only relevant question was: what were the terms to which the parties had agreed to be bound pending issuance of a final policy? Thus, evidence indicating that the parties might have agreed to ultimately issue policies based on the Travelers form was irrelevant. The court conclusively rejected the arguments of the insured that the Wilprop insurers were bound by a final policy not yet issued at the time of the loss on the basis that it might have ultimately been a final policy. Further, the court was not convinced that the policy referred to in the email negotiations was the Travelers policy. The court agreed with the District Court findings that there was no question that, according to the Wilprop definition of occurrence, the destruction of the WTC resulted from a single occurrence.

In the second appeal, the court found that, since the binder signed by Travelers did not contain a definition of ‘occurrence’, it was an open question as to whether the damage of 11 September resulted from one occurrence or two, under the general law of New York. The court agreed with the District Court that the legal authority on the matter was ambiguous and certainly not clear enough to warrant a summary judgment on the matter. As a result, the question warranted full consideration by the District Court to determine a definition for occurrence, based on the parties’ intentions.
Although not binding on Australian courts, it is likely that similar principles would apply. The decision underlines the importance of a binder as a contract in its own right. If an event occurs under cover of a binder, it is the binder, rather than any policy that might have been issued later, which will apply. The case demonstrates the vital importance, to both insurer and insured, of carefully examining the form of a policy underlying a binder before agreeing to be bound by it.
This case is concerned with whether, for the purposes of a contract of reinsurance, a claim for the loss of a British Airways Boeing 747 during the Gulf War could be aggregated with the loss of the Kuwait Airways Corporation fleet arising from Iraq's invasion of Kuwait.

The facts
On 2 August 1990, Iraq invaded Kuwait. By mid-morning, Iraq's forces were in complete control of Kuwait International Airport and all the aircraft there on the ground. Kuwait Airways Corporation (KAC) had 15 aircraft at the airport, which were a prime target of Iraq's premeditated policy of plunder. Also at the airport was a British Airways (BA) Boeing 747. The presence of the BA aircraft was unscheduled.

The KAC fleet was flown to Iraq and incorporated into the Iraqi fleet. The BA aircraft remained at Kuwait. It was still there when war broke out between Iraq and the coalition forces on 16 January 1991, but was destroyed by Allied bombing by, on, or around, 27 February 1991.

The contract of reinsurance provided for losses occurring during 12 months from 1 April 1990, and aggregation of claims for losses 'arising from one event'.

Justice Langley held that the KAC fleet had been lost on 2 August 1990 and that these were all losses 'arising from one event', namely Iraq's invasion of Kuwait and capture of the airport. However, the judge held that the loss of the BA aircraft did not arise out of the same event. He did not define that event, save possibly by reference to the cause of its loss, which he said was 'the actual destruction of the aircraft or the war or perhaps the inevitability of war'.

The Court of Appeal decision
The appeal from Justice Langley's decision was concerned with whether the claim for the loss of the BA aircraft was to be aggregated with the claim for the losses of the KAC aircraft.

Lord Justice Rix (with whom Lord Justices Keene and Schiemann agreed) concurred with Justice Langley that the loss of the BA aircraft did not arise from the invasion, and, in particular, did not arise out of the same event as the loss of the KAC fleet. Rather, the court found that the loss arose from its own particular circumstances, at different times and for different reasons as set out by Justice Langley. While Lord Justice Rix conceded that the location of the aircraft, and the timing of the start of the story, were the same, he thought that these factors, as they concerned the BA aircraft, were a matter of chance. He reasoned that, while
the KAC fleet was at home when Iraq intended to seize it and make it its own, the tortuous events of international diplomacy and coalition building that led to war, and to the loss of the BA aircraft as a result of war some six months later, had nothing to do with the loss of the KAC fleet.

Lord Justice Rix did not accept the syndicates’ submission that the causal link expressed by the phrase ‘arising from’ was weak. He thought that ‘it was inherent in the concept of aggregation that a significant causal link is required’, because a weak causal link would result in no limit to the theoretical possibility of tracing back to the causes of causes.

Lord Justice Rix also rejected the syndicates’ submission that, in the absence of a clear and reasoned finding by Justice Langley as to what event caused the loss of the BA aircraft (Justice Langley only found that it did not arise from the same event as the loss of the KAC fleet), the inference should be drawn that the loss arose from the same event that had caused the original deprivation of possession. Lord Justice Rix held that the eventual question was still whether the loss of the BA aircraft arose from the same event as the loss of the KAC aircraft, not whether it arose from the same event that had caused the original deprivation of possession. However, he did consider the loss of the BA aircraft to be caused by the event of its destruction, or by the war.

A significant causal link is required where aggregation clauses are to be relied upon to aggregate claims for losses arising from ‘one event’. Where property is lost and time elapses between the original deprivation of possession and the ultimate loss, courts will not look to whether the loss arose from the same event that caused the original deprivation of possession.
Many liability policies contain an aggregation clause, which provides for all claims arising from the same act or omission or series of acts of omissions to be aggregated for the purpose of applying the policy limit and/or any deductible. In this case, the English High Court considered the interpretation of ‘single claim’ in the absence of an aggregation clause.

Mabey was an engineering company with an international business involving the design, fabrication and supply of steel bridges. The insurers wrote Mabey’s primary layer indemnity insurers for the 1996-1997 period.

During the period of insurance, a bridge supplied by Mabey and erected in Ethiopia collapsed. This caused Mabey to review the design and construction of a number of its bridges. The review included bridges already built in Ghana (the Ghana I bridges) and bridges planned to be built in Ghana (the Ghana II bridges).

In rectifying the actual and potential faults in the Ghana bridges, Mabey incurred costs exceeding £2 million. The policy limited the indemnity to £2 million for ‘a single claim’.

**The parties’ submissions**

The insurers argued that only one claim was made by Mabey on the basis that the design errors in the Ghana I bridges had been incorporated into the calculations for the Ghana II bridges. The insurers also contended that there was only one contract for the Ghana I bridges, which was subsequently extended and varied to incorporate the construction of the Ghana II bridges.

Mabey argued that it had two claims based on the fact that:

- there were two separate design and supply contracts;
- at the time when the Ghana I contract was made, there was no phase II;
- it was therefore the duty of Mabey in relation to each of the contracts to exercise due care and skill in the design work; and
- each failure gave rise to breaches of two different contracts and therefore Mabey had two separate claims.
Legal principles

Justice Morison held that the following principles emerge from the authorities:

- the formulation of a claim by a third party is not decisive of an insurer’s liability. Thus, the fact that the remedial work done by Mabey had pre-empted any claim by the Ghanian government was immaterial;
- a ‘claim’ for the purposes of an insurance policy does not necessarily mean a claim made in legal proceedings. It does not necessarily follow that, where there is a separate cause of action, there is a separate claim. This is because the policy is looking for the existence of a claim *in the policy period* made by a third person against the insured arising from his alleged negligence;
- a claim arises when it is first made (i.e. upon the first demand), not when proceedings are commenced; and
- whether there is one claim or more depends on the underlying facts, not the formulation of the claim.

Justice Morison accepted the submissions made by Mabey, holding that ‘[t]he substance, rather than the form of the arrangements is all important, because it is to the “realities” that I must have regard’.

He noted that there were separate contracts for the Ghana I and Ghana II bridges. He considered that each bridge had to be designed individually and the negligence in respect of the Ghana II design work was the separate act of failing to re-examine the assumptions made in respect of the Ghana I bridges. The insurers were therefore liable for two claims, not one.

This decision demonstrates the distinction between a ‘claim’ for the purposes of an indemnity insurance policy and a claim (i.e. cause of action) in legal proceedings. In determining whether a claim is a single claim under a policy, the courts will consider the facts underlying the claim against the insured, rather than the way in which the claim is formulated by the third party.
CONSTRUCTION OF POLICIES

Determining the relevant ‘event’ that causes the loss when a train goes off the rails

Case Name:
Midland Mainline Ltd v Commercial Union Assurance Company Ltd

Citation:
[2003] EWHC 1771, English High Court of Justice per Steel J

Date of Judgment:
17 July 2003

Issues:
- Meaning of ‘event’
- Meaning of ‘wear and tear’ exclusion
- Determining the proximate cause of loss

Can an ‘event’ or ‘occurrence’ said to trigger an insurance policy be made up of several incidents that take place at different times and in different places? The High Court of England and Wales summarises the law in the context of insurance against loss of revenue in the British rail system.

The facts
On 17 October 2000, a Kings Cross to Leeds passenger train derailed on a curved section of track, killing four passengers and injuring a number of others. The accident was found to have been caused by ‘rolling contact fatigue’ leading to cracking and splitting of the rail line. In response, the British Rail Authority ordered that all lines be checked and imposed ‘emergency speed restrictions’ on hundreds of miles of rail line. This resulted in widespread delays and cancellation of services over a period of six months.

The companies who operated rail services (the rail companies) had insured against loss of business revenue resulting from an ‘event’, including ‘the actions of a competent authority for reasons of public safety’. However, these contracts expired on 31 October 2000. Much of the loss occurred after that date.

The issues
1. Meaning of an ‘event’

The rail companies argued that the imposition of ‘emergency speed restrictions’ was part of a sustained program by the British Rail Authority and therefore constituted one ‘event’ beginning on 17 October 2000 and continuing thereafter. The insurance companies argued that each ‘emergency speed restriction’ was a separate event, and that the rail companies were therefore only insured against loss of revenue caused by restrictions imposed on or before 31 October.

Justice Steel reviewed the meaning of ‘event’, concluding that it was difficult, but not impossible, to characterise a series of occurrences in different places and at different times as one ‘event’. The relevant principles were summarised as follows:

(a) There must be a sufficient degree of unity to justify the label of an event.
(b) The assessment of unity will be by reference to time, locality, cause and motive.
(c) The matter is to be scrutinised from the perspective of an informed observer in the position of the assured.
(d) The assessment is to be made both analytically and as a matter of intuition and common sense.
Justice Steel concluded that the ‘emergency speed restrictions’ were not one ‘event’ since they were imposed over a period running into months and at thousands of locations over the entire rail network. While there was a degree of unity in the cause and intent of the restrictions, he held that the program by the Rail Authority was incremental and variable.

2. Meaning of ‘wear and tear’

The insurance contracts held by the rail companies excluded recovery if the ‘event’ causing loss of business revenue was ordinary ‘wear and tear’. Justice Steel held that ‘wear and tear’ in an insurance contract means deterioration caused by ordinary service conditions operating upon the machinery. The fact that the emergence and spread of damage is unpredictable or that it could have been prevented by proper maintenance is not relevant. He held that ‘rolling contact fatigue’ was a clear example of ‘wear and tear’.

3. How is proximate cause determined?

Although ‘rolling contact fatigue’ was found to be wear and tear, Justice Steel concluded that the loss of business revenue was caused by the imposition of speed restrictions, not by the damage to the track. The task of determining proximate cause was said to be ‘essentially one of common sense’.

Therefore, the rail companies were able to recover under the insurance contract for losses of business revenue caused by ‘emergency speed restrictions’ imposed on or before 31 October 2000, but could not recover for losses caused after that date.

This case contains a useful summary of the law related to the meaning of ‘event’ in an insurance contract. It illustrates the difficulty in showing that incidents which occur in different times and at different places are all part of the one ‘event’, although the possibility of this conclusion being reached in an appropriate case is not ruled out.
Liability insurance: joint venture clause limited to liability of named insured only

Case Name:
Egis Consulting Australia Pty Ltd v Kvaerner Oil & Gas Australia Pty Ltd & Anor

Citation:
[2003] NSWSC 19, New South Wales Court of Appeal per Meagher, Hodgson and McColl JJA

Date of Judgment:
30 September 2003

Issues:
- Interpretation of joint venture clause in insurance contract
- Insurance taken out in name of one joint venturer
- Whether indemnity extended to the other joint venturer

The New South Wales Court of Appeal has rejected a joint venturer’s attempt to extend a joint venture clause in a professional indemnity policy to cover all players in the joint venture.

The facts
Egis Consulting Australia Pty Ltd (Egis) entered into an unincorporated joint venture with Kvaerner Oil & Gas Australia Pty Ltd (Kvaerner). The joint venture was sued by John Holland Construction and Engineering Pty Limited (Holland) for negligence relating to the design and engineering services. The joint venture defended the claim and brought a cross-claim seeking payment of fees. Kvaerner and Egis had entered into a deed, under which Kvaerner agreed to fund and conduct the cross-claim. Under the deed, the whole of the sum recovered from the cross-claim would be paid to Kvaerner. Kvaerner agreed to indemnify Egis in relation to the cross-claim (but not any other claim in the proceedings).

Holland and Kvaerner ultimately agreed to settle Holland’s claim at approximately $3.7 million, and the cross-claim at $1 million. In accordance with the deed, settlement of the cross-claim was paid wholly to Kvaerner. Kvaerner then sued Egis for a 50 per cent contribution to the $3.7 million settlement of Holland’s claim and the legal costs. Egis claimed, among other things, that Kvaerner’s professional indemnity policy covered the whole liability of the joint venture to Holland, including the liability of Egis. The primary judge rejected this contention. Egis appealed.

The relevant provision in Kvaerner’s insurance policy stated:

This policy is extended to indemnify the Insured in respect of any liability for work undertaken by any Firm, Company or Individual with whom the Insured are operating jointly and any Joint Venture, Joint Company and/or Consortium which includes the Insured.

The decision
The Court of Appeal dismissed the appeal, holding that ‘the clause is limited to indemnifying the insured, and only the insured, in respect of liability for work undertaken by the various entities referred to in the clause’. The court rejected the appellant’s contention that clauses giving general indemnities against liability to parties associated with the insured are commonplace, distinguishing certain examples cited on the basis that the third parties for whom indemnity was arranged by the insured were subcontractors, not joint venturers.
Kvaerner argued that the proper construction of the clause is that it only indemnifies the named insureds (ie the Kvaener group) whereas Egis argued that it is also insured under the policy, because it is a member of a joint venture including Kvaerner.

Kvaerner claimed the clause should be read as follows:

‘This policy is extended to indemnify the Insured in respect of any liability for work undertaken:
(1) by any firm, Company or Individual with whom the Insured are operating jointly
(2) by any Joint Venture, Joint Company and/or Consortium which includes the Insured.’

Egis claimed that the clause should be read as follows:

‘This policy is extended to indemnify
(1) the Insured in respect of any liability for work undertaken by any Firm, Company or Individual with whom the Insured are operating jointly
(2) any Joint Venture, Joint Company and/or Consortium which includes the Insured’.

Although acknowledging that a particular policy may cover all parties to a joint venture, the Court of Appeal clearly indicated that this situation was very much the exception to the rule and it would not be prepared to read such a meaning into a policy.

This decision gives some comfort to insurers. It illustrates that there are limits on the extent to which courts are prepared to construe policies in favour of insureds where the insured alleges ambiguity. The courts are prepared to look at commercial purpose. Justice Einstein at first instance had stated in his conclusions that ‘ultimately the matter is one of impression’.
CONSTRUCTION OF POLICIES

Cover denied where the intention is not carried into the express words of a policy

What happens if the definition of an essential term refers to a schedule that is left blank? The Victorian Court of Appeal was not prepared to read into definition terms that did not form part of the policy and the insured found that its claim was not covered by the incomplete definition.

The facts

Manren Limited claimed indemnity from its insurer, Royal and Sun Alliance Insurance Australia Limited (Royal & Sun), under a public liability policy. Manren, previously known as Hudson Conway Management Ltd, was one of the defendants in a proceeding with respect to injuries, damage and losses suffered by the plaintiff in a fall over a balustrade rail on a residential building development site. Manren was found to be negligent, through the actions of one of its employees involved in the development, and it claimed indemnity from Royal & Sun under a policy taken out by its parent company Hudson Conway Limited (Hudson) for the Hudson group of companies (the group).

The policy provided, among other things, that Royal & Sun:

...will indemnify the Persons Insured in respect of all sums which they shall become legally liable to pay as compensation for... [p]ersonal injury... happening... as a result of an Occurrence and in connection with the Business.

The main issue before the court was the meaning of the term, 'The Business'. The policy set out the meaning as follows:

'The Business' shall mean that described in the Schedule and shall also include (emphasis added)

...

3. the ownership or occupation of, the carrying out of repairs maintenance alterations and additions to, or the demolition of, the Policyholder's premises to which this Policy applies.

...

Unfortunately, both in 1995 and 1996, the schedule where the description of the business was to be entered was left blank.
The matter was heard by Justice Eames in the first instance. The first instance decision is reported in the *Annual Review of Insurance Law 2002*. It is the decision in *Toomey v Scolaro’s Concrete Constructions Pty Ltd and Ors (No. 5) [2002] VSC 48*.

Royal & Sun submitted that, because no description of ‘The Business’ had been inserted in the schedule, the only relevant business covered by the policy was that defined in paragraph 3 of the general definition, that is the ‘ownership or occupation of… the policyholder’s premises to which the policy applies’.

Manren noted that the proposal form submitted by it clearly and expressly stated ‘property investment, development, construction’ as the ‘full description of business or occupation including all subsidiaries’. Accordingly, Manren argued that Royal & Sun could only maintain its preferred construction by virtue of its own failure to insert the words ‘property investment, development, construction’ in the relevant schedule and that the omission should not be allowed in defiance of the clear intention demonstrated by the proposal form to cover all aspects of the group’s business. Alternatively, it was argued that, since the schedule was left blank, the policy meant that the business was, in fact, carried on by the insured, which includes property development and construction.

Justice Eames held that:

- Manren carries the onus of establishing that its business was covered by the policy;
- the policy does not provide professional indemnity coverage, nor coverage for purposes of construction;
- the policy did not address the two additional occupations of ‘development’ and ‘construction’ specified in the proposal form;
- the omission of a description of ‘The Business’ in the schedule leads to the result that the only business that is covered is stated in the general definition and is confined to ownership and occupation of premises;
- Manren did not itself own, nor occupy, the relevant residential development, which was owned by another subsidiary in the group; and
- consequently, the claim for indemnity must fail.

Manren appealed the decision of Justice Eames to the Court of Appeal.

**The decision**

The Court of Appeal dismissed Manren’s appeal and held that:

- no narrow or pedantic approach is to be taken in the construction of commercial contracts, including insurance policies;
- contracts are to be construed in a fashion that accords with common sense, facilitates commerce, contains costs and secures public confidence in the courts;

---

the view taken by Justice Eames was obviously right as a matter of common sense and the natural meaning of words and such a construction should be unhesitatingly upheld;
whatsoever Hudson may have subjectively intended, objectively ‘The Business’ means the business set out in the policy, which is the general description and the business defined in the schedule;
although the proposal form disclosed that the business of the group included property development and construction as well as property investment, that proposal form was merely descriptive of the proposer and did not convey to Royal & Sun that the insurance was to cover property development and construction; and
given that the schedule was left blank, ‘The Business’ means the business of owning and occupying property.

This case illustrates the principle that the intention of parties to a contract must be construed objectively, based on the words used by the parties. Insureds and their brokers should always ensure that the policy contains the correct wording and provides for cover in all of the intended circumstances. Unless the remedy of rectification is available, reliance cannot be placed on what was said in proposal forms and the like to remedy any deficiencies arising from the policy wording. It is not enough that an insured intends to be covered for certain events that may be alluded to in the proposal form; that intention must be carried over into the express terms of the policy in order for cover to be effective.
D & O insurance: insurer seeking to rely on fraud exclusion not liable to pay defence costs upfront

Case Name:
Silbermann v CGU Insurance Ltd; Rich v CGU Insurance Ltd; Greaves v CGU Insurance Ltd

Citation:
[2003] NSWCA 203, New South Wales Court of Appeal per Beazley, Hodgson and Tobias JJA

Date of Judgment:
25 July 2003

Issues:
- D&O insurance
- Indemnification for cost of defending an allegation for fraud

Does a standard indemnity for defence costs under a directors' and officers' insurance policy (D&O policy) extend to costs of defending allegations of fraud? The New South Wales Court of Appeal held that it does but that these costs need not be paid upfront. They become payable only when the fraud allegation has been disproved or otherwise determined in favour of the insured director.

The facts
The contract of insurance in this case provided for the following:
- an insuring clause providing general cover for directors and officers for any loss arising out of any claim for which their corporation could not indemnify them;
- an automatic extension provision so that where the insurer did not take over the defence or settlement of any claim, it will meet the defence costs of defending or settling any claim as it is incurred and prior to the finalisation of the claim, provided it had confirmed in writing the indemnity for such a claim; and
- further, a provision to the effect that where the insurer has not confirmed indemnity nor taken over the defence, it could, in its discretion, pay defence costs as they are incurred and prior to the finalisation of the claim, provided that it had consented in writing to such defence costs before they are incurred, such consent not being withheld unreasonably.

The policy excluded indemnity for any claim made against a director or officer brought about by, contributed to by, or which involved, among other things, fraud by the director or officer. However, as is common practice, the exclusion was expressed to apply only to the extent that the relevant conduct had been established by judgment or other final adjudication adverse to the director or officer.

The court was asked to consider three questions:
1. whether, in the absence of an existing judgment, order or other final adjudication adverse to the insured, it could rely on the exclusion clause as a basis for refusing to indemnify;
2. whether the insurer itself is entitled to seek a judgment, order or other final adjudication adverse to the insured and, thereby, exclude liability for a claim under the exclusion clause in the same proceedings in which the insured makes a claim for indemnity against the insurer; and
3. whether the exclusion clause (which is expressed as applying to claims) operates to exclude liability on the part of the insurer to pay claims by the insured for indemnity for defence costs under various other clauses of the policy.

The judgment

In relation to questions 2 and 3, the court unanimously answered yes in both cases. In relation to question 2, this was because otherwise the insurer may not be able to take advantage of the exclusion unless it could raise the fraud defence in the same proceeding. In relation to question 3, this was because, although the exclusion clause referred to an indemnity against any claim and 'claim' was defined in terms of documents, what clearly was meant was an indemnity for the consequences of the claim. This includes the costs.

The court, however, did not agree on the answer to the first question: whether the insurer could wait for the outcome of the claim involving fraud before considering whether to indemnify for defence costs, or whether it had to indemnify as and when costs were incurred and then seek to recover these monies if there was a finding of fraud.

The majority held that an insurer could wait for the outcome of a claim involving fraud before indemnifying for defence costs. This was because the clause relating to the advancement of defence costs stated that the insurer need only indemnify for these if it had confirmed in writing that it would do so. However, an insurer’s refusal to indemnify for defence costs must be based on reasonable grounds.

Further, the majority pointed out that, where the insured had not confirmed indemnity in writing, the insurer still had a discretion to provide for these defence costs. However, this discretion only existed up to the moment of a finding of ‘no fraud’.

Justice Hodgson (in the minority) observed that in cases such as this one, an insured can say (if it does not have the funding for its defence) that there will not be a fair decision as to whether there was dishonesty; and the insurer can say (if it is compelled to fund the defence) that the money will be unrecoverable and it will lose the benefit of the dishonesty exclusion. He gave greater emphasis to the insured’s interest in a fair hearing, and found for the insured.
This decision is of considerable practical importance. It means that where an insurer has a discretion as to payment of defence costs, it may rely on a fraud exclusion as a basis for refusal to pay, even though the exclusion is expressed to be subject to judgment or final adjudication adverse to the insured. However, the insurer must exercise the discretion consistently with its obligation to act in good faith. In practice, this would require a legal opinion to the effect that there is a reasonable basis for invoking the fraud exclusion.

The majority view was accepted as correct and applied by Justice Nicholas of the Supreme Court of New South Wales in Daniel Wilkie v Gordian RunOff Limited & Anor handed down in November 2003.
Fraud exclusions: what is the boundary between gross negligence and dishonesty?

Case Name:  
*Harle v Legal Practitioners Liability Committee*

Citation:  
[2003] VSCA 133, Victorian Court of Appeal per Callaway, Buchanan and Chernov JJ

Date of Judgment:  
11 September 2003

Issues:  
- Professional liability insurance  
- Meaning of ‘dishonesty’ for the purposes of an exclusion clause  
- The *Briginshaw* standard of proof in cases of fraud or dishonesty.

Did the trial judge misapply the test for dishonesty, or was this merely gross negligence? The Victorian Court of Appeal upheld the trial judge’s decision that the appellant solicitor was not entitled to an indemnity provided under a professional negligence policy of insurance, even though the appellant did not expressly ‘realise’ that his acts were dishonest.

Alianda Close Pty Ltd (*Alianda*) had brought proceedings against the appellant solicitor (*Mr Harle*) claiming damages for negligence and breach of duty in relation to advice he gave that allegedly brought about the investment of US$2 million in an investment ‘scam’. During the trial, the parties settled; however, the settlement was conditional upon an indemnity being provided to Mr Harle under a professional negligence insurance policy. Mr Harle pursued the respondent insurer for the indemnity.

The insurance policy provided that the insurer would not indemnify Mr Harle against any liability ‘...[a]rising in whole or in part, directly or indirectly from, or brought about by – (a) The dishonesty or fraudulent act or omission of any Insured on or before 31 December 1997 ...’.

The promoters of the scheme promised a return on the $2 million investment of $20 million, payable over 40 weeks at US$500,000 per week. They also promised a guarantee from a reputable bank. They provided a number of letters and documents that were, on their face, extravagant, and incomprehensible in some places. When funds were initially sought by Alianda and Mr Harle from the ANZ Bank, the bank refused, on the basis that the scheme was probably fraudulent.

The trial judge held that Mr Harle’s advice was both ‘objectively and subjectively’ dishonest, and that the exclusion clause applied because Mr Harle must have known that there was a real risk that Alianda ‘would lose its funds, a risk which he was prepared to take in the hope that he would earn US$2 million.’

Mr Harle appealed, essentially on the basis that the trial judge misapplied the test for dishonesty by treating Mr Harle’s gross negligence in advising Alianda as amounting to dishonesty.

In relation to the meaning of ‘dishonesty’, the Court of Appeal enunciated the following established principles.

1. Where dishonesty is not used in a special sense in relation to statutory offences, it is to be given its ordinary meaning.
2. The term embraces deliberate conduct that is considered to be dishonest by the standard of ordinary decent people.
3. Whether the conduct amounts to dishonesty involves the consideration of the mental state – the knowledge, belief or intention – of the person whose conduct is impugned, but this does not involve considerations whether, subjectively, the person realised that his or her conduct was dishonest by the above standard.

The Court of Appeal held that the trial judge's findings of fact were reasonably open to him and capable of supporting the conclusion that Mr Harle's negligent conduct was also dishonest.

It was reasonably open to the trial judge to reject Mr Harle's sworn evidence that he believed, at all relevant times, that the proposed transaction was *bona fide* and that the investment would be secure, because the circumstances in which the investment took place 'screamed out for an explanation as to how the money would be used to earn such staggering profits'. Also, Mr Harle 'must have known' that the transaction might be a 'scam' given that 'a reputable major bank' (ANZ) had advised that the scheme was probably fraudulent, and Mr Harle had never sighted a bank guarantee.

Justice Chernov noted that, although stupidity does not amount to dishonesty, 'it can be of such magnitude as to warrant rejecting the claim that the conduct was pursued in ignorance of the otherwise obvious facts on account of such a belief.' Accordingly, it was reasonably open to the trial judge to find that Mr Harle's advice to proceed with the transaction was intentionally false and misleading.

The *Briginshaw* standard of proof requires that the judge be satisfied that there is clear or cogent evidence of the fraud or dishonesty alleged. The Court of Appeal held that an inference, properly and firmly drawn from the facts, can satisfy the *Briginshaw* standard just as well as a finding couched in direct terms.

This case is a useful illustration of what is required to prove fraud or dishonesty for the purpose of an exclusion clause in an insurance policy. Direct evidence of dishonest intent is not always essential. It may be enough to justify a finding of dishonesty if circumstances suggest the insured 'must have known'.
CONSTRUCTION OF POLICIES

Exclusion clauses, cross-liability clauses and election

Case Name
National Vulcan & Ors v Transfield; National Vulcan & Ors v Connell Wagner; National Vulcan & Ors v Coffey Partners International

Citation:
[2003] NSWCA 327, New South Wales Court of Appeal per Santow and Ipp JA and Young CJ in Equity

Date of Judgment:
11 November 2003

Issues:
- Construction insurance: contract works
- Effect of exclusion and cross-liability clause where multiple parties are insured under the one policy

Background
This case concerns the construction of part of the New Southern Railway in New South Wales. The works that were the subject of the insurance claim comprised a 158-metre reinforced-concrete tunnel under the Princes Highway. The project’s lead contractor, Transfield Bouygues Joint Venture, had subcontracted construction of the tunnel to Transfield Contractors Pty Limited.

All parties involved in constructing the tunnel were insured under Transfield’s contractors’ floaters insurance policy, obtained by Transfield’s parent company, Transfield Holdings. The policy covered Transfield, along with any subcontractors they might retain, for any liability for loss of, damage to, or destruction of, or loss of use of property.

Two incidents at the site damaged property belonging to Transfield and to two subcontractors. In both instances, damage was caused when a portion of wall sheet piling leaked, causing part of the tunnel to flood.

Transfield brought an action against the subcontractors in negligence. Each of the subcontractors brought an action in negligence against the other subcontractor and against Transfield. Each party sought indemnity under the insurance policy for any liability it may have to any other party.

The insurance policy contained two relevant terms. The first was an exclusion that excluded indemnity for any liability for damage to property ‘owned by the Insured’. The second was a cross-liability clause, which stated:

Each of the persons comprising the Insured shall for the purposes of this policy be covered as a separate and distinct unit and the words ‘the Insured’ shall be considered as applying to each of such persons in the same manner as if a separate policy had been issued to each of them.

The insurers refused to indemnify Transfield and the subcontractors, relying on the exclusion.

Issues before the Court of Appeal
There were two issues before the court:

1. whether Transfield and the subcontractors could jointly be described as ‘the Insured’ under the policy. If they could, then the policy would not respond because the exclusion excluded from cover any liability ‘for damage to property owned by the Insured’; and
2. whether, by purporting to exercise their right of subrogation, the insurers had elected to provide indemnity.
The exclusion

The insurers submitted that, because the policy insured Transfield and the subcontractors, they should come within the description, ‘the Insured’, as it was used in the exclusion. The insurers’ argument was that, since the damaged property was owned by parties insured under the policy, the property was ‘property owned by the Insured’ and the exclusion that excludes liability for damage to the insured’s own property should apply.

The insurers argued that any other interpretation of the term ‘the Insured’, would ‘leave the [Exclusion] with no work to do’, because there can be no liability for damage to one’s own property.

The Court of Appeal did not accept the insurers’ arguments. It decided that, for the purposes of the exclusion, ‘the Insured’ must mean the Insured making the claim under the policy. The court reasoned as follows:

1. In the exclusion, ‘the Insured’ means ‘the Insured making the claim’. The exclusion did not apply to ‘any Insured’ or ‘the Insureds’ or even ‘an Insured’, but it excluded property owned by ‘the Insured’.
2. This interpretation was supported by the cross-liability clause. If a separate policy had been issued to Transfield alone there would be no basis for the insurers’ argument.
3. More broadly, the insurers’ interpretation would frustrate the commercial purpose of the insurance policy, which was to spare the need for parties to a common goal (ie completion of a construction project) to fight between themselves following an accident for which one of them was responsible.
4. The exclusion may still have work to do if the words ‘the Insured’ are limited to the particular insured making the claim. The court considered that liabilities sometimes arise when one damages one’s own property, for instance where the property is leased, mortgaged, or jointly owned.

Did the insurer make a binding election to indemnify?

The circumstances of the alleged election were that the insurers’ lawyers had written to Transfield purporting to exercise rights of subrogation and agreeing to provide indemnity to Transfield. Nine days later, Transfield received another letter from the insurers’ solicitors, purporting to revoke that grant of indemnity.

The Court of Appeal upheld the trial judge’s decision that there had been no election because acceptance by an insurer of a claim to which the policy does not respond cannot amount to an election. However, as the policy here did respond to the claim, the issue was not material to the outcome of the case.
The Court of Appeal’s decision illustrates how policies covering contract works may be construed to cover claims between co-insureds in respect of damage to property. Insurers will not be able to exercise rights of subrogation to override the intended scope of cover. It also reinforces the importance of the policy wording. If the policy exclusion had used the term ‘an Insured’, rather than ‘the Insured’, then the outcome could have been different. No doubt, insurers and insureds alike will wish to pay close attention to their policy wording and, in particular, the wording of any cross-liability clause.
CONSTRUCTION OF POLICIES

Construction of an exclusion clause, knowledge of a broker and the duty of disclosure

Case Name:
QBE Mercantile Mutual Ltd v Hammer Waste Pty Ltd & Anor

Citation:
[2003] NSWCA 356, New South Wales Court of Appeal per Sheller, Santow and McColl JJA

Date of Judgment:
9 December 2003

Issues:
- Construction of exclusion clause
- Implied terms excluding cover
- Whether the broker’s and insured’s knowledge that the ‘rejected driver’ drove the truck amounted to non-disclosure under s21 of the Insurance Contracts Act

In this case, the New South Wales Court of Appeal ruled on three issues:

(a) it rejected an attempt by the insurer to exclude cover by construing the policy in a particular manner;
(b) it rejected an implied term in the policy disallowing coverage to an employee driver who was ‘rejected’ by the insurer; and
(c) it considered whether the knowledge of the broker that the driver was ‘rejected’ but continued to be employed to drive in the insured’s business amounted to non-disclosure under section 21 of the Insurance Contracts Act 1984 (Cth) (ICA).

The facts
The plaintiff in the original case was a garbage removalist company. In November 2003, it decided to employ a new driver. It filled in a ‘Driver’s Declaration Form’ and sent it to its broker. The broker forwarded the form to the insurer, which subsequently informed the broker that the driver was not acceptable because of his inexperience in driving trucks of the relevant class.

The trial judge, Justice Palmer, held (resolving conflicting evidence) that the broker did not inform the insured of the insurer’s decision.

The policy provided for a greater excess to apply if the driver had less than two year’s experience driving the same type of vehicle (as was the case here).

The policy also excluded cover where the insurer had not ‘received and accepted a Driver’s Declaration’ and one of four specified circumstances had occurred in the past five years. It was common ground that there were no such specified circumstances.

The policy was renewed in July 2001. In August 2001, the truck was involved in a serious accident while being driven by the new driver.

The insurers sought to deny cover because either:
- under the terms of the policy, cover was excluded when the truck was driven by the new driver; or
- the insured failed to disclose, at the time of the policy renewal, that it had continued to employ the new driver.
The decision at first instance

At first instance, Justice Palmer held for the insured on all three issues. He held:

- There was no reference in the policy to a separate category of ‘rejected’ drivers. There being no express exclusion, the court should be reluctant to infer one.
- As to the implied term argument, the courts will not imply a term that is inconsistent with an express term of the policy. It is not appropriate to distinguish between ‘not receiving and accepting’ and ‘declining’. In this case, the policy expressly provided that the cover would be excluded if the driver’s declaration form had not been received and accepted and one of four specified circumstances had occurred in the previous five years. This was inconsistent with an implied term that cover would be excluded only if a driver’s declaration form had not been received and accepted.
- There was no breach of the insured’s duty of disclosure. The insured was only obliged to disclose matters that are known to it and is not obliged to disclose matters that it ought to have known. In this case, the broker had forgotten about the rejected driver by the time of renewal. In those circumstances, even if the broker’s knowledge could be attributed to the insured, at the relevant time the broker did not ‘know’ all of the relevant facts.

The Court of Appeal decision

The Court of Appeal agreed with Justice Palmer’s interpretation of the policy.

On the issue of knowledge, the Court of Appeal considered that the insured, having already informed the insurer of the name of its driver, would not be expected to know, when renewing the policy, that the fact that the driver continued to be its driver was a matter relevant to the insurer’s decision whether to accept the risk and, if so, on what terms, within the meaning of s21 of the ICA.

Furthermore, s22(2) of the ICA provides that the duty of disclosure does not require the disclosure of a matter that the insurer knows or, in the ordinary course of the insurer’s business, an insurer ought to know. The court considered that, had the insurer conducted its business properly and not proceeded upon the basis of a misinterpretation of its own policy to reject the driver without any justification, it would have known that the driver was the insured driver when asked to renew the policy.

Significantly, the court noted that it should not be taken to agree with all that Justice Palmer said about the knowledge to be imputed to the insured. The court did not need to decide on the correctness of Justice Palmer’s reasoning that the matter is not ‘known’ when, in the ordinary course of events, it was forgotten by the time of renewal.

This case illustrates the difficulties facing insurers seeking to exclude cover in the absence of clear and express terms. It is also a further authority on the degree of knowledge required for the purposes of s21 of the ICA.
CONSTRUCTION OF POLICIES

When is a vehicle not a vehicle?

Case Name:
Palframan v Jackson's House Removals (a firm) & Ors

Citation:
[2003] QCA202, Queensland Court of Appeal per de Jersey CJ, Davies and Jerrard JJA

Date of Judgment:
23 May 2003

Issues:
- Exclusion clause covering ‘vehicles’
- ‘Vehicle’ defined within the policy
- Whether definition of ‘vehicle’ in the relevant statute prevailed over policy definition

The Queensland Court of Appeal has held that mere reference to an Act within a policy does not automatically import a definition from the Act into the policy, where it already defines the relevant term.

The insurer appealed against a determination that an exclusion clause in an insurance policy was inapplicable. The claim arose from an accident that happened during the removal of a house, using a prime mover and a trailer. The accident occurred when part of the house, sitting on the stationary trailer, collapsed.

The relevant policy defined ‘Vehicle’ as being something that is self-propelled. Clause 9 of the policy excluded liability arising out of the use of a Vehicle that is required to be registered or insured by virtue of any legislation relating to Vehicles. According to the relevant Queensland Act, ‘vehicle’ was defined to include a trailer.

The trial judge held that the policy definition applied and that any liability arose out of the use of the trailer, not a combination of the trailer and the prime mover. As the trailer was not self-propelled, the exclusion clause would not apply.

On appeal, the insurer contended that the reference to the Act in clause 9 meant that the definition in the Act applied. The insurer relied on the Western Australian case of Container Handlers Pty Ltd v Insurance Commission of Western Australia & Ors [2001] WASCA 304, in which the definition of ‘vehicle’ in the relevant Act was held to prevail over the policy definition. However, the Court of Appeal distinguished this case on the basis that it turned on a Western Australian statutory prohibition on issuing the cover if the policy was construed the other way. No such prohibition applied in Queensland.

In dismissing the appeal, the Court of Appeal stated that the fact that the word ‘Vehicle’ was repeatedly written with a capital ‘V’ throughout the relevant clauses strongly suggested that the definition expressed in the policy was to apply. The mere reference to legislative requirements in clause 9 was not enough to establish that term ‘Vehicle’ therein should include non-self-propelled vehicles.

This case reaffirms the courts’ reluctance to look beyond the wording of an insurance policy when there is no apparent textual ambiguity, legislative inconsistency or other commercial reason for doing so.
CONSTRUCTION OF POLICIES

Insurer not liable where an excluded event contributed to loss, even if not the sole cause of loss

Case Name: Prosser & Anor v AMP General Insurance Ltd

Citation: [2003] NTSC 80, Supreme Court of the Northern Territory per Angel J

Date of Judgment: 22 July 2003

Issues:
- Flood exclusion
- Concurrent causes of loss including flood

An insurer has once again succeeded in defending a claim under a house and contents policy where the damage was caused by a combination of rising flood waters and surface run-off from rainfall.

The facts
At about 6.30pm on 26 January 1998, Mr and Mrs Prossers’ house, situated near the Katherine River, became inundated with water following heavy rains earlier in the day.

The policy under which the house was insured covered loss caused by storm, tempest or rainwater, being ‘rain falling naturally from the sky, including rainwater run-off over the surface of the land’, but excluded loss caused by ‘flood, being the inundation of normally dry land by water escaping or released from the normal confines of any natural water course or lake... reservoir, canal or dam’.

The general area of the Prossers’ property is limestone country, characterised by numerous ‘sink holes’, which act as drains under normal conditions. However, in the event of heavy rains, rather than acting as drains, the sink holes expel water to the surface. By early afternoon on 26 January, rain had caused the level of the nearby Katherine River to rise such that the surface water could not drain normally.

The Prossers claimed that they were indemnified as their loss was caused by an event within the terms of the policy, that is, ‘rainwater run-off over the surface of the land’. However, both AMP and the Prossers agreed that the rainfall, in isolation of other factors, would have been insufficient to inundate the dwelling.

The decision
The Supreme Court of the Northern Territory found that the Prossers’ loss was caused by a ‘combination of accumulated surface rainwater and sink hole ground water dammed up by the flooding Katherine River’.

Following what has become an established principle of insurance law, the court held that, because the Prossers’ loss was caused by ‘concurrent effective or proximate causes’ (one of which was covered by the policy, and the other, excluded), AMP was not liable for the damage.
This case illustrates the application of the principle first identified in *Wayne Tank & Pump Co Ltd v Employers Liability Assurance Corp Ltd* [1974] QB 57. The principle provides that where there is an exclusion clause in a policy, provided the insurer can show that an excluded event effectively contributed to the damage and notwithstanding any other concurrent causes, the insurer will not be liable under the policy.
Case Name:
If P&C Insurance Limited (Publ) v Silversea Cruises Limited & Ors
Citation:
[2003] EWHC 473 (Comm), English High Court of Justice per Tomlinson J
Date of Judgment:
19 March 2003
Issues:
- Business interruption losses
- Interpretation of insurance policy
- Limits and deductibles

This case concerns an attempt by Silversea Cruises Limited to recover from its insurers substantial losses which, it alleged, it suffered in consequence of the terrorist attack in the United States on 11 September 2001.

Silversea Cruises Limited (Silversea) operates cruise ships in the ‘ultra luxury’ sector of the market. Following the events of 11 September 2001, a considerable portion of Silversea’s regular customer base either cancelled bookings, or were afraid to make bookings. Silversea claimed in respect of four vessels: Silver Cloud (the Cloud), Silver Wind (the Wind), Silver Shadow and Silver Whisper.

The policy relevantly provided as follows:

Ai) This insurance covers loss to the vessel being… deprived of income as a consequence of an occurrence within the policy of one of the following events:

... Blockage or closure… of any canal or navigable waterway… or any other event which directly interferes with the scheduled itinerary of the insured vessel by any state authority … [or] terrorists, whether actual or threatened.

... Acts of war [or] armed conflict…which interfere with the scheduled itinerary of the insured vessel, whether actual or threatened.

Aii) To cover the Ascertained Net Loss resulting from a… warning… regarding acts of war…[or] terrorist activity whether actual or threatened, that negatively impacts the Assured’s bookings and/or necessitates change to the scheduled cruise itinerary, subject to a maximum period per event of six months from a date that Silversea shall determine...

B) Subject to the same conditions as in Ai) above… this insurance covers the cost to the Assured of issuing cruise credits and/or on-board credits to… passengers where the cruise has been cancelled or interrupted as a consequence of the happening of an insured event.

(emphasis added)

The policy also provided for a limit of US$5 million applicable to section Aii ‘in the annual aggregate and in all’ and a deductible of US$250,000 ‘per occurrence’.

The claim under section Ai

Silversea claimed for passenger cancellations for the four vessels, and for the Cloud’s cancelled 2002 itinerary. (The Cloud performed the Wind’s 2002 itinerary instead, as the Wind was laid-up for repairs.) Although the claim was in respect of voyages that were performed exactly as scheduled, Silversea contended that the
circumstance of passenger cancellations in the aftermath of 11 September and associated travel warnings itself constituted an interference with the scheduled itinerary. Silversea argued that ‘interference’ under section Ai must embrace economic interference, or else the policy would be of little benefit to Silversea.

Justice Tomlinson regarded Silversea’s claim as ‘quite misconceived’. Section Ai required interference ‘with the scheduled itinerary of the vessel’. Each vessel other than Cloud performed exactly as scheduled. In the case of the Cloud, every scheduled itinerary could have been performed. Her voyages were not cancelled because of any perception that the places that were to be visited were unsafe, but rather to enable her to perform the Wind’s itinerary.

The claim under section B

This required proof of the occurrence of a peril under section Ai. Justice Tomlinson found this claim to be similarly misconceived. Moreover, the terms of section B required the cancellation of a cruise by Silversea, or interruption of a cruise by reason of an insured peril, rather than mere cancellation of a booking on a cruise by a customer. The Cloud’s scheduled voyages were indeed cancelled by Silversea, but not by reason of the scheduled itinerary having been interfered with by an insured peril. Accordingly, Silversea’s claim under section B was dismissed.

The claim under section Aii

Silversea claimed the revenue that was projected to have been booked by 11 March 2002, less the revenue actually booked by that date. Adjustments were made for lost on-board revenue and savings in respect of hotel and food costs. The claim was further reduced by credit being given for the amounts claimed under section Ai of the policy for customer cancellations in respect of those voyages.

Justice Tomlinson considered whether the US$5 million limit was applicable to Silversea’s aggregate losses suffered by its business across the entire fleet, or whether it was a limit applicable to each vessel so that Silversea’s potential recovery under section Aii was US$20 million. He concluded that the limit was intended to be a single limit, irrespective of the number of vessels insured under the policy. This was because the cover offered under section Aii focused on Silversea’s business as a whole, and not on the operation of individual vessels. Furthermore, the deductible was a single deductible per occurrence, not a deductible per vessel.

Justice Tomlinson found the multiple travel warnings arising out of 11 September to be a single occurrence for the purpose of the deductible, since they all arose from the same set of circumstances. He also found it impossible to divorce the anxiety derived from the attacks themselves from the anxiety derived from the warnings issued in the immediate aftermath of the attacks.

Justice Tomlinson thought that losses derived from cancelled bookings were recoverable under section Aii rather than section Ai, where they were in fact claimed. He thought that the losses recoverable under that section were limited to cancellations related to bookings made on cruises due to depart between 11 September 2001 and 11 March 2002.
This case illustrates the principles applying to construction of an insurance policy providing limited coverage for business interruption losses following a terrorist attack. A broad reading of the policy wording, as advocated by the insured, was rejected by the court.
How significant are credit limits when ascertaining amounts recoverable under a policy-of-credit insurance?

Case Name: Moore Large & Co Ltd v Hermes Credit & Guarantee Plc (sued as Credit and Guarantee Insurance Co Plc)

Citation: [2003] EWHC 26 (Comm), English High Court of Justice per Colman J

Date of Judgment: 20 January 2003

Issues:
- Credit insurance
- Construction of policy – significance of credit limit
- Non-disclosure
- Affirmation

Will the amount recoverable under a credit insurance policy be limited to the credit limit in force at the date of insolvency or at the date the unpaid goods were delivered? The England and Wales High Court held that, as a matter of construction of the policy (and based on commercial and practical considerations), the credit limit to be applied is that which exists at the time of insolvency.

The facts
Moore Large & Co Ltd (Moore) claimed monies allegedly due under a policy of credit insurance taken out with Credit and Guarantee Insurance Co Plc (CGI). The policy insured against the insolvency of Moore’s two biggest customers, Motorworld and Blane.

On 6 October 2003, Motorworld went into administrative receivership. At that date, its outstanding debts to Moore amounted to more than £2.2 million plus VAT.

The first issue was one of construction of the policy. The policy defined the insured loss as extending to whatever indebtedness did not exceed the credit limit and qualified for admission to rank in the insolvent estate of the customer. The insurer contended that the indemnity was limited to the credit limit in force before 1 October 2000 (£600,000). The insured contended it was limited to the much larger credit limit (£2 million) introduced by endorsement no. 9 (E9) with effect from 1 October 2000.

The insurer contended that the relevant credit limit was that applicable at the dates when the goods (which were never paid for) were delivered to Motorworld, which was before the credit limit increase.

The insurer further contended that it was entitled to avoid the variation of the policy by E9 because the insured failed to disclose certain material facts at the time the variation was agreed; namely, that it had already delivered and was proposing to deliver to Motorworld, before 1 October 2000, goods with a value substantially over the credit limit of £600,000 then in force. The insurer argued that had this information been given to them, it would have wanted to investigate why there should be such a substantial increase in orders outside of the peak period.
The decision

Justice Colman held that the policy wording linked the credit limit to the outstanding debts that existed at the date of insolvency, for the following reasons:

1. To exceed the credit limit was not a breach of the policy conditions; the policy contemplated that this may occur in some circumstances.
2. It is more consonant with the apparent purpose of having a credit limit that relates to the financial liability of the customer that the limit should be applied upon insolvency and not at the date of each invoice.
3. Had it been the policy's purpose to limit the indemnity by reference to the relationship between the credit limit and each separate invoice, one would have expected as a matter of ordinary drafting technique to find such a limitation expressly alluded to. Nowhere in the policy wording was the credit limit expressed by reference to the amount of an individual invoice or to the date when such invoice was issued.
4. CGI's contention is commercially and practically improbable: tracing the aggregate of all outstanding debts to the date of the invoice involves a potentially cumbersome accounting exercise and investigation. By comparison, the application of the credit limit at the date of insolvency is a relatively simple exercise.

On the issue of material non-disclosure, Justice Colman held that CGI had established that, had it known all the undisclosed information, it would most likely have declined to increase the credit limit until it had made further investigations into the financial viability of Motorworld. CGI had therefore established that it had been induced to agree to E9 by a material non-disclosure.

Nevertheless, Justice Colman held that E9 had been affirmed by CGI and the insurer was therefore not entitled to avoid it. This was because, despite the benefit of advice from solicitors and counsel, CGI had, in its original defence, unequivocally represented an intention to treat E9 as binding on it. Such an affirmation meant CGI was not entitled to avoid its liability for non-disclosure.

To insurers, the importance of this case is twofold. First, insurers intending to limit the scope of an indemnity by reference to losses arising because a credit limit is exceeded (or similar such conduct on the part of the insured) must clearly and expressly set out that limitation. Second, upon discovering a non-disclosure of material facts, insurers should obtain and act upon proper legal advice to avoid an affirmation operating against them. The case contains a useful illustration of the principles applicable (and the evidentiary difficulties facing insurers) where a case of affirmation is raised against them.
Life insurance: representation that an existing policy would be cancelled held to have no contractual effect

Case Name:  
Paul Raymond Stone v Tower Australia Ltd

Citation:  
[2003] NSWSC 777, Supreme Court of New South Wales per Nicholas J

Date of Judgment:  
26 September 2003

Issues:  
- Life insurance  
- Pre-contractual representations of policy conditions

Underwriters beware: in order to give a representation contractual effect, it is necessary to write it into the contract. A question and answer contained in a personal statement will not necessarily be incorporated as a condition of the insurance contract.

The proceedings arose from a refusal by Tower Australia Ltd (Tower) to indemnify the insured (Mr Stone) under an insurance policy (the Tower policy). The claim was defended by Tower on several grounds which, essentially, were based upon Mr Stone’s failure to cancel the life insurance policy he held with Lumley Life Ltd (the Lumley policy) after he received the policy issued to him by Tower.

Of importance to the proceedings was question 2(d) of the personal statement signed by Mr Stone, which stated:

(d) Will this Tower Life insurance policy replace any other Policy?  
If YES, I will cancel the other Policy as detailed on acceptance of the Tower Life insurance.

In response to question 2(d), Mr Stone placed a tick in the box marked ‘Yes’, and the name ‘Lumley’ was placed in the adjoining box.

Several years later, Mr Stone was diagnosed with bowel cancer. He had retained his policy with Lumley and received a payout under that policy of more than $1.25 million.

Justice Nicholas found that at the time Mr Stone signed the personal statement he intended to cancel the Lumley policy. Mr Stone admitted that he understood this was a matter relevant to Tower’s decision on whether or not to accept the risk, but denied that he thought it was a condition of the policy. The evidence suggested Mr Stone changed his intention shortly after the Tower policy had been accepted. He did so because of the absence in the Tower policy documents of a statement that it was conditional on cancellation; his desire that his family be provided for; and his ability to afford the two policies.

Tower’s chief underwriter gave evidence that its reinsurer would not reinsure an insured where the combined total of all crisis insurance held by an insured exceeded $1 million. For that reason, Tower did not accept applications for cross-insurance where the benefit sought exceeded that limit, unless the applicant agreed to cancel any life insurance with other insurers that would take the total above that event.
Tower submitted that question 2(d) was incorporated into the contract of insurance as a condition that Mr Stone would cancel the Lumley policy upon acceptance of the Tower policy, or, alternatively, that Tower’s liability under the Tower policy was subject to cancellation by Mr Stone of the Lumley policy.

**The decision**

Justice Nicholas held that the effect of question 2(d) is a matter of construction, which must be undertaken by reading and construing together all the documents that comprise the Tower policy.

Justice Nicholas held that the Tower policy did *not* include the condition claimed by Tower, for the following reasons:

(a) The Customer Information Brochure (the *brochure*) contained the wording of the total protection package sought by Mr Stone, and was an important document intended by Tower to be relied upon by applicants. The brochure stated that it contained all the major conditions of the policy; however, it contained no reference to the fact that Tower’s acceptance of an application was conditional upon cancellation of any existing policies with another insurer. Justice Nicholas held that it was reasonable to infer that, if such matters were regarded by Tower as important to it, it would have included appropriate information about them in the brochure.

(b) The application form completed by Mr Stone did not state that any cover available under the Tower policy was subject to cancellation of an existing policy. Tower knew that under its reinsurance contract, it was constrained as to the amount of cover it could provide. Therefore, Justice Nicholas held that, had Tower intended to draw the attention of an applicant who was the holder of an existing policy to such a requirement, the application form provided an obvious context in which to do so.

(c) Question 2(d) of the personal statement sought information regarding Mr Stone’s intention as to replacement of the Lumley policy with Tower’s policy. However, Justice Nicholas held that the very words of question 2(d) did not convey any meaning that failure to cancel the Lumley policy would disentitle Mr Stone to the insurance for which he was applying. Question 2(d) simply amounted to information to be taken into account by Tower in deciding whether to accept the risk. Nothing in the document suggested that it was not open to Mr Stone to hold both policies or that he would be denied liability if he did.

Justice Nicholas reinforced the importance of clarity and certainty in contracts of insurance that incorporate by reference other documents. Justice Nicholas stated that, for Tower to have achieved the conversion of question 2(d) into a condition of its policy, it was necessary for Tower to have informed Mr Stone, in clear terms, of the condition it required and that non-compliance by failure to cancel would discharge Tower from liability.
The intention of the parties as to the conditions of a contract is to be ascertained from the documents that evidence it. Where there is doubt or ambiguity, the courts will adopt the construction that is more favourable to the insured. Therefore, it is important that underwriters clearly and expressly set out the terms and conditions that they require in the formal insurance contract, and do not rely on personal statements or answers in proposal forms.
REINSURANCE

Distribution of the assets of an insolvent reinsurer

Case Name: New Cap Re v Faraday Underwriting

Citation: [2003] NSWSC 842, Supreme Court of New South Wales per Windeyer J

Date of Judgment: 12 September 2003

Issues:
- Section 562A Corporations Law (NSW)
- Section 116(3) Insurance Act 1973 (Cth)
- Distribution of liquidation assets of a reinsurance company

How do section 116(3) of the Insurance Act 1973 (Cth) and the Corporations Law (NSW) interact in determining priorities for distribution of the assets of a reinsurance company in liquidation? The Supreme Court of New South Wales considered this issue in determining the order of priorities.

The facts
New Cap Re was in the business of international reinsurance. It took out its own outward reinsurance in respect of liabilities under inwards reinsurance policies written by it. It went into liquidation in 1999. The recoveries under the outward reinsurance policies are substantial, but there was a significant shortfall. The court had to deal with how those recoveries would be distributed as between insurance creditors of New Cap Re and its general creditors.

The case was brought as a test case to guide the liquidator on how to deal with all creditors. The defendants to the proceedings comprised:

1. Lloyds Underwriting syndicates, which reinsured certain insurance risks with New Cap Re;
2. an Australian reinsurer that retroceded some of its risk to New Cap Re; and
3. a creditor of New Cap Re in liquidation.

The liquidator of New Cap Re sought directions on the application of s116(3) of the Insurance Act 1973 (Cth) (Insurance Act) and the priority provisions of the Corporations Law (NSW) (CL), particularly s562A, because these provisions were held to be the relevant legislation in force at the time the New Cap Re creditors resolved that the company should be wound up (ie 16 September 1999).

At this relevant time, s116(3) Insurance Act relevantly provided:

In the winding up of a body corporate authorised under this Act to carry on insurance business... the assets in Australia of the body corporate shall not be applied in the discharge of its liabilities other than its liabilities in Australia unless it has no liabilities in Australia.

Section 562A CL set out a regime for distributing the reinsurance proceeds of a company that is insured under a contract of reinsurance in respect of a relevant contract of insurance.

The decision
The court held that, by virtue of s109 of the Commonwealth of Australia Constitution Act (Cth), any inconsistency between s116(3) Insurance Act and the CL was to be resolved in favour of the former, as it was a Commonwealth statute.
Justice Windeyer considered that an inconsistency existed between these statutes and, therefore, held that, in accordance with s116 *Insurance Act*, New Cap Re’s Australian assets, including Australian reinsurance recoveries, are to be applied firstly to all Australian liabilities (and not just policy-holding creditors). Justice Windeyer stated that claims under reinsurance policies will normally be situated where the reinsurance company, as debtor, resides (except where the policies are governed by a different jurisdiction, which was not the situation in this case). These claims, therefore, were held to be assets in Australia.

Justice Windeyer held that the second priority is governed by s562A CL. This means that s562A only applies to give a priority to policy holding creditors in relation to:

- any excess Australian reinsurance assets that have not been exhausted by Australian liabilities; and
- any foreign reinsurance recoveries.

With respect to the proper construction of s562A CL, the court was faced with the following alternatives for the distribution of reinsurance recoveries:

- direct matching (ie to those policy holding creditors whose insurance policies match the reinsurance policies under which the recoveries were made);
- narrow pooling (ie to those policy holding creditors whose claims actually produced a reinsurance recovery); or
- broad pooling (ie to all policy holding creditors).

Justice Windeyer favoured the broad pooling approach. This meant all creditors would be treated equally.

Finally, Justice Windeyer held that the general priority provisions in the CL provided the final priority.

With respect to the conflict between s116(3) *Insurance Act* and the CL, Justice Windeyer made the comment that ‘it is likely and almost certain that no one gave the slightest thought to the conflict between the provisions, so one should not think that the legislative intent can be found’. He further noted that there is an urgent need for amending legislation to make clear the intentions so that the problems dealt with in his judgment do not arise again.

**Appeal**

New Cap Re and its liquidator, the second defendant, AssetInsure Pty Limited (formerly Gerling Global Reinsurance Company of Australia Pty Limited) and the third defendant, Faraday Underwriting Limited, have appealed this decision on various grounds.

Firstly, New Cap Re and its liquidator assert that s562A is not intended to capture reinsurance for reinsurance contracts (ie retrocession); rather, it is limited to reinsurance for insurance contracts.

AssetInsure Pty Limited’s appeal focuses on Justice Windeyer’s finding that the reinsurance contracts relating to Faraday Underwriting Limited’s interests are ‘liabilities in Australia’ within the meaning of s31(4) of the *Insurance Act.*
Finally, Faraday Underwriting Limited contends that:

- s116(3) of the *Insurance Act* is purely directory and does not give rise to a priority to be recognised by the liquidator in the distribution of assets in Australia; and
- s116(3) of the *Insurance Act* has no effect on this liquidation because it was repealed by the *General Insurance Reform Act 2001* (Cth) or the *Corporations Act 2001* (Cth).

Alternatively, Faraday Underwriting Limited contends that:

- the judge erred in determining the order of priorities; and
- any recoveries under reinsurance contracts are to be distributed in accordance with s562A CL without regard to s116 *Insurance Act* and only thereafter may the assets in Australia be distributed in accordance with s116 *Insurance Act*.

This case determines that the order of priority for the liquidation assets of a reinsurance company is as follows:

1. liabilities in Australia are to be satisfied out of assets in Australia (s116(3) *Insurance Act*);
2. foreign reinsurance recoveries and any reinsurance assets in Australia not exhausted by the first priority are to be distributed to all policy holding creditors (s562A CL); and
3. thereafter, the liquidation assets are to be distributed in accordance with sections 555 and 556 CL.

However, it remains to be seen whether various assets of this decision will be overturned on appeal.
Case name:
Allianz Australia Insurance Ltd v General Cologne Re Australia Ltd

Citation:
[2003] NSWSC 144, Supreme Court of New South Wales per McClellan J

Date of judgment:
13 March 2003

Issues:
- Reinsurance
- Cover for ‘aggregate stop-loss protection’

In construing the terms of a reinsurance policy between a reinsurer and a further reinsurer, Justice McClellan of the Supreme Court of New South Wales took account of the pre-contractual conduct of the parties to conclude that the extent of cover under the further reinsurance policy was not the same as that provided in the policy between the reinsurer and the original insurer.

The Solicitors Liability Committee of Victoria (the committee) provided professional indemnity insurance to solicitors in Victoria during the period from 31 December 1989 to 31 December 1990. The committee obtained reinsurance for part of that risk from Switzerland General Insurance Co Ltd (SGI) (being a related company of the plaintiff). SGI in turn effected reinsurance of its risk with the defendant, then known as Reinsurance Co of Australia Ltd, and now known as General Cologne Re Australia Ltd (GCR).

The policy between the committee and SGI firstly provided ‘per claim excess of loss protection’ for up to $400,000 including costs, per claim, paid by the committee where the claim against the committee exceeded $200,000. The first $200,000 of any claim was retained by the committee. Secondly, the policy provided ‘limited aggregate loss protection’ for up to $2 million for all claims, when the aggregate loss of all claims paid by the committee for the period of the risk exceeded $10 million. Under the policy, this aggregate loss would comprise the accumulation of the individual claims up to $200,000 that were retained by the committee, together with any amount by which any individual claim exceeded $600,000, inclusive of costs.

Relevantly, the policy between SGI and GCR provided SGI with aggregate stop-loss protection ‘in respect of aggregated claims in respect of the committee’s $200,000 any one claim retention’. The issue of contention was whether GCR had also agreed to provide reinsurance cover for any amount by which individual claims exceeded $600,000 (as per the policy between the committee and SGI), notwithstanding that this was not referred to in the policy between SGI and GCR.

SGI argued that the phrase, ‘in respect of aggregated claims in respect of the committee’s $200,000 any one claim’ was merely a shorthand description and the true nature of the reinsurance should be understood as including a liability calculated by reference to any claim for $200,000 and, in addition, any amount that might cause the total of any one claim to exceed $600,000.
In a nutshell, SGI argued that, in light of industry practice and the fact that the policy between SGI and GCR expressly stated that it incorporated the terms and conditions of the policy between SGI and the committee, it was unreasonable to suppose that the parties to the further reinsurance contract were intending to cover something less than what SGI was providing to the committee.

Justice McClellan rejected the plaintiff’s submissions and held that GCR’s liability could only derive from the $200,000 any one claim retention by the committee. The judge considered that there was some difficulty in construing the terms of the policy between SGI and GCR and, in accordance with established authority, held that it was proper to admit and utilise pre-contractual conduct to resolve the difficulties. He referred to conversations and correspondence between relevant representatives of SGI and GCR leading up to the placement of the further reinsurance contract. These communications referred only to the committee’s $200,000 retention. They showed that ‘reinsurance was neither sought nor provided for any part by which a claim exceeded $600,000.’

Justice McClellan’s judgment also deals with a second issue: the efficacy of various deeds of assignment relating to the original reinsurance contracts. This issue largely turned on the facts, and did not need to be decided having regard to Justice McClellan’s views on the construction issue.

This decision demonstrates the primary importance placed by courts on the actual wording of the policy but also shows that courts will, in appropriate circumstances, resort to pre-contractual conduct to resolve any difficulties in the construction of the policy. This is important in relation to reinsurance contracts where often the commercial purpose will not be apparent from the relatively brief wording used in the slip.
Multi-year contracts: pitfalls facing reinsurers seeking to invoke review clauses

Case Name:
Charman v New Cap Reinsurance Corporation Limited (in liquidation)

Citation:
[2003] EWCA Civ 1372, English Court of Appeal per Potter LJ, Rix LJ and Holman J

Date of Judgment:
16 October 2003

Issues:
- Meaning of ‘extraordinary claims developments’ in the context of a review clause within a multi-year reinsurance contract
- Whether on the facts there were ‘extraordinary claims developments’ so as to entitle the reinsurer to invoke the review clause
- Whether the review clause had in fact been invoked in any of the relevant years

The facts
Mr Charman, as representative of two marine syndicates, reinsured his whole account with two reinsurance companies carrying on business in Australia: GIO Insurance Limited (now known as Gordian RunOff Limited) and New Cap Reinsurance Corporation Limited, now in liquidation (New Cap). The policy was to cover losses for the three-year period beginning 1 January 1997. Under the terms of the policy, New Cap retained the right to increase the annual premium payable at the anniversary date in certain prescribed circumstances, one of which was in the event of ‘any extraordinary claims developments’.

By the end of the first year and in the face of significant losses, New Cap sought to cancel the contract; alternatively, it sought to revise the existing terms on the basis that there had been an ‘extraordinary claims development’. The syndicates disputed New Cap’s right to cancel the contract or to revise the terms. The dispute escalated, with New Cap seeking to avoid the contract and raising a number of other policy coverage defences.

The decision
By the time the matter came to trial in the Commercial Court four years later, New Cap had abandoned all of the avoidance and cancellation claims and the additional policy points, and relied only on the review clause. New Cap asserted that there had been an ‘extraordinary claims development’ and, as no increased premium had been agreed, the review clause entitled New Cap to terminate the policy at the end of the first year (1997). The issues to be determined were:

i) whether there was, as a matter of fact, an ‘extraordinary claims development’ so as to entitle a review of the premium to be paid for either the 1998 or 1999 years of account; and

ii) if so, whether a review of the premium had in fact been invoked by New Cap.

The court at first instance found for New Cap on both these issues but in relation to the 1999 year of account only. Significantly, the court found that the claims performance of the syndicates during the first year was ‘pretty awful’ but not ‘extraordinary’, the test being whether a hypothetical informed bystander when faced with a development would react by saying ‘I don’t believe it’. The position was, however, different for the 1998 year of account, as New Cap were being called upon to pay the full limit and the claims were some US$50 million more than for the 1997 year. This, said the judge, would have resulted in the required disbelief in an informed bystander. The finding that an ‘extraordinary claims development’ did not occur in the first year was not challenged on appeal.
As to the second issue, the judge held that the correspondence at the end of 1997 had validly invoked the clause for 1998 and 1999, notwithstanding that the notice given at the end of the first year was invalid because the event that triggered the review clause (‘an extraordinary claims development’) had not occurred in the first year. In reaching this conclusion, the judge said that it would be ‘unfair, uncommercial and wrong, I think, to say that the reinsurers would not have been able to insist on a review for the 1999 year, in light of the extraordinary claims development which had come to light in 1998’.

It was this second issue that was the subject of the successful appeal by the Syndicates. The Court of Appeal adopted a strict application of contractual principles in holding that it was impossible to reach a finding that the invalid invocation of the premium review clause at the end of the first year was a continuing act such that it was still effective in terminating the relationship at the end of the second year of the contract. Nor was there any basis for an argument of waiver or estoppel on the part of the syndicates.

The Court of Appeal expressly referred to the Commercial Court judge’s comments that that interpretation would lead to an ‘unfair’ and ‘uncommercial result’ and rejected the comments as providing no basis for a decision on the facts.

At the end of his leading judgment, Mr Justice Rix concluded as follows:

… It seems to me that in such circumstances it is for commercial men to look out for themselves. There was no overreaching by the syndicates, no waiver or any representation by them that relieved New Cap of its duty to have regard for its own interests, but only a mistaken claim by New Cap to a right to increase its premium in respect of the 1988 year, a wrongful attempt to cancel or avoid a contract, and a failure by it to exercise what has in the end emerged to be an opportunity to increase its premium in respect of the 1999 year.

This decision provides a warning that reinsurers must be on guard to protect their commercial interests strictly in accordance with the terms of the reinsurance contract. An appropriately worded notice must be given at an appropriate time in order to invoke the exercise of a right of review. All possibilities need to be considered in case the exercise on one occasion is invalid, but it may be valid on another occasion. Reinsurers having any doubts should seek legal advice before purporting to exercise their rights.
Film finance insurance: reinsurer able to rely on breach of warranty not contained in insurance contracts

Unlike the more usual film finance scenario, where insurance is based on the risk of a revenue shortfall on a specific film or slate of films, this case concerned insurance of the risk of default by a start-up film company on repayment of the capital of the company.

Destination Film Company (Destination) received finance of $100 million, to be repaid within five years. Sixty per cent of the risk of default was insured by New Hampshire. Of that, about 37 per cent was reinsured. When Destination became insolvent, the reinsurers sought declarations that they were not liable under the reinsurance contracts between them and New Hampshire. They alleged breaches of two warranties in the reinsurance slip.

The first such warranty stated that the employment of Mr Stabler (a ‘creative mind’ behind the film project) by Destination must continue throughout the policy period. This did not happen. There was no equivalent provision in the insurance policy. New Hampshire contended that the provision was to be read in the context of the insurance policy and the fact that the insurance and reinsurance policies were understood by the parties to exist ‘back-to-back’. However, even read in this context, the court found that there was a breach of the warranty that Mr Stabler’s employment be maintained. The warranty was to be inferred from the plain meaning of the words used. It was also supported by the fact that Mr Stabler’s role and involvement in Destination was likely to be crucial to its success. The reinsurers were thereby discharged from their obligations under the contracts.

The reinsurers also claimed that New Hampshire breached a warranty requiring it to retain 20 per cent of its original subscription. They relied on the following wording on the reinsurance slip: ‘Ceding Company retains 20 per cent (with Reinsurance)’. Acknowledging the ambiguity of the relevant wording, Justice Langley held that to infer a warranty of retention would require a provision expressed with ‘greater clarity than this one’. He observed that there is a contradiction in terms between ‘retaining’ a full line and ‘reinsuring’ it. He confirmed the words as doing no more than restarting the effect of the particular reinsurance slip.

New Hampshire then sought to recover its losses from its broker, who handled both the insurance and reinsurance, for failing to bring the Stabler provision in the reinsurance slip to its attention. The broker claimed contributory negligence against New Hampshire for failing to make its own inquiries as to the terms of the insurance and reinsurance. The broker’s claim failed, largely because New Hampshire did not receive notice of the terms of the reinsurance until it was too late. New Hampshire was therefore entitled to recover damages from the broker without any reduction for contributory negligence.
While acknowledging that the ‘Stabler provision’ might operate ‘uncommercially’, the wording was not so ‘absurd’ as to enable the court to search for an alternative meaning. Despite the discrepancy between the insurance and reinsurance policies, Justice Langley refused to override the express terms of the reinsurance contract to imply that the reinsurers’ liability should mirror that of the insurer.
’Follow the settlements’ clauses in contracts of reinsurance: when will a reinsurer be bound to follow a settlement made?

Case Name: Assicurazioni Generali SpA v CGU International Insurance PLC & Ors

Citation: [2003] EWHC 1073, English High Court of Justice per Gavin Kealey QC

Date of Judgment: 2 May 2003

Issues:
- The proper construction of ‘follow the settlements’ clauses in contracts of reinsurance
- Meaning of ex gratia

When must a reinsurer indemnify a reassured under a ‘follow the settlements’ provision in a contract of reinsurance? The English High Court set out the true meaning and scope of ‘follow the settlements’ provisions in contracts of reinsurance, holding that it is not necessary for the reassured to prove that the loss fell within the risks covered by the underlying policy of insurance. Subject to ‘two provisos’, reinsurers will be bound by settlements made, even if it appears that they could prove, after trial, that there was in fact no liability under the original insurance cover.

The plaintiff, Assicurazioni Generali SpA (Generali) was reassured by the defendants and Lloyd’s syndicates in relation to ‘erection all risks’ (EAR) insurance cover provided to Pirelli Cables Inc (Pirelli) for a project for the supply and installation of three single-armoured, high-density, submarine power cables in Quebec, Canada. Generali had an arrangement with Continental Insurance Company (CIC), under which CIC would ‘front’ risks in Canada for Generali (CIC then reinsured 100 per cent risk to Generali) in consideration for a ‘fronting fee’ of 11 per cent of the premium. The defendants and their co-reinsurers at Lloyd’s, in turn, reinsured Generali.

Generali settled a claim made by Pirelli under the original contract of insurance. The Lloyd’s syndicates paid out their share of the claim to Generali. Generali sought summary judgment against the other co-reinsurers (the defendants), seeking an order that they pay out their proportion of the claim. The defendants argued that the loss fell outside the terms of the contract of reinsurance because it fell outside the original contract of insurance.

The ‘follow the settlements’ provision was in the following terms:

CONDITIONS: As original: anything herein to the contrary notwithstanding, this reinsurance is declared and agreed to be subject to the same terms, clauses and conditions, special or otherwise, as the original policy or policies and is to pay as may be paid thereon and to follow without question the settlements of the Reassured except ex-gratia and/or without prejudice settlements.

The court noted that the intention of ‘follow the settlements’ provisions in contracts of reinsurance is for the insurer ‘to get around the need to prove their loss by proving an insured loss of original subject-matter.’ (Lord Justice Hobhouse in Toomey v Eagle Star Insurance Co Ltd [1994] 1 Lloyd’s Rep 516, 523.)

The court endorsed the decision of the Court of Appeal in The Insurance Company of Africa v Scor (UK) Reinsurance Company Limited [1985] 1 Lloyd’s Rep 312 (Scor) as the leading authority on the meaning of the words ‘follow the
settlements’. The judgment of Lord Justice Robert Goff in that decision set out ‘two important provisos’ to the proposition that the words ‘follow the settlements’ bind reinsurers to a compromise made by the insurers. The two provisos are:

1. the claims recognised by the insurers must fall within the risks covered by the contract of reinsurance as a matter of law; and
2. the insurers have an implied obligation to act honestly and take all proper and businesslike steps in making the settlement.

Based on this authority, the court stated that: ‘subject to the application of the two provisos, the effect of the follow the settlements wording is that the reinsurers are obliged to indemnify the insurers in respect of their compromise of the original assured’s claim on both any question of liability and also any question of amount.’

The court explained the meaning of the ‘first proviso’: that the claim must fall within the risks covered by the contract of reinsurance ‘as a matter of law’. The factual and legal ingredients of the settlement of the claim by the insurers may need to be examined in order to ascertain whether the claim falls within the reinsurance as a matter of law. This is the case even where the contract of insurance and the contract of reinsurance are back-to-back and subject to identical terms.

The court provided examples of situations where a claim would not fall within the risks covered by the contract of reinsurance ‘as a matter of law’. One example is where the insurers waive reliance on exclusion clauses – the court said that the reinsurers would still be able to rely on any such exclusion clauses in their own contract of insurance. Another example is where the insurers overlook an exclusion altogether and settle a claim. This situation is to be compared, however, with where the insurers considered the application of the exclusion clause but determined that it did not apply: such claim would fall within the loss covered by the contract of reinsurance as a matter of law.

The court emphasised the view of Justice Evans in Hiscox v Outhwaite (no 3) [1991] 2 Lloyd’s Rep 524 that ‘the insurers may be able to recover an indemnity from their reinsurers in respect of settlements of claims which arguably as a matter of law fell within the scope of the original contract regardless of whether a court might in fact hold, after full argument, that they did not.’ It seems, therefore, that, provided an insurer can show it genuinely considered the claim as falling within the terms of the original insurance cover as a matter of law, it is irrelevant to the question of whether the loss falls within the contract of reinsurance that there might be an argument that it did not fall within the original insurance.

Gavin Kealey QC, sitting as Deputy High Court Judge, stated that this conclusion ‘does not leave the reinsurers unreasonably exposed to, or vulnerable to capricious or unreasonable behaviour on the part of insurers.’ The second proviso outlined above, that insurers have an implied obligation to act honestly and take all proper and businesslike steps in making the settlement, should be enough protection for reinsurers.

Furthermore, the fact that Generali was not the insurer of the original assured, and that CIC was ‘interposed’ as a ‘front’ for Generali, made no difference to the
decision of the court on the facts of the case. Although there was no indication in
the contractual relationship between Generali and the defendants that Generali
was not the direct insurer of the original assured, the evidence was that Generali
‘behaved’ as if it was the direct insurer of the original insured.

The court also held that, on the facts, the settlement of the claim was not an ‘ex
gratia’ payment. This decision was based on the principles outlined above. Gavin
Kealy QC pronounced the meaning of ‘ex gratia’ in this context:

I consider that the exception of ex gratia settlements covers settlements where the basis
on which they were made was that there was no liability to indemnify. ... If, however, the
real basis on which the claim was settled and so recognised was an arguable liability to
indemnify which, by the settlement, was admitted or compromised, the settlement would
not be ex gratia and the question whether or not there was in fact a liability to indemnify,
something that might be established after trial, is irrelevant.

The case demonstrates that a reinsurer will not be permitted to
look behind the terms of a settlement made by an insurer when
considering its own liability under a ‘follow the settlements’
provision. As long as the insurer can show evidence of some
genuine dispute by it as to whether the claim fell within the
original insurance, the claim will fall within the contract of
reinsurance. This is the case even if it could be proved, at trial,
that the insurer was not actually liable for the claim under the
original insurance. Provided then that the insurer acted honestly
and took all proper and businesslike steps, a reinsurer will be
bound to follow the settlement made.
Avoiding contracts of reinsurance for misrepresentation

**Case Name:**
Assicurazioni Generali SpA v Arab Insurance Group (BSC)

**Citation:**
[2002] EWCA Civ 1642, English Court of Appeal per Ward LJ, Clarke LJ and Sir Christopher Staughton

**Date of Judgment:**
13 November 2002

**Issues:**
- Avoidance of contracts of reinsurance
- Misrepresentation as to participation of another reinsurer
- Non-disclosure of imprudent or unusual reserving policy

Can a reinsurer avoid a reinsurance contract because of misrepresentation of another reinsurer's participation or non-disclosure of an imprudent reserving policy? The UK Court of Appeal found that it could, but only if it proved that it would not have taken its quota share if it had known the other reinsurer's true participation or had received more accurate reserving data.

Assicurazioni Generali (Generali) reinsured a package of builders' risks on United States construction projects and retroceded part of the risk to Arab Insurance Group (ARIG) and others. Generali engaged loss adjusters (G&T) to investigate claims and recommend reserves. ARIG began accepting premiums from 1992 but on 7 February 1999 refused to continue paying claims. Generali commenced proceedings against ARIG who, by way of defence, sought to avoid the contract of retrocession. Unsuccessful at trial, ARIG appealed, reasserting avoidance of the contract on two grounds:

1. misrepresentation of Munich Re's participation in the retrocession; and
2. non-disclosure of G&T's imprudent or unusual reserving policy.

Both grounds were rejected on appeal (with Lord Justice Ward dissenting on the first).

The court found that Generali had misrepresented Munich Re's participation by not clarifying that it accepted risk in only one section of the package. This misrepresentation was accepted as material to ARIG's decision to participate but the majority found that it did not constitute inducement. As ARIG could not establish that it would not have participated on the same terms but for the misrepresentation, it failed to prove that the misrepresentation caused it any loss and ARIG was not entitled to avoid.

G&T's policy was to set zero reserves until the circumstances of a claim could be thoroughly investigated and an accurate reserve set. Lord Justices Clarke and Ward found nothing imprudent or unusual about this policy, holding that a zero-reserves policy would only be imprudent if investigations were taken to the extreme and reserves were never set before losses were determined. Since there was no relevant non-disclosure so far as the reserving policy was concerned, questions of materiality and inducement therefore did not arise, but the court noted in any event that ARIG had not established that disclosure of the reserving policy or more accurate data would have influenced its decision to participate.
This case illustrates the principles applicable to reinsurers seeking to avoid contracts of reinsurance on grounds of misrepresentation or non-disclosure. Reinsurers should make thorough inquiries before assuming risk because they will be able to avoid contracts only if they can prove, on the balance of probabilities, that accurate representation and disclosure would have affected their decision to participate on the terms agreed.

Although this is a UK case, similar principles are likely to apply in Australia in those instances where the Insurance Contracts Act does not apply. This would include all reinsurance contracts.
Case Name:  
Johnson Tiles Pty Ltd v Esso Australia Pty Ltd

Citation:  
[2003] VSC 27, Supreme Court of Victoria per Gillard J

Date of Judgment:  
20 February 2003

Issues:
- Proof of damage
- Duty of care to avoid purely economic loss
- Duty of care to avoid property damage

Facts
The plaintiffs, on their own behalf and representing the interests of others, sought compensation from the defendants for damage and losses incurred as a result of an explosion at the Longford gas processing plant in Victoria, resulting in the interruption and cessation of the state’s gas supply. The explosion occurred on 25 September 1998 at the plant controlled and operated by the defendants. Gas was restored to customers on or about 6 October 1998. The lack of gas led to some customers suffering damage to materials and plant, and they and others incurring substantial economic loss.

Three groups were represented by the plaintiffs:
1. business users: gas users for the purpose of operating a business, who suffered damage to property and/or pecuniary loss as a result of the September stoppage;
2. domestic users: gas users for domestic purposes who suffered damage to property and/or pecuniary loss as a result of the September stoppage; and
3. stood-down workers: persons who were stood down from their employment because of the September stoppage and suffered pecuniary loss as a result.

The gas users had no contractual relationship with the defendant gas suppliers, Esso Australia Pty Limited (Esso). There was a contract between Esso and Gascor, a contract between Gascor and the retailer who sold gas as its agent, and a contract between the retailer and the gas customer. The contract between Esso and Gascor contained an exclusion of liability for economic loss. The contract between the retailer and the customer provided that the retailer would not be liable for any cessation of supply unless caused by its own negligence.

The decision
The main issue in the proceeding was whether Esso owed a duty of care to the plaintiffs or any member of the groups they represented. Esso did not deny the breach of duties, although it denied that it owed any duties of care. To establish the existence of duties of care, Justice Gillard first identified the particular losses by the plaintiffs and group members. The damage claimed in the proceeding was either property damage (including consequential economic loss), or purely economic loss. Substantial evidence was given by individual group members as to the type of loss suffered.

In relation to members of the domestic users group, Justice Gillard reached differing conclusions as to whether the loss claimed was caused by the gas stoppage. Users who had bought electrical appliances were held to have suffered...
purely economic loss. A claim by one user that the stoppage caused the destruction of a gas storage, hot-water service failed.

Findings as to members of the stood-down workers group also differed. One worker who took paid annual leave during the gas stoppage was held to have not suffered any economic loss, but, rather, mere inconvenience. Another worker who was stood down during the stoppage and lost net wages of $398.76 was held to have suffered a pecuniary loss as a result of the gas stoppage. Clearly, all members of this group suffered economic loss only.

Justice Gillard made detailed reference to the development of the common law in relation to duty of care, specifically in the context of purely economic loss and property damage. He noted the reluctance of courts to allow recovery for purely economic loss, given the concern that claims may have no boundaries and an act of negligence may permeate into many diverse areas.

Justice Gillard held that a reasonable person in the shoes of Esso would have reasonably foreseen the chain of events after the explosion, leading to the stoppage of the gas supply. Furthermore, the damage was not too remote to preclude the finding of a duty of care. The defendants submitted that to impose a duty of care would be an unreasonable and disproportionate burden. Justice Gillard rejected this submission, stating that it ‘defies logic, common sense and the principles of corrective justice that a duty of care should depend on whether there are two victims instead of one million victims’.

Justice Gillard held, on the facts, that the duty of care only extended to loss for property damage. Esso did not owe any duty of care to avoid economic loss to the domestic users or stood-down workers. It only owed a relevant duty of care to the business users who had suffered property damage. As a result, the business users were entitled to recover their property damage from Esso and any economic loss resulting from that damage.

Justice Gillard found against a duty of care to avoid purely economic loss for a number of reasons. Firstly, gas customers are aware that there is no guarantee of uninterrupted supply. They are in a far better position to assess their likely loss due to interruption of supply and, if insurance is the preferred means of minimising loss, they can take out insurance, based upon a reasonable assessment of the likely harm, and factor the expense of the premium into the price of their products or services. Secondly, the gas customer and the defendants are the beginning and the end of the supply chain, joined by contracts that deal with the basis upon which the parties supply and purchase. The parties have defined their rights, obligations and expectations, and they should be left to their contractual arrangements to determine their rights and duties. Thirdly, given that the state, through Parliament, regulates all aspects of the gas industry, it should be for the state to decide, after proper consultation, investigation and consideration, whether the gas producer should be liable to the community for a stoppage of supply.

Justice Gillard concluded that finding that Esso did not owe a duty of care to avoid purely economic loss in the circumstances of the case would not act as an inducement to the defendant to approach its gas processing with less care. He ultimately held that the plaintiffs had failed in their claims and that Esso was
entitled to judgment against them. Only two members of the business users group were entitled to compensation as a result of property damage: Barrett Burston, which had to dispose of barley being processed to produce malt as a result of production ceasing at its plant; and Nando’s Australia Pty Ltd, which had to destroy chicken stock that was not cooked in time.

This case demonstrates the limited circumstances in which a duty of care to avoid pure economic loss will be found to exist. The case should be contrasted with the High Court decision in *Perre v Apand*. Of significance in this case was the fact that the imposition of a duty of care extending to pure economic loss would be inconsistent with the contractual rights and obligations established through a claim in contract from the supplier to the customer. Similar principles would apply to the sort of contractual arrangements that exist in many industries, particularly the mining, building and construction industries.
Occupier's liability: High Court on duty to warn

Case Name: Hoyts Pty Ltd v Burns

Citation: [2003] HCA 61, High Court of Australia per McHugh, Gummow, Hayne, Callinan and Kirby JJ

Date of Judgment: 9 October 2003

Issues:
- Occupier's liability
- Failure to warn entrants upon premises of risk
- Whether warning would have prevented injury

Hoyts successfully appealed to the High Court against a finding that it was negligent for failing to warn patrons of the risks associated with self-retracting cinema seats.

The respondent, Ms Burns, was working as a teacher's aide with disabled children when she attended Hoyts' Cinema in Bankstown, Sydney. During the movie, she left her seat to retrieve a screaming four-year-old boy who was in her care. Unaware that the seats automatically retracted, she sat back down on the metal support structure of the upright seat, injuring her tailbone.

Ms Burns alleged that Hoyts was negligent in failing to warn her about the automatic retraction of the seats. In her initial submission, Ms Burns claimed that the seats were inherently dangerous. The 'failure to warn' argument was put forward only after she sought leave to adduce further evidence. After the primary judge found that the seats were not inherently dangerous, the case proceeded on the basis of a failure to warn.

The claim was rejected at first instance. The primary judge was not satisfied that a warning would have had any impact upon Ms Burns' conduct in the circumstances. Ms Burns' evidence on this issue was described by the judge as 'unreliable' and based on 'mere speculation'.

The decision was reversed on appeal, on the basis that a reasonable person in the position of the appellant would have foreseen the risk and that there should have been a warning sign in the foyer.

Hoyts then appealed to the High Court. Unanimously upholding the appeal, the High Court found that the Court of Appeal had given insufficient regard to what Ms Burns would have done had a warning sign been erected, particularly in light of the fact that she had been distracted by a highly agitated child at the time. The court held that Ms Burns' movements in seating herself were more impulsive than conscious and deliberate. It was also relevant – but not decisive – that Ms Burns had not raised the failure to warn in her initial submission.

Given the absence of a causal nexus between the injury and the lack of warning, it was not necessary for the court to decide whether Hoyts had failed to discharge its duty of care by not providing a warning.
However, the joint reasons for judgment contain a useful examination of the relevant authorities on an occupier’s duty to provide warning signs. The court concluded that considerations relevant to the obligation to provide a warning notice will include:

1. whether the occupier has an economic or other interest in the entry of the plaintiff;
2. whether, because of previous incidents, public discussion or otherwise, the occupier could be expected to know of any particular risks against which warnings should be given;
3. whether there was any hidden feature of the place or activity which might not be plain to an ordinary entrant but that should be known to, or reasonably discoverable by, the occupier, calling for a warning;
4. whether, if the risk eventuated, the consequences were thought to be minor or significant for the person affected;
5. whether the imposition of a requirement to give notice could be confined to a particular place or places, or would have large implications, or cost consequences; and
6. whether the nature of the activity in question was such as to render the presence of the sign irrelevant to the actual prevention of injury.

This case revisits the familiar concept of occupiers providing warnings to people who enter their premises. It is a useful summary of some of the considerations that may be relevant to whether there is an obligation to provide such a warning.
New South Wales Court of Appeal overturns jury negligence verdict based on failure to warn

Case Name:  
*Waverley Municipal Council v Swain*

Citation:  
[2003] NSWCA 61, New South Wales Court of Appeal per Spigelman CJ and Handley and Ipp JJA

Date of Judgment:  
3 April 2003

Issues:  
- Negligence  
- ‘Inherent’ or ‘obvious’ risks  
- Jury verdict  
- Whether verdict against the evidence

In this case, the New South Wales Court of Appeal considered whether a jury had reached its verdict against the evidence presented. The jury found that Sydney’s Waverley Council had breached its duty of care to Mr Swain, who became a quadriplegic after diving into the water at Bondi Beach.

The facts
On 7 November 1997, Mr Swain visited Bondi Beach with his friend, Ms Galvin, and her flatmate, Mr Wilson. Although both men had consumed one 750ml bottle of full-strength beer each, Mr Swain gave evidence that he was not adversely affected by the alcohol. There was no evidence to the contrary.

Mr Swain later went for a swim, allegedly between the flags, although this fact was disputed by Waverley Council. While in the water, he dived under a wave and allegedly struck a sandbar, causing injuries that rendered him a quadriplegic.

In the first instance, a jury found that Waverley Council breached its duty of care in:

(a) failing to warn of the risk of a sandbar; and  
(b) the placement of flags on the beach.

The decision
Although there were numerous grounds of appeal, the decision of the Court of Appeal turned on the question of whether the findings of breach of duty were against the evidence or the weight of the evidence. This was considered in relation to both the failure to warn, and the placement of the flags.

Chief Justice Spigelman formulated the issue in the following terms:

…should the Council have provided some kind of warning of the risk and/or should it have ensured that the position of the flags was such as to avoid a section of the beach where there was a sudden rise in the sand level of the character suggested in the evidence in this case?

The failure to warn
The Chief Justice noted that in cases involving warning, or more precisely the lack of warning, one of the factors to be considered is the degree of obviousness of the risk, which may lead to an examination of whether a warning would have made a difference, and the level of reasonableness of the conduct suggested to have been necessary to avoid or minimise the risk.
Chief Justice Spigelman then noted that:

…no person attending an Australian beach could fail to know that there are sudden variations in the sand level under water … There is an element of hidden danger involved in the inability to see the formation of the floor beneath an oncoming wave. Unlike the slip and fall cases…, the Council officers are in a better position to assess the risk because they have elevated viewing platforms. However, unlike many other cases of hidden danger… the fact that any danger was hidden was itself quite apparent to the swimmer…

The Chief Justice assessed the degree of obviousness of the risk of diving into a wave without knowing the formation of the floor as high, although not at the end of the spectrum described as ‘inherent in body surfing’ in *Prast v Cottesloe*.

Chief Justice Spigelman considered that:

- the risk was obvious;
- given the nature and size of the beach, warning signs would have to run along the entire length of the beach;
- the positioning of the signs would be a difficult task to assure that all who approach the water see them;
- the wording of the warning would be required to cover a wide range of risks associated with swimming; and
- a warning would need to be provided in a variety of languages.

He concluded that there was no evidence before the jury to justify a finding that the council had breached its duty of care to beach users by failing to warn them about the dangers in diving, arising from underwater sand formation. Justices Handley and Ipp agreed.

**The placement of the flags**

However, in respect of the issue concerning the placement of flags on the beach, the Chief Justice considered that the placement involves an indication that bathing between the flags is reasonably safe. While the flags are not an assurance of safety, they give rise to an assumption of responsibility on the part of Waverley Council.

Chief Justice Spigelman held that it was open to the jury to infer that the council officers had failed to have regard to the hazard involved in the existence of a steep and sudden increase in the level of the sand when placing the flags and that there was evidence of breach before the jury. He held that the verdict was not against the weight and dismissed the appeal on this ground.

Justices Handley and Ipp disagreed.

Although the majority agreed with the Chief Justice’s comment that ‘placement [of the flags] involves an express indication that bathing between the flags is reasonably safe’ (emphasis added), they held that this indication does not extend to the activity of diving.
Justices Handley and Ipp held that there was no evidence to sustain a finding of negligence on the part of Waverley Council in the flag placement, and noted that:

The risk of channels and sandbar close to the shore, are ... well-known and can only be avoided by not diving or diving with care. When one dives into a wave over a channel close to the shore there is an inherent and well-known risk of encountering a sandbar. (emphasis added)

By majority, the appeal was dismissed.
No duty to provide pool fencing when risk of injury is obvious

Case Name: Waterways Authority & Anor v Mathews

Citation: [2003] NSWCA 330, New South Wales Court of Appeal per Meagher, Handley and Sheller JJA

Date of Judgment: 12 November 2003

Issues:
- Liability of a public authority
- Occupier’s liability
- Duty of care
- Obvious risks

Where a person who is affected by alcohol, subject to giddy fits and fully aware of a risk, voluntarily climbs along a narrow poolside ledge and falls onto rocks, the lessor and lessee of the property will not be liable for failing to build a fence. The risk is so obvious that there is no duty of care.

Facts
This was an appeal by two defendants against a judgment and verdict awarded to the plaintiff in the District Court.

The facts were that the respondent fell 2.4 metres from the end of a harbourside pool onto exposed rocks. The accident occurred at 4am and only a day after the respondent had experienced an attack of ‘dizzy fainting’. The respondent had also consumed seven glasses of wine earlier that night.

The first appellant, the Waterways Authority (the authority), was the lessor of the land on which the pool was constructed. The second appellant was the occupier and lessee of the property.

The respondent sued the first appellant, the authority, for its failure to erect a fence, wall or chain around the pool such that a person in the position of the respondent would not fall. The second appellant was sued for not lodging an appropriate request for such a fence, wall or chain to be erected.

Judgment
The lead judgment was delivered by Justice Meagher, with whom Justice Handley agreed. Justice Sheller delivered a brief judgment in agreement with Justice Meagher.

Justice Meagher considered that neither appellant owed a duty of care to the respondent, who, ‘fully knowing the risk, affected (even if slightly) by liquor, and subject to giddy fits, climbed voluntarily at the dead of night along a narrow (and probably slippery) ledge.’ He acknowledged that the duty of care owed by an occupier of land to an entrant is high, such that negligence on the part of a plaintiff will not automatically negate a defendant’s duty of care. However, in this case, he considered the risk was so clear. That is,

It was obvious to anyone who knew the site that there was a risk of falling if one walked along either the upper or lower ledge, a risk which was magnified if the ledge was wet and slippery. That fact was obvious to the respondent, and was equally obvious to both appellants.
Justice Sheller quoted from the judgment of Justices Toohey and Gummow in *Romeo v Conservation of the Northern Territory* (1998) 192 CLR 431 to the effect that an occupier of land is not obliged to ensure, by whatever means, that anyone coming onto their land will not suffer injury by ignoring an obvious danger.

This case clearly demonstrates that although the general rule is that there will be a duty of care owed by an occupier of land to an entrant, this will not always be the case. Where the risk is obvious, the occupier is not obliged to ensure, by whatever means, that those entering the property will not suffer injury by ignoring such a danger.
Case Name: Mulligan v Coffs Harbour City Council & Ors

Citation: [2003] NSWSC 49, Supreme Court of New South Wales per Whealy J

Date of Judgment: 14 March 2003

Issues:
- Negligence
- Breach of duty
- Obviousness of danger

The case considers whether the defendants, who had care and control of a tidal creek and its surrounding area, breached their duty of care by failing to warn of the risk that tidal sand formations may pose to swimmers in a tidal creek.

The facts
Mr Mulligan, an Irish tourist, visited Coffs Harbour during his holidays in Australia. During his visit he travelled to the Coffs Creek area. While diving in a creek, Mr Mulligan hit his head on a sandbar and suffered injuries that rendered him a quadriplegic.

Mr Mulligan sued multiple defendants, including the Coffs Harbour City Council, the State of New South Wales and the Coffs Jetty Foreshore Reserve Trust. It was accepted that a rock retaining wall on the northern side of the creek (which the council had constructed) had altered the tidal flow and caused sand dunes to form in the creek bed.

The issues
Mr Mulligan claimed that the defendants:

- owed a duty to exercise reasonable care to avoid foreseeable risk of injury to persons entering the creek from the reserves located around it; and
- breached their duty of care by failing to erect signs at public access points to the recreational areas adjacent to the creek, warning of the dangers posed by the creek’s variable depth.

The defendants stressed the obviousness of the risk identified by Mr Mulligan and the entitlement of occupiers of public reserves to assume that people entering upon public land would exercise reasonable care for their own safety.

The defendants also argued that there was no evidence to show that Mr Mulligan would have heeded any warning sign if it had been placed as suggested.

The parties came to a number of arrangements in respect of damages.

The decision
Duty of care
Justice Whealy, having reviewed the relevant authority on occupiers’ duty of care for visitors, concluded that all defendants owed a duty of care to Mr Mulligan to take reasonable steps to avoid foreseeable injury while he was swimming lawfully in the creek.
Scope and breach of the duty of care

Justice Whealy again reviewed the relevant authorities and facts of the case and, having regard to extensive expert opinion presented to him by both sides, concluded that the failure to warn Mr Mulligan of the risk of diving in the creek due to its variable depth did not involve a breach by any of the defendants of their duty of care.

Although Justice Whealy was satisfied that:

- the danger of a person sustaining severe injury as the result of diving in the creek was reasonably foreseeable; and
- it was neither far-fetched nor fanciful to consider that a person swimming in the creek might sustain very serious injury by coming into contact with the creek bed, sand dunes on the creek bed or other objects on the creek bed,

he nevertheless considered that the risk was obvious to any person exercising reasonable care for his or her own safety. He referred to Justice Kirby’s comments in Romeo v Conservation Commission (NT) (1998) 192 CLR 431 to the effect where a risk is obvious to a person exercising reasonable care for his safety, the notion that an occupier must warn an entrant about the risk is neither reasonable nor just.

Justice Whealy also noted that:

- Mr Mulligan was an experienced, strong swimmer who was also experienced at diving;
- sand dunes and tidal conditions occur in creeks and oceans around the world; and
- Mr Mulligan was aware of the fact that the creek was sand-based and that its depth varied.

Justice Whealy rejected the argument that the bedform struck by Mr Mulligan was hidden from him as a misleading analysis because:

- the natural conditions of the creek meant that, by definition, everything below its surface is hidden; and
- what was hidden was a naturally occurring and dissipating sand dune of normal dimension.

Justice Whealy concluded that the scope of the duty of care owed by the defendants to Mr Mulligan in this case did not require that Mr Mulligan be warned of the risk that was plainly inherent in the activity he was undertaking.

Causation and damages

Although Justice Whealy concluded that the defendants did not breach their duty of care and therefore were not liable to Mr Mulligan for the damages arising from the injuries he suffered, Justice Whealy went on to resolve the issues of causation and damages. For the purposes of this exercise, he assumed the defendants were liable (contrary to his decision).
Justice Whealy held that the onus was on Mr Mulligan to prove on the balance of probabilities that if the missing signs were in fact erected he would not have suffered his injuries. Justice Whealy, relying largely on the character of Mr Mulligan, accepted that Mr Mulligan would have obeyed warning signs if they were present and he would have refrained from diving in the manner he did and consequently would not have suffered his injuries.

Justice Whealy rejected the defendants’ argument that Mr Mulligan voluntarily accepted the risk of his activities, because the defendants failed to establish that Mr Mulligan:

- was fully aware of the risk; and
- completely understood the nature and extent of the risk.

However, Justice Whealy stated that, in the circumstances, he would have held that Mr Mulligan failed to exercise reasonable care for his own safety at least to the extent that he chose to dive into a creek, not knowing the depth of the water in circumstances where the water was murky and fast-moving, preventing him from seeing below the surface. For that reason, he would have found contributory negligence and reduced damages recoverable by 15 per cent.

In respect of damages, Justice Whealy rejected the defendants’ submission that they should receive the benefit of rental monies collected by Mr Mulligan on a house he bought prior to his holidays, but could no longer occupy because of its unsuitability for a quadriplegic person.

On the other hand, Justice Whealy allowed a claim by Mr Mulligan for the full cost of modifications to the house of Mr Mulligan’s parents, which was made in order to accommodate and care for Mr Mulligan. He was also sympathetic to a claim for the costs of future physiotherapy, hydrotherapy and consequential pool hire.

An appeal has been lodged and is due to be heard in February 2004.

Although this case was largely decided on its own facts, it is a good illustration of the principle that there is no duty to warn of ‘obvious’ or ‘inherent’ risks. Pending a foreshadowed appeal by Mr Mulligan, this case provides some guidance to the future interpretation of the concept of ‘obvious risk’ and ‘inherent risk’ under sections 5F and 5I of the Civil Liability Act 2002 (NSW) respectively.
Negligence: whether the defendant's negligence caused the plaintiff's severe psychiatric condition

Case name:
Shorey v PT Limited

Citation:
[2003] HCA 27, High Court of Australia per Gleeson CJ and McHugh, Gummow, Kirby and Callinan JJ

Date of judgment:
28 May 2003

Issues:
- Negligence
- Proof of causation where a number of factors contribute to injury
- Obligation of tortfeasor to take victim as it finds him or her

A majority of the High Court upheld the plaintiff’s appeal against a decision of the New South Wales Court of Appeal and held that she was entitled to succeed in negligence against the defendants in respect of her bizarre, near-paraplegic condition that had no physiological basis. In order for the plaintiff to succeed, the majority held it was sufficient that the defendants’ negligence was shown to be a cause of her present condition, even if other causes played a significant role.

The facts
The plaintiff had been injured on 2 April 1988 in a fall at a shopping centre. From this seemingly unremarkable incident, she claimed that a severe and grossly disabling condition developed. The plaintiff claimed she could not walk, but her alleged disability did not have a probable organic foundation.

The decision of the trial judge and NSW Court of Appeal
The Court of Appeal accepted the finding of the trial judge that the plaintiff genuinely experienced the extreme and bizarre symptoms of which she complained and was not malingering. All judges accepted that the plaintiff’s symptoms were the result of a psychiatric condition known as a ‘conversion disorder’.

The trial judge had accepted the evidence of the plaintiff’s leading expert and concluded that the fall was a relevant cause of her condition. The Court of Appeal held that the trial judge had erred on the issue of causation and took the view that the plaintiff had not discharged the onus of proving a causal link between the fall and her conversion disorder.

The decision of the High Court
A majority of the High Court rejected the reasoning of the Court of Appeal, instead taking the view that the medical evidence showed a clear causal link between the plaintiff’s fall and her conversion disorder.

The majority considered that it was ‘beyond doubt’ that there were other factors contributing to her condition, but stated that she would be entitled to succeed if the fall could be regarded as merely a cause of her condition. The extraneous factors involved were a pre-existing back disability (for which the plaintiff had undergone an operation two years before the fall) and a sense of grief and guilt associated with her husband’s death (which occurred shortly after the fall).
The principal reason for the differing views of the High Court majority and the Court of Appeal lay in the evaluation of the evidence of Dr Philips, a psychiatrist, who was the plaintiff’s leading expert at trial. In his evidence-in-chief, Dr Philips had stated that the fall was the ‘sentinel event in the causal chain’. However, the Court of Appeal considered that Dr Philips had effectively withdrawn this opinion under cross-examination. In the High Court (Justice Callinan dissenting) it was held that the Court of Appeal had erred in concluding that Dr Philips had withdrawn his testimony. The majority’s view of Dr Philip’s cross-examination was that he had merely acknowledged that ‘other stressors’ had contributed to the plaintiff’s condition, but had not retracted his view regarding the causative link between the fall and the conversion disorder.

The majority also re-affirmed the principle that a tortfeasor takes its victim as he finds him or her. Justice Kirby stated that the defendant’s liability to compensate the plaintiff is unaffected by the fact that the plaintiff’s pre-accident operation and post-accident grief (associated with the death of her husband) rendered her especially susceptible to suffering unusual psychiatric consequences.

This High Court decision illustrates and reinforces some important principles of tort law, namely:

- a claimant does not have to prove that an impugned event was the sole cause of the injury; and
- a negligent defendant takes its victim as it finds him or her and must pay damages accordingly. This is sometimes referred to as the ‘egg-shell skull rule’.
Was a legislative declaration of plants as ‘prohibited’ reasonably foreseeable?

Case Name: 
Dovuro Pty Limited v Robert John Wilkins & Ors

Citation: 
[2003] HCA 51, High Court of Australia per McHugh, Gummow, Kirby, Hayne, Callinan and Heydon JJ and Gleeson CJ

Date of Judgment:  
11 September 2003

Issues: 
- Product liability 
- Reasonable foreseeability 
- Breach of duty 
- Powers of Federal Court to make ‘declarations of liability’
- Effect of admission by a party on a matter of mixed law and fact

Where particular weed seeds were not known to be dangerous at the time they were imported into Australia, it was not reasonably foreseeable that they would be declared as ‘prohibited’ seeds, thus causing loss to the respondents.

Facts
Dovuro Pty Ltd produced canola seed in New Zealand, which it imported into Western Australia for sale by third parties. The Wilkins purchased some canola seed from a local merchant, which had been produced and imported by Dovuro. The seed was labelled ‘minimum 99 per cent purity’. This statement reflected seed analysis certificates issued by the New Zealand Ministry of Agriculture and Fisheries, which certified that the seed was at least 99.5 per cent pure and ‘complied with the Seeds Acts of all Australian States’. The seeds were also analysed and released by the Australian Quarantine and Inspection Service at the time of importation.

In May 1996, the Wilkins purchased the canola seed, without knowing that it included elements of three weed varieties: redshank, field madder and cleavers. Dovuro knew of the presence of those weeds in the seed. However, it did not specify their presence on the label, nor did it bring this fact to the attention of the agricultural authorities of Western Australia or the growers, before the seed was imported and sold.

At the time of the sale of the canola seed to the Wilkins, the three weeds were not prohibited weeds under relevant Western Australian legislation. Subsequently, when their presence in the canola seed was discovered, the Western Australian authorities immediately declared the seeds as prohibited. On 5 July 1996, each of the three species of weed were prohibited from importation and sale in Western Australia. Agriculture Western Australia, the relevant state government department, then wrote to the relevant growers, recommending that all growers who had acquired the relevant canola seed take action to eradicate the weeds. The Wilkins complied with this direction at their own expense.

Following the declaration of the particular weeds as prohibited plants, Dovuro’s general manager issued a media release, stating: ‘We apologise to canola growers and industry personnel. This situation should not have occurred.’

Dovuro’s western region manager also sent a letter to a local grower’s organisation, stating that Dovuro had ‘fail[ed] in its duty of care to inform growers as to the presence of these weed seeds. We got it wrong in this case, and new varieties will not be brought on the market again in this manner.’
Federal Court proceedings

On 7 April 1998, the Wilkins commenced proceedings for damages in the Federal Court, alleging negligence and contravention of section 52 of the Trade Practices Act 1974 (Cth) (the TPA). They brought the action under Part IVA of the Federal Court of Australia Act 1976 (Cth), on behalf of themselves and as representatives of persons in a class identified as those canola growers who, in 1996, bought and planted canola seed supplied by Dovuro to distributors in Western Australia.

At trial, Justice Wilcox ordered that issues of liability be tried in advance of questions of damage. During submissions, Dovuro accepted that it owed a duty of reasonable care to the growers not to expose them to risk of injury that was reasonably foreseeable. However, it denied that it had breached that duty. Justice Wilcox held that Dovuro had breached its duty to the growers in that it negligently failed to make inquiries of the relevant Western Australian authorities about the three seed varieties and failed to disclose the presence of the weed seeds to the growers. He held that Dovuro had not breached s52 of the TPA.

Dovuro appealed to the Full Court of the Federal Court. That court, by majority (Justices Branson and Gyles; Justice Finkelstein dissenting), dismissed Dovuro’s appeal. Justice Branson held that Dovuro’s admissions provided a factual basis for the finding that Dovuro was negligent in not making greater efforts to extract the weed seeds from the canola seed or to inform the growers of the presence of the specific weed seeds. Justice Gyles expressed the view that it was not reasonably foreseeable that the Western Australian authorities would react as they did to prohibit the weeds. However, he found that the apologies and admissions made on behalf of Dovuro provided a factual basis for the findings made by the primary judge, who was in a superior position in having heard all of the evidence, and, therefore, the decision was open on the facts and ‘should not be disturbed’. Justice Finkelstein (dissenting) would have allowed the appeal, on the basis that the subsequent prohibition of the weeds by the Western Australian authorities was not reasonably foreseeable to Dovuro at the relevant time.

The decision

The case against Dovuro was put by the Wilkins as follows:

1. Dovuro knew, or ought to have known, that the canola seed contained, or may contain, undesirable weed seeds, including cleavers, redshank and madder;
2. Dovuro owed the Wilkins and the other growers 'a duty... to exercise reasonable care to avoid injury to them'; and
3. Dovuro was negligent in that: (i) it failed to advise of the presence of the weed seeds; (ii) it failed to place any warning on the bags of canola seed that it contained the specified weed seeds; and (iii) it failed to generally advise the canola seed-growing industry of the possible presence of the weed seeds.

By a majority of 5-2 (Chief Justice Gleeson and Justice Kirby dissenting), the High Court held that, even assuming that Dovuro did owe the farmers a duty of care, there was no breach of that duty as it was not reasonably foreseeable that the weeds would be declared prohibited plants by the Western Australian Government with consequent financial loss to the purchasers of the seed.
Duty of care

At trial, Dovuro conceded that it did owe the Wilkins and other growers a duty of care, but denied breach of that duty. The court therefore did not need to deal with the issue of whether or not Dovuro owed a duty of care to consumers of the canola seed.

Breach of duty

In respect of the question of breach of duty, Justices Hayne and Callinan (with whom Justices McHugh, Gummow and Heydon agreed) found that, as none of the seeds were known to be dangerous or had been prohibited at the time the seeds were distributed, there was no basis for concluding that Dovuro should reasonably have foreseen that the weeds would be declared prohibited plants by the Western Australian authorities. As it was the fact of this declaration that led to the grower’s loss, there was no liability on the part of Dovuro.

In concluding that it was not reasonably foreseeable to Dovuro that purchasers of the canola seed would suffer damage by reason that the seeds would become prohibited plants, Justice McHugh said:

If negligence law is to serve any useful social purpose, it must ordinarily reflect the foresight, reactions and conduct of ordinary members of the community or, in cases of expertise, of the experts in that particular community. To hold defendants to standards of conduct that do not reflect the common experience of the relevant community can only bring the law of negligence, and with it the administration of justice, into disrepute.

He went on to say that, while compliance with common practice will not always excuse a defendant from liability, it is powerful evidence that the defendant did not act negligently. This presumption should only be displaced where there is a persuasive reason for concluding that common practice falls short of what reasonable care requires.

Justice Gummow also agreed with Justice Finkelstein, that it was not reasonably foreseeable that the three particular weeds would be declared prohibited where they were not known to be dangerous and where no similar action had been taken by an Australian government in the past. In respect of the ‘admissions’ made by Dovuro following the declaration of the weeds, Justice Gummow held that such ‘admissions’ provided no basis for a finding of negligence. He said that, while a party may admit facts from which legal conclusions may be drawn, it is the role of the court to apply the relevant legal standard. An ‘admission’ by a party that he or she was ‘negligent’ or ‘owed a duty of care’ is valueless, as the maker of the statement is not familiar with the relevant legal standard.

Chief Justice Gleeson (dissenting) held that Dovuro’s admissions did provide a factual basis for the view formed by the primary judge that the presence of these particular seeds would have been of concern in the industry and that the primary judge’s finding of negligence should, therefore, not be disturbed.

Justice Kirby (also in dissent) held that it was enough that it was reasonably foreseeable that Dovuro’s introduction of the three weed seeds involved a possible risk of harm to the Wilkins. He found that, given the superior position of the primary judge in assessing the evidence, there was no basis for the High Court to...
substitute a different view of the facts. He also found that, consistently with other
cases on this point, Dovuro had a duty to notify the growers of a known risk where
it was in a position of superior knowledge. He said that the greater the risk, the
higher the duty to notify.

Interlocutory declaration: damages
As noted above, the primary judge made an order that questions of liability be
determined in advance of damages. In the result, he made orders in the form of
declarations that Dovuro ‘owed a duty of care to the [Wilkins] and group members
and that it was in breach of such a duty’ and that ‘some damage was suffered by
the [Wilkins] as a result of such a breach of duty’.

In their joint judgment, Justices Hayne and Callinan (with whom Justice Heydon
agreed) held that an interlocutory declaration is not a form of order known to
law and should not be made. They said that the case illustrates the difficulties
in separating liability for negligence from questions of damage, as damage is an
essential element of the tort.

This High Court decision illustrates a concern to ensure that
negligence law reflects the reasonable foresight, reactions
and conduct of ordinary members of the community. While
compliance with common practice will not always excuse
a defendant from liability, it is powerful evidence that the
defendant did not act negligently and this presumption will only
be displaced where there is a persuasive reason for concluding
that common practice falls short of what reasonable care
requires. Arguably, this case is an example of the judicial trend
of curtailing the scope of liability for negligence.
Is a hotel liable for a patron who drinks there and subsequently has an accident and injures herself? The Supreme Court of New South Wales found that the defendants did not have a duty of care to protect the plaintiff from the consequences of her own inebriation and found for the defendants. The plaintiff was ordered to pay the defendants’ costs.

The facts
At about 8.20pm on 10 November 2000, Francine Parrington was seriously injured in a car accident while she was well above the ‘legal limit’ for blood alcohol concentration.

Mrs Parrington later began proceedings against the defendants: Hotelcorp (the owner of the hotel at which she had been drinking); Peter Calligeros (the licensee); and Colin Picton and Kim Picton (the managers).

It was alleged that all defendants owed a general duty of care to those people coming upon their hotel premises for their safety and wellbeing and similarly owed the same duty of care to patrons when they had been on the hotel.

Particular breaches of duty alleged included lending money to Mrs Parrington to continue drinking at the hotel when the defendants knew, or ought to have known, that Mrs Parrington was driving and knew, or ought to have known, that she was drunk.

The accident was the result of Mrs Parrington’s inebriated condition. The extent of her inebriation, where the alcohol was drunk, and who served her on the day of the accident, were issues between the parties. Mrs Parrington had consumed alcohol at a number of places on the day (including other licensed premises).

Mrs Parrington had no recollection of the day of the accident. She said that she often drove her car drunk and that she understood the dangers of driving drunk and the risk she posed to herself and others. She had previously had an accident at the same place as the subject accident, when her car ran off the road as a result of her inebriation.

Mrs Parrington had three drinks at the hotel at around 1.30pm, where she stayed until 3pm (at which stage nobody says she was affected by liquor). She borrowed $50 from one of the Pictons shortly after 1.30pm, which was used to buy two of the three drinks. Mrs Parrington’s whereabouts between 3pm and 6pm are not precisely known, but she visited her mother-in-law at 4pm, who said she seemed affected by alcohol at that time. Mrs Parrington returned to the hotel and borrowed a further $50 from one of the Pictons at about 6pm. She left the hotel between
7.30pm and 8pm and drove to her mother-in-law's house. The accident occurred on her way home from that house.

The decision

Justice Cripps found that it would have been obvious that Mrs Parrington was affected by alcohol between 6pm and 7.30pm (when she was at the hotel), although how much of that was due to what she drank while at the hotel was unclear.

When Mrs Parrington left the hotel at 7.30pm, it was not obvious that she was going to drive, particularly because she left with another person. Mrs Parrington’s fitness to drive had been raised with her by her companions. That evidence, together with Mrs Parrington’s statement that it was her habit to drive drunk, foreclosed any argument that hotel staff, even if they knew she was proposing to drive, would have had any success in persuading her not to do so.

In Tweed Heads Rugby League Football Club v Cole (2002) 55 NSWLR 113, the NSW Supreme Court held that no duty of care is owed by a club licensee to a person who is served alcohol by that licensee when that person is, or becomes, intoxicated and subsequently suffers injury contributed to by that intoxication. This statement was qualified:

There may, however, be circumstances which bring about a different result... it may be that where a person is so intoxicated as to be completely incapable of any rational judgment or of looking after... herself, and the intoxication results from alcohol knowingly supplied by an innkeeper to that person for consumption on the premises, the scope of the duty of care of the innkeeper will be extended to require reasonable steps to be taken for the protection of the intoxicated person.

Mrs Parrington submitted that there were circumstances which should lead to a different result from Cole; that is, she was twice lent money by the hotel, which was used for alcohol supplied by the defendants. Justice Cripps inferred that, more probably than not, Mrs Parrington spent money on alcohol at places other than the hotel, between 3pm and 6pm.

Although Mrs Parrington had probably passed the ‘legal limit’, Justice Cripps was not satisfied that she had reached that state of intoxication where she no longer had the use of her physical or intellectual faculties such that the hotel staff were guilty of a breach of the Liquor Act by supplying her with liquor (if indeed that is what they did).

Justice Cripps concluded that Mrs Parrington’s case did not fall within the type of exception contemplated by Cole. As observed in Cole:

...save perhaps in extraordinary cases, the law should not recognise a duty of care to protect persons from harm caused by them becoming intoxicated by alcohol following a deliberate and voluntary decision on their part to drink to excess.

Mrs Parrington’s intoxication was the consequence of a ‘deliberate and voluntary decision’ by her to drink to excess. The circumstance that she may not have been able to do that, had the hotel not lent her money (and assuming she could not have borrowed money from others), did not alter that conclusion.
There was no distinguishing feature in this case from those presented in *Cole* by reason of the fact that Mrs Parrington was an inebriated driver who injured herself; whereas in *Cole*, the plaintiff was an inebriated pedestrian who was injured by a driver. Noting that Mrs Parrington was, at the time of her accident, committing a serious offence, whereas in *Cole* the plaintiff was not, the judge held that the mode of accident, if anything, strengthened the defendant’s case.

In general, a hotel breaches no duty of care to a person who is served alcohol, but who later becomes intoxicated and subsequently suffers injury contributed to by that intoxication. This case illustrates that an extraordinary case where a duty of care is to be found may be difficult for a plaintiff to establish. Reforms to tort law in many Australian states make such claims even more difficult.
The contributory negligence of an intoxicated passenger

The determination of an intoxicated passenger’s contributory negligence rests on a consideration of all relevant facts and circumstances that a reasonable, sober person would be aware of, and is not confined to the circumstances immediately before the accident.

The facts

On 27 October 1996, Sally Joslyn (the driver) overturned a utility motor vehicle while driving around a sharp corner on a country road in New South Wales, causing severe injuries to Allan Berryman (the passenger). The accident occurred at 8.45am after a weekend of heavy drinking, with both the passenger and the driver drinking until about 4am on the morning of the accident. The driver had been seen to be ‘quite drunk and staggering about’ at about 4.30am.

Shortly before the accident, the passenger had been driving the vehicle; however, the driver noticed that he had been dozing off and insisted on taking over the driving. At that time, the driver did not manifest any signs of intoxication. The passenger (who owned the vehicle) also knew that it had a propensity to roll over, its speedometer was broken, and that the driver was inexperienced and did not hold a current driver’s licence.

The passenger sued the driver, claiming that she had driven negligently and he also sued the Wentworth Shire Council (the council) for failing to provide adequate warning signs. At first instance, the District Court held that both the driver and the council were guilty of negligence and apportioned liability at 90 per cent and 10 per cent respectively. The trial judge also reduced the damages by 25 per cent, finding the passenger guilty of contributory negligence at common law in allowing the driver to drive when he ought to have been aware that she was unfit to drive.

The Court of Appeal of New South Wales overturned this finding. In reaching this conclusion, the Court of Appeal took the view that the contributory negligence of the plaintiff should be evaluated by reference to what the plaintiff knew or could have observed when he became a passenger of the vehicle. As the driver exhibited no signs of intoxication at that time, the Court of Appeal held that the passenger was not guilty of contributory negligence. Special leave to appeal to the High Court was confined to the ‘contributory negligence’ issue.

Section 74 of the Motor Accidents Act 1988 (NSW) (MAA) directs a finding of contributory negligence against ‘voluntary passengers’ if they are ‘aware, or ought to have been aware’ that the driver’s ability to drive the vehicle ‘was impaired as a consequence of the consumption of alcohol’.
The High Court's decision

The High Court held that the Court of Appeal erred in deciding the appeals without reference to s74 of the MAA and by applying a subjective test of the reasonableness of the passenger's conduct.

In coming to its decision, the majority of the High Court clarified the test of contributory negligence at common law as shaped by s74 MAA.

The court stressed that the test is an objective one, and considered that any fact or circumstance is relevant in determining contributory negligence if it proves, or assists in proving, a reasonably foreseeable risk of injury to the plaintiff in engaging in the conduct that gave rise to the injury suffered.

It went on to find that 'whether the passenger knew or ought to have known that the driver's driving ability was impaired by alcohol' requires a consideration of all those facts and circumstances occurring in the previous 12 to 36 hours of which he was, or ought to have been, aware. Given the fact that the driver was seen 'staggering drunk' at 4.30am, the High Court held that the passenger ought to have been aware that the driver's driving ability was impaired and found the passenger guilty of contributory negligence under s74 MAA.
Salmonella outbreak from contaminated orange juice: supplier liable, despite absence of negligence

The Federal Court of Australia examined the assignment of liability in the chain of supply of juicing oranges, following an outbreak of salmonella poisoning among people who drank contaminated juice. The case illustrates how suppliers of contaminated or defective products can be found liable for loss and damage suffered by consumers, even though they have not acted negligently.

The facts
Between 1 January 1999 and 31 May 1999, approximately 507 cases of salmonella poisoning were notified to the South Australian Government following consumption of contaminated fruit juice manufactured and distributed by Knispel Fruit Juice Pty Ltd (Nippy’s). The salmonella contamination was traced back to the fungicide and wax tanks at the packing sheds of Messrs Peter and Theo Constas (the Constas). The Constas sold the contaminated oranges to Nippy’s Waikerie Producers Pty Ltd (Packing), which then on-sold them to Nippy’s.

Previously, orange juice was not considered a high-risk source of salmonella poisoning. The process of immersing the oranges in chlorine solution before juicing (which Nippy’s undertook), together with the high acidity of oranges, usually killed any salmonella present in the oranges and their juice. In this case, the salmonella was effectively protected from the chlorine solution by the layer of wax on the oranges. Also, the acid content of the juice was lowered, as a result of immediate chilling. This enabled the salmonella to survive in the orange juice sold to the injured consumers. Had the injured consumers allowed the orange juice to warm to room temperature before consuming it, the acidity of the orange juice would have been sufficient to kill the salmonella.

A representative proceeding brought by some of the injured consumers was settled, with Nippy’s admitting that it was strictly liable, under manufacturers’ liability provisions of the Trade Practices Act 1974 (Cth), for the injuries caused by the salmonella poisoning. The court was asked to determine the respective liability of Nippy’s, Packing and the Constas as a result of cross-claims brought by both Nippy’s and Packing.

The decision
Essentially, the court made the following findings in respect of the cross-claims:

- The negligence claims failed because none of the parties could have reasonably foreseen that consumers could suffer salmonella poisoning from orange juice. This was because there were no previously known cases of salmonella poisoning from orange juice, and the community’s expectation that the acidity of the juice...
destroyed any bacteria present in it. Therefore, there was no duty on the parties to take steps (such as pasteurisation) that may have prevented the poisoning of consumers.

- The breach-of-contract claim brought by Packing against the Constas succeeded because the Constas had breached terms implied by the Sale of Goods Act 1895 (SA), namely those requiring that the oranges supplied by them be fit for their required purpose (namely, for the manufacture of unpasteurised juice for human consumption) and that they be of a merchantable quality. In implying the fitness-for-purpose term into the contract, the court found that the Constas knew of the purpose for which Packing had purchased the oranges and that Packing relied on the Constas' skill and judgment in supplying oranges for that purpose. Clearly, the contaminated oranges were neither fit for the manufacture of orange juice for human consumption, nor of a merchantable quality.

- Similarly, the breach-of-contract claim brought by Nippy's against Packing succeeded because Packing breached the merchantable quality term implied by the Sale of Goods Act 1895 (SA). However, the court held that the contract did not contain an implied term of fitness-for-purpose, because Nippy's did not rely on Packing to exercise any skill or judgment in supplying the oranges.

Given these breaches of contract, the court held that Packing was liable to Nippy's for its loss and damage and that the Constas were liable for Packing’s loss and damage. This effectively meant that the Constas were liable for the loss and damage suffered by Nippy’s and were ordered to pay approximately $3 million in damages (which included the amounts paid to the injured consumers and amounts representing Nippy's lost profits and damage to its reputation).

This case illustrates the potential for suppliers of contaminated or defective products to be found liable for their conduct, even though they have not acted negligently. Suppliers of products need to consider the potential for liability resulting from breaches of contractual terms implied by Sale of Goods legislation throughout Australia when negotiating appropriate insurance cover, and to ensure that they are covered for this liability.
Medical negligence: damages available for costs of maintaining an unintended child

In this controversial decision, the High Court allowed recovery for the costs of raising and maintaining an unintended child, born as a result of medical negligence.

Facts and proceedings

Mr and Mrs Melchior became the parents of an unintended child as a result of Dr Cattanach’s negligent advice and failure to warn about the risks of conception following a sterilisation procedure undertaken by Mrs Melchior.

The damages awarded by Justice Holmes at trial had three components: Mrs Melchior received a first award of $103,672.39 for pain and suffering, lost earnings and health, travel, clothes and future care expenses. Mr Melchior received a second award of $3000 for the loss of his wife’s consortium. The parents jointly received a third award of $105,249.33 for the cost of ‘raising and maintaining’ the unintended child until the age of 18.

On appeal, a majority of the Queensland Court of Appeal (Justices McMurdo and Davies; Justice Thomas dissenting) affirmed the trial judge’s decision. Dr Cattanach and the State of Queensland were granted special leave to appeal to the High Court in respect of the third component of damages.

The decision

A bare (4:3) majority of the High Court dismissed the appeal and affirmed that the parents jointly could recover the costs for raising and maintaining a child born as a result of negligence; and no reduction of the award was to be made for the pleasure and benefit derived from the child. (Justices McHugh, Gummow, Kirby, Callinan; Chief Justice Gleeson and Justices Hayne and Heydon dissenting). The majority refused to follow the English decision of the UK House of Lords in McFarlane v Tayside Health Board [1999] 3 WLR 1301.

The scope of the duty of care

Justices McHugh and Gummow considered that the correct inquiry in tort cases of this nature is not whether the parents are precluded from claiming the costs of raising the child on grounds of public policy, but whether damages of the kind suffered were ‘reasonably foreseeable’ within ordinary principles of negligence, so as to give rise to the right of recovery.

They considered that damage is either physical injury to person or property, or the suffering of a loss measurable in money terms, or the incurring of expenditure as the result of the invasion of an interest recognised by the law.
Justices McHugh and Gummow found that the cost of raising and maintaining the child is an expenditure causally connected to Dr Cattanach's negligence, and the doctor ought to have reasonably foreseen that an expense of that kind might be incurred. They said it did not assist understanding to describe the damage as 'economic loss'. Justice Kirby agreed, adding that the parents did not have to satisfy the special tests adopted by the common law for so-called 'pure' economic loss. Justice Callinan concurred, stating, however, that it is reasonable in the circumstances to characterise the entitlement as economic loss.

The role of ‘public policy’ in tort law
Justices McHugh and Gummow affirmed that 'public policy' is central to judicial decision-making in tort law. However, they considered that for policy considerations to displace a plaintiff's ‘right of action’, they would need to be ‘so definite’ as to apply without reference to the ‘real mischief’ for which the case was begun, in this case, the doctor’s negligent advice and failure to warn.

Justice Kirby agreed, stating if the application of ordinary legal principles is to be denied on the basis of public policy, it is essential that such policy be spelt out so as to be susceptible of analysis and criticism. Desirably, it should be founded on empirical evidence, not mere judicial assertion. Yet this was not attempted in the present case, whether at trial or on appeal.

Birth of a child: a blessing or a legal harm?
In particular, Justices McHugh and Gummow emphasised that the appellant’s submission (accepted in the United States in the 'wrongful birth' cases) was the wrong approach. Arguments concerning whether the child was healthy or not implied differential treatment according to health status. This is discriminatory and directs attention away from the ‘right of action’ and remedies available to the parents in respect of the breach of duty by Dr Cattanach.

Similarly, to say that a child is always a ‘blessing’ denies the widespread use of contraception and, if accepted, would logically preclude recovery for all other costs incurred by the parents and associated with the birth.

Each of the three dissenting judges considered that the nature of the damage claimed was the result of the creation of a loving, healthy ‘new life’ and a ‘parent-child relationship’ that cannot properly be characterised as a loss recoverable at law. The minority considered that the loss was imprecise, and that to allow recovery would subvert other principles of law, and statutory provisions, which encourage the natural love and mutual confidence in family relationships.

Damages not limited nor indeterminate
Justice Kirby commented there was no legal basis on which the courts could limit compensation to the immediate damage by drawing a distinction between the pain and suffering and expenses incurred due to the immediate error, as distinct to the long-term costs of medical error. Justice Callinan stated that the fact that the damages may be substantial, or vary greatly from case to case, does not mean they are indeterminate or preclude an assessment capable of ‘a reasonably high degree of precision’.

Allens Arthur Robinson
No ‘off setting’ of damages

The majority considered that the benefits received from the birth of a child are not legally relevant to the head of damage that compensates for the cost of raising and maintaining the child. As Justice Callinan stated, ‘the reciprocal joy and affection of parenthood can have no financial equivalence to the costs of rearing the child’.

The High Court has confirmed that the door remains open for recovery of the cost of maintaining an unintended child resulting from medical negligence. The costs recoverable will not be reduced by the fact that the unintended child is healthy or ‘a blessing’. The costs were relatively modest in this case, but may vary, depending on the circumstances of the parents. In Queensland, draft legislative amendments to the Civil Liability Act 2003 (Qld) in August 2003 propose to prevent recovery of the costs of maintaining a healthy child, while confirming the availability of any additional costs of maintenance incurred as a consequence of a child being severely disabled due to medical negligence. In November 2003, similar amendments were put before the New South Wales Parliament.
Medical negligence: no extension to Griffiths v Kerkemeyer damages

Case Name:
Diamond v Simpson (No 1)

Citation:

Date of Judgment:
7 April 2003

Issues:
- Damages for the market cost of gratuitous services provided by charitable institutions
- Limit of application of principles in Griffiths v Kerkemeyer
- Basis for calculation of damages for future attendant care

The New South Wales Court of Appeal unanimously held that Griffiths v Kerkemeyer damages are not available to an injured party to whom gratuitous services have been provided by a charitable institution as a result of the actions of the tortfeasor. The court must also consider the intention of the charitable institution in providing the gratuitous services.

The decision of Justice Whealy at first instance is reported in the AAR Annual Review of Insurance Law 2001 at page 106.

The facts
On 5 July 1979, Dr Diamond was the attending obstetrician at the delivery of Calandre Simpson (Calandre).

Dr Diamond admitted that inter alia his negligence caused Calandre to be totally dependent on others for all of her needs.

The Spastic Centre of NSW (the Spastic Centre) provided medical and allied professional services (the services) to Calandre from 1981 to the date of the trial in June 2001.

The Spastic Centre informed the Simpson family on 8 August 1994 that it expected Calandre to add the cost of the services to any claim for compensation.

Calandre’s mother did not consider that she would have to pay for the services until the Spastic Centre sent the invoices.

The Simpson family did not give an undertaking to pay the amount of the invoices.

Decision at first instance
The relevant issue at trial was the amount of damages to which Calandre was entitled.

1. Future Attendant Care

In relation to future attendant care, Justice Whealy received submissions on the cost of an agency being contracted to employ the staff (managed care) and the cheaper cost of an agency selecting appropriate carers and Calandre employing the carers directly (referred care). Justice Whealy based his calculations on the assumption that referred care would be used for 75 per cent of the year and managed care for 25 per cent of the year and made allowance for a case manager to oversee Calandre’s care program.
2. Gratuitous services provided by the Spastic Centre

Justice Whealy referred to the High Court decision in *Griffiths v Kerkemeyer* (1977) 139 CLR 161, in which it was held that a plaintiff was entitled to recover damages representing the market cost of services rendered gratuitously to the injured plaintiff by family members or friends. Justice Whealy held that this doctrine should be extended to gratuitous services provided by a community-based charitable institution, such as the Spastic Centre. Accordingly, Justice Whealy awarded Calandre $1,103,452 for out-of-pocket expenses, including the cost of the services provided by the Spastic Centre, being $614,752.

In total, Justice Whealy awarded Calandre $14.2 million.

Dr Diamond appealed the quantum of damages.

**Decision of the Court of Appeal**

The NSW Court of Appeal held *inter alia* that:

- ‘(W)here there is a case manager, there is no requirement for managed care’ and reduced the quantum of damages awarded for future attendant care accordingly.
- Justice Whealy erred in extending the doctrine in *Griffiths v Kerkemeyer* to community-based charitable institutions, such as the Spastic Centre.
- The entitlement of an injured person to a claim for gratuitous services provided by a publicly or privately funded charitable institution depends on the application of the principles in *National Insurance Company of New Zealand Limited v Espagne* (1961) 105 CLR 569 (*Espagne*).

In *Espagne*, the High Court identified a two-stage approach. First, the need for the service must be caused by the plaintiff’s loss. Second, the court must consider the intention of the provider of the gratuitous service. If the intention was to confer the benefit on the plaintiff independently of an entitlement to a claim against a wrongdoer, so that the plaintiff might enjoy the benefit even if he or she obtains compensation, the plaintiff is not entitled to recover the value of the gratuitous service from the wrongdoer.

The Court of Appeal observed that the Spastic Centre did not require Calandre to pay its charges in the event of her receiving compensation from Dr Diamond. It further found that the Spastic Centre’s ‘motives were solely charitable and benevolent’. As such, the court held that the Spastic Centre did not intend its services to be in addition to any claims for damages that Calandre may make.

Accordingly, Calandre was not entitled to recover the market cost of the provision of the gratuitous services by the Spastic Centre.
This decision illustrates that the courts are reluctant to extend the scope of *Griffiths v Kerkemeyer* damages. Accordingly, charitable institutions that want to recover the cost of gratuitous services must ensure that the injured person is obliged to seek damages for the cost of those services and pay that amount to the charitable institution if the injured person receives compensation.

This decision has also limited the basis for the calculation of cost of future attendant care to that of referred care where allowance is made for a case manager to oversee the care program.
Negligence and medical practitioners: what duty does a doctor owe to a patient whose partner tests positive for HIV?

Case Name:
PD v Dr Nicholas Harvey

Citation:
[2003] NSWSC 487, Supreme Court of New South Wales per Cripps AJ

Date of Judgment:
10 June 2003

Issues:
- Medical practitioners
- Scope of duty of care
- Calculation of damages

The Supreme Court of New South Wales found that doctors at a medical clinic were negligent for failing to take lawful steps to protect a patient who, to their knowledge, was about to begin a sexual relationship with a person who was HIV-positive.

The plaintiff attended her doctor with her partner, who she indicated she intended to marry, and had blood tests for sexually transmissible diseases. She later collected her results, which were negative, but was denied her partner’s results, on the basis that they were confidential. Her partner had tested positive for Hepatitis B and HIV. The plaintiff was not told of her partner’s results, even when she attended the clinic later for a contraception pill and then for vaccines for a trip to Ghana, her partner’s home country. The partner told the plaintiff that his results were negative. The couple later began having unprotected sex and the plaintiff contracted HIV.

The court found that the doctors at the clinic had a duty to take all reasonable, lawful steps to protect the plaintiff from contracting HIV in such circumstances. Although they were prohibited under section 17 of the Public Health Act 1991 from disclosing the partner’s positive HIV result, the doctors failed to discharge their duty to the plaintiff by failing to:

- adequately counsel the couple at the initial consultation about the consequences of each having a different result;
- counsel the plaintiff’s partner in relation to the legal issues associated with a positive result, including the fact that it would be an offence for him to fail to take precautions against spreading HIV;
- follow up to ensure that her partner kept appointments with external specialists and that those specialists were aware of the circumstances surrounding the initial joint consultation with the plaintiff; and
- contact specialist agencies such as the Medical Defence Union or the Department of Health for guidance as to the appropriate course (eg referring the matter to the Director-General of Health, who has the statutory power to warn people who are at risk of contracting HIV from their partners).

After the initial joint consultation, the plaintiff saw a different doctor at the clinic who was not aware of her relationship with her partner. The court criticised the clinic for not having a patient-records system that ensured that any doctor who saw the plaintiff was made aware of her connection with her partner.
The plaintiff was awarded damages, including an amount for the loss of her ability to care for a dependent child. It was held that an entitlement to such an amount depended upon a link between the birth of the child and the harm that was the subject of the claim. In this case, the court found that the plaintiff would not have had a child with her partner, had she known his HIV status.

This case further defines the scope of doctors’ duty of care to their patients. It highlights a potential conflict between doctor-patient confidentiality and the duty of care owed by doctors. It establishes that, in appropriate cases, professionals must seek outside help to deal with difficult situations that are beyond their expertise or that pose serious ethical dilemmas. The decision also signals the importance of clear, risk-management procedures aimed at ensuring that perceived conflicts of interest are appropriately managed.
This case considers whether a school authority is liable to a pupil who has been sexually abused by a teacher employed at the school.

The facts
Mr Lepore was sexually abused by a teacher, during school hours, as a seven-year old primary pupil in 1978. The teacher was convicted of common assault in the same year. Mr Lepore sued the State of New South Wales in 2001, claiming compensation for breach of the school authority’s non-delegable duty of care. Although the original claim was not on the basis of vicarious liability, the High Court granted leave to argue this claim before it.

The case was heard together with similar cases brought by Ms Samin and Ms Rich, who were also abused while pupils at schools in Queensland.

The legal background
For more than a century, courts have described certain common law duties of care as ‘non-delegable’ or ‘personal’. Traditionally, the relationship was accepted to exist between hospital and patient, school and pupil, and between employer and employee in certain circumstances.

The decision
A majority of five allowed the appeals and ordered that a new trial be held on the question of vicarious liability. This majority also found that, while the schools owed a non-delegable duty of care to their pupils, in this case the duty had not been breached.

It was common ground that school authorities have a (direct) duty to take reasonable care for the safety of pupils, and that breach of that duty and consequent harm will result in liability in damages for negligence. However, there was no allegation of actual fault on the part of the school authorities. Accordingly, there were two bases upon which the High Court was asked to find the schools liable:

- that there was a breach of a non-delegable duty of care to the students; and/or
- that the schools were vicariously liable for the act of their employees.

The High Court delivered six separate judgments.
Non-delegable duties

All members of the court accepted that a school authority owes a non-delegable duty to its pupils and that a school is liable for the negligent acts of its delegates (including employees), even if the authority itself was not negligent in appointing or supervising the delegates. However, their Honours agreed that this did not imply a ‘warranty’ that a school is strictly liable for any harm suffered by a pupil in its care. While Justice McHugh held that a school is liable for the intentional criminal acts of its employees, the remainder of the court rejected this contention.

In explaining the nature of non-delegable duties, Chief Justice Gleeson held that such duties are not simply those that cannot be delegated. They are ‘personal’ duties, where delegating responsibility to a third party (even if that delegate is competent and well-supervised) is insufficient to discharge the duty. Non-delegable duties are, therefore, a form of strict (or no fault) liability: the holder of the duty may be liable, even though he or she was not personally negligent in any act or omission. These are duties to take reasonable care to ensure that reasonable care is taken. It is therefore a question of whether the conduct of the school increased the risk of harm to the children.

Vicarious liability

A majority of the court (excluding Justice McHugh, who did not address the issue) agreed that an employer is liable for the acts of an employee, where those acts:

(i) are authorised by the employer; or
(ii) constitute an unauthorised mode of performing an authorised act.

The corollary is that an employer will not be liable for acts done by an employee while ‘on a frolic of his or her own’. The court was divided over when the acts of an employee will fall within category (ii). A majority of the court, comprising Chief Justice Gleeson and Justices Gummow, Hayne and Callinan, regarded the appropriate test as being whether the unauthorised acts were done ‘in the course of the employee’s employment’. Chief Justice Gleeson and Justices Gummow and Hayne thought, for various reasons, that it was conceivable that the sexual abuse of a pupil could fall within this category.

Justice Gaudron held that, at common law, an employer is vicariously liable only for the authorised acts of its employees (under the general principles of agency). However, her Honour considered that, where an employee commits unauthorised acts that are within his or her ostensible authority, then the employer is estopped from denying that the employee was acting within authority.

Justice Kirby agreed that intentional wrongdoing was not a bar to the imposition of vicarious liability, but adopted an even broader test, namely, whether there was a sufficiently ‘close connection’ between the acts alleged to constitute wrongdoing and the employment or enterprise. His Honour held that the sexual assault of pupils by teachers is so closely connected with the teacher’s employment as to justify holding the school vicariously liable.
Overall, a majority of the court (with Justice Callinan dissenting) held that it was open to the plaintiffs to sue, claiming that the schools were vicariously liable for the teachers’ conduct. Since Justice McHugh would have held the school liable for breach of its non-delegable duty, he did not address this issue.

The court’s finding that non-delegable duties exclude intentional wrongs means that non-delegable duties are defined more narrowly than the vicarious liability of employers. Additionally, the court indicated a reluctance to expand the categories of relationship where a non-delegable duty will arise. The duty will exist in cases of special vulnerability, e.g. hospital and patient; child day-care centres and children. Some of the judgments indicated a tendency toward a broader interpretation of what actions could constitute an ‘unauthorised mode of performing an authorised act’. While the circumstances of this case made it unnecessary for the court to reach a final decision on whether vicarious liability of a school arose, several members of the court indicated that it conceivably did.

The impact of this decision must be considered in light of various recent legislative reforms relating to civil liability, particularly as applied to providers of recreational services. These reforms were outlined in the *Annual Review of Insurance Law 2002.*
Broker’s duty to advise insured about its insurance requirements

Case Name: Katherine Electronic Services Pty Ltd v CGU Insurance Limited trading as Commercial Union Insurance and Nonpareil Pty Ltd trading as Pfitzner & Partners Insurance Brokers

Citation: [2003] NTSC 72, Supreme Court of the Northern Territory per Angel J

Date of Judgment: 20 June 2003

Issue:
- Duty of care of broker to advise in relation to insurance requirements

A business insurance policy obtained from a broker did not include flood cover, a relevant risk for the insured. The broker was held to have breached its duty of care to sufficiently inform the insured about its insurance requirements.

Katherine Electronic Services Pty Ltd (KES) was insured for damage caused by storm, tempest or rain, but not against damage due to flood. The stock and plant of the business was damaged by water after a storm, and subsequent flooding of the Katherine River. KES claimed against both:

(a) CGU Insurance Limited, trading as Commercial Union Insurance (the insurer), claiming that the entire loss was caused by an initial inundation of water, and not as a result of the subsequent flooding; and

(b) Nonpareil Pty Ltd, trading as Pfitzner & Partners Insurance Brokers (the broker), for not exercising reasonable care, in failing to:

- arrange flood cover, as the threat of flood was a known hazard relevant to KES; and

- draw KES’s attention to the express exclusion of flood cover in the policy.

The Supreme Court of the Northern Territory gave judgment for KES against both the insurer and the broker. The court found that the ‘sole proximate cause’ of damage to the KES plant and stock resulted from the initial inundation caused by the excessive storm rains, and not from flooding of the Katherine River. The insurer was, therefore, liable to pay out under the policy. However, this did not cover most of the loss, which would have been covered under flood cover.

The court found that the broker failed to exercise reasonable care in failing to bring the availability and desirability of obtaining flood cover to KES’s attention and in failing to expressly draw KES’s attention to the exclusion of flood cover from the policy.

As KES’s insurance broker, the broker was obliged, both in contract and tort, to advise KES sufficiently to enable the company to make an informed decision about its insurance requirements.
Review of the Insurance Contracts Act

Background
On 10 September 2003, Assistant Treasurer Helen Coonan announced the Federal Government's intention to undertake a comprehensive review of the *Insurance Contracts Act 1984* (Cth) (*Insurance Contracts Act*), the main piece of legislation regulating the relationship between insurers and consumers. The two-part Review is being headed by Alan Cameron and Nancy Milne.

Objective and scope
The objective of the Review is to seek recommendations aimed at improving the overall operation of the *Insurance Contracts Act* by correcting deficiencies and clarifying ambiguities in its operation.

It is proposed to:

- identify the specific provisions that do not operate satisfactorily and reasons for these deficiencies;
- identify and recommend measures to ameliorate ambiguities in drafting, or resulting from judicial interpretation;
- recommend amendments (including new provisions or the repeal of existing provisions) that would improve the operation of the *Insurance Contracts Act*; and
- identify areas of the *Insurance Contracts Act* that operate in a satisfactory manner (that is, the specific areas that should not be amended and, if appropriate, why).

Stage 1
The Review comprises two stages. The first stage was to examine the operation of section 54 and make recommendations to improve this section. It prevents an insurer from relying on a term of a contract of insurance that would allow the insurer to refuse a claim for the sole reason of an act, error or omission of the insured. Instead, the insurer may reduce the claim to the extent of the prejudice it has suffered.

The report on s54 was released to the public on 18 November 2003 and the Review recommended that any amending legislation should be the subject of further consultation with stakeholders before being introduced.

The following recommendations were made:

1. Section 54 should be expressly stated to continue to operate in relation to ‘occurrence based’ policies as it does now; and
2. an amendment to the section should:

- provide that it does not excuse a failure to notify facts or circumstances that may give rise to claims under ‘claims made’ and ‘claims made and notified’ policies (or those that are subject to s40(3) of the Insurance Contracts Act);
- exclude contracts as prescribed by regulation (or declared by the Australian Securities and Investments Commission) or, alternatively, provide that it apply to express categories of insurance;
- require an insurer to notify the insured between seven business days and one month before the expiration of a policy of the importance of notifying facts or circumstances, unless the insurer knows the insured is advised by an insurance broker (although a failure by the insurer to notify should not be a condition of the exclusion of s54); and
- provide an extended reporting period of 45 days for facts or circumstances (not claims) to which s40 of the Insurance Contracts Act applies.

The Review identified the application of s54 to the late notification of facts or circumstances as being ‘the real mischief’. It did not endorse submissions that s54 should be amended to exclude relief for late notification of claims (as opposed to facts or circumstances), stating that, for many years, s54 has been interpreted to provide such relief and no submission had provided solid evidence of the problems that this interpretation had caused.

Stage 2

The second stage of the Review will examine the balance of the Insurance Contracts Act. A report to government on the second stage is expected by 31 May 2004 and should be released to the public soon after.
Tort law reform

Background

In the AAR Annual Review of Insurance Law 2002, we detailed the recommendations of the Review of the Law of Negligence, chaired by Justice Ipp, and the steps taken by the Commonwealth, States and Territories to implement those recommendations.

In 2003, the States and Territories enacted many legislative instruments, partly for the purpose of implementing some of the Review’s recommendations. However the insurance industry needs to be aware that the reforms of 2003 extend beyond the scope of the Review recommendations, to other significant aspects of the law of negligence. In addition, the Commonwealth has made clear its focus on national professional standards legislation and proportionate liability reforms, two areas that are likely to receive considerable attention in 2004, particularly from professional service providers. Legislation proposing these reforms was introduced immediately before Parliament adjourned for 2003 and is expected to receive considerable interest in the first half of 2004.

Another widely anticipated development in 2004 will be the final report of the Review of the Insurance Contracts Act due before June. The interim report is discussed below, together with each of the other initiatives of the Commonwealth, States and Territories in 2003.

Commonwealth initiatives

Legislation

As at January 2003, the only legislative reforms enacted by the Commonwealth Parliament to reform civil liability laws were the Taxation Laws Amendment (Structured Settlements and Structured Orders) Act 2002 and the Trade Practices Amendment (Liability for Recreational Services) Act 2002. These Acts respectively remove income tax disadvantages of structured settlements and allow corporations providing recreational services to contract out of warranties of due care and skill implied by the Trade Practices Act 1974 (TPA). Each of these Acts commenced in December 2002.

In 2003, the only further legislative reform of civil liability passed at federal level was the Commonwealth Volunteers Protection Act 2003, which protects persons doing voluntary work for the Commonwealth from civil liability. However, the Act was never proclaimed and its main provisions commenced, by default, in August.

No further legislative reforms introduced into the Commonwealth Parliament have yet been passed.
The Trade Practices Amendment (Personal Injuries and Death) Bill was introduced in March. It proposes to amend the TPA by preventing the bringing of claims for personal injury and death arising from breach of the ‘unfair practice’ provisions of the TPA (including the prohibition on misleading and deceptive conduct). The Bill was the subject of report by the Senate Economic Legislation Committee and was amended by the Senate, but those amendments have been rejected and the Bill returned to the Senate. Its future remains uncertain.

The Treasury Legislation Amendment (Professional Standards) Bill 2003 was introduced on the last sitting day of 2003. It proposes to allow State and Territory professional standards laws to limit liability of professionals and tradespeople under the misleading and deceptive conduct prohibitions contained in the TPA and equivalent provisions of the Australian Securities and Investments Commission Act 2001 and Corporations Act 2001. However, the current form of the Bill enables the Commonwealth to modify standards schemes enacted by the States and Territories.

Introduced on the same day, the Corporate Law Economic Reform Program (Audit Reform and Corporate Disclosure) Bill (also known as CLERP9), proposes to apply proportionate liability principles to Commonwealth legislation but only to breaches of section 52 TPA and equivalent provisions in the ASIC Act and Corporations Act. There remains the possibility of claims under other sections of those Acts which will not be subject to proportionate liability.

Ministerial meetings

The Ministerial Meetings on Public Liability, of which four were held in 2002, continued in 2003.

April The meeting considered the national adoption of proportionate liability and professional standards legislation. The Commonwealth announces that it will amend the Trade Practices Act 1974 as the basis for a national approach on these issues. Also discussed the need for appropriate disclosure by brokers of renewal terms, the operation of s54 of the Insurance Contracts Act 1984 and taxes on insurance.

August The Ministers endorsed a national scheme for professional standards legislation for economic loss and committed to implement proportionate liability across Australia. Discussion about the impact of s54 of the Insurance Contracts Act 1984 on the cost and availability of professional indemnity and similar types of insurance.

Reports

The following reports released in 2003 were commissioned by the Commonwealth following the Ministerial Meetings on Public Liability.

January Productivity Commission report Public Liability Claims Management is released, which concludes that competition in the public liability
insurance sector is sufficient to ensure efficient and cost-effective claims management practices in Australia.

August    
Australian Competition and Consumer Commission (ACCC) report *Public Liability And Professional Indemnity Insurance: Monitoring Report* is released, the first of four monitoring reports to be produced by the ACCC over the next two years. Several major insurers in the public liability and professional indemnity insurance sectors provided quantitative and qualitative information on costs and premiums to the ACCC. The ACCC concludes that some public liability insurers expect government reforms to reduce claims costs and moderate premium increases in 2003 but uncertainty remains about the short- and long-term impacts of recent reforms on claims costs. The implementation and impact of professional indemnity reforms considered in 2003 may be considered in future monitoring reports. The ACCC states that it is too early to say to what extent reforms have lowered insurers’ costs and whether these cost savings have been passed on to consumers.

November    
Commonwealth releases *Report into the Operation of Section 54*, an interim report of the broader Review of the *Insurance Contracts Act* announced in September. The Review Panel recommends that:

– s54 be amended only for ‘claims made’ insurance and not in relation to ‘occurrence based’ policies;

– s54 be amended so as not to apply to failures to notify circumstances (overriding the Australian Hospital Care case); and

– an extended reporting period be made available for the late notification of circumstances and that insurers be required to notify insureds, prior to the expiration of these policies, of the necessity to make such notifications.

The Commonwealth announces that the amendments to s54 will be released for public exposure and introduced into Parliament early in 2004. The remainder of the Review will be delivered to the Government by 31 May 2004.

**State and Territory reforms**

Each of the States and Territories enacted legislation in 2003 to implement reforms to civil liability – some of which were recommended by the Review of the Law of Negligence but some of which are unique and inconsistent with other States and Territories.

**Australian Capital Territory**

March    
The *Civil Law (Wrongs) Act 2002* is amended to exclude liability for death or injury caused by acts of terrorism before 1 October 2004 if the death or injury arises out of the use of a motor vehicle.
July  The Civil Law (Wrongs) Regulations 2003 are enacted. The Civil Law (Wrongs) Act 2002 requires insurers carrying on business in relation to property in the ACT or any act happening in the ACT to report to the Minister by 31 July each year with information about premiums collected and claims paid (and refused) for each class of insurance prescribed by the regulations, being professional indemnity insurance (doctors and non-doctors are separate classes requiring separate disclosure) and the classes of direct business for which information must be reported to the Australian Prudential Regulation Authority (that is, all classes, both domestic and commercial).

September  Substantial amendments are made to the Civil Law (Wrongs) Act 2002, including the prescription of the principles of standard of care, causation and the duty of care concerning mental harm. The amendments allow courts to reduce damages awards to nil on account of contributory negligence, provide protection for a person who makes an apology that contains admissions of fault, protect public authorities from liability, promote mediation of claims, and modify limitation periods for personal injury claims. A reform unique to the ACT limits liability in relation to some equine activities (not including horseracing).

December  The Attorney-General proposes to amend the Civil Law (Wrongs) Act 2002 to restrict awards of general damages against doctors for the provision of health services. The Civil Law (Wrongs) (Thresholds) Amendment Bill proposes a threshold so that no damages may be awarded for non-economic loss in medical indemnity cases unless the severity of the non-economic loss is at least $12,001. Where the severity of the non-economic loss is between $12,001 and $20,000, a formula determines the general damages that may be awarded. From $20,001, full damages for non-economic loss are payable.

Pending  Amendments to the Civil Law (Wrongs) Act 2002 have been passed that prescribe procedures with which claimants and respondents must comply before commencing legal proceedings for personal injury claims. The Act also restricts the use of expert medical witnesses in such proceedings and requires the sharing of documents and information relevant to the claim.

The Civil Law (Wrongs) Act 2002 will also be amended to allow costs orders to be made against lawyers who act in damages claims that do not have reasonable prospects of success. A certificate of reasonable prospects is also required to be filed by the lawyer before signing any pleading in a claim for damages.
Each of the pending amendments above begins on 8 March 2004, unless notified earlier.

**New South Wales**

**January**  
The *Civil Liability Act 2002* is amended to allow a term of a contract for the supply of recreation services to exclude, restrict or modify any liability in negligence for harm to a person that results from breach of an express or implied warranty that the services will be rendered with reasonable care and skill.

**February**  
The *Civil Liability Regulation 2003* prescribes non-government schools as public authorities for the purposes of the *Civil Liability Act 2002*, putting them on the same footing as government schools with respect to civil liability in tort.

**October**  
The cap applied by the *Civil Liability Act 2002* on awards of general damages in personal injuries claims is adjusted to $384,500.

**December**  
The *Civil Liability Act 2002* is amended to restrict a person’s right to recover damages if the conduct of the person would have constituted a serious offence, but for the person’s mental illness at the time of the conduct. Other amendments include excluding damages for the costs of rearing a child or for lost earnings where there is civil liability for the birth of the child; limiting further the liability of public officials exercising public functions; and protecting from liability a person who acts in self-defence in response to conduct of another person that would have been unlawful if that other person had not been suffering from a mental illness.

Amendments to the *Legal Profession Act 1987* are passed urgently to further restrict advertising by legal practitioners for legal services connected with personal or work injuries and penalties for a breach rise from $1,100 to $22,000.

**Pending**  
Some amendments were made in December to the proportionate liability provisions of the *Civil Liability Act 2002* that are intended to apply to property damage and economic loss claims. The amendments require a defendant to notify the plaintiff to proceedings of the identity of concurrent wrongdoers of which the defendant is aware. The amendments also exclude from the proportionate liability provisions any wrongdoer who intentionally or fraudulently caused the loss. However no commencement date has been announced for any of the Act’s proportionate liability provisions.

Amendments to the *Legal Profession Act 1987* were passed in December, which propose to allow the Law Society Council, Bar...
Council and Legal Services Commissioner to obtain restraining orders against unlawful advertising by lawyers.

**Northern Territory**

**May** The *Personal Injuries (Liabilities and Damages) Act 2003* introduces a significant number of reforms, including protection from liability for volunteers, community organisations and good Samaritans; the inadmissibility of expressions of regret; limitation on recovery of personal injury damages by criminals and intoxicated persons; caps and thresholds for personal injury damages claims; and the ability of courts to order structured settlements.

The *Consumer Affairs and Fair Trading Act* is amended to allow a term of a contract for the supply of recreational services to exclude, restrict or modify liability for death of, or personal injury to, a person that results from breach of an express or implied warranty that the services will be rendered with due care and skill.

**July** The *Personal Injuries (Civil Claims) Act 2003* commences in part, empowering courts to make rules prescribing procedures to be followed before commencing litigation. In addition, legal professional privilege no longer attaches to medical reports, although parties can redact statements of opinion on liability before being required to disclose the contents of reports.

Amendments to the *Legal Practitioners Act* empower the Law Society to make rulings in relation to professional misconduct for advertising personal injury legal services.

**Pending** Amendments to the *Legal Profession Act*, which make it an offence to advertise personal injury legal services, have been passed but have not yet commenced.

**Queensland**

**April** The *Civil Liability Act 2003* commences, although many of its provisions are taken to have commenced in December 2002. The Act prescribes principles for the standard of care, causation, assumption of risk, and contributory negligence. The duty of professionals is prescribed separately, including the duty of doctors to warn patients of risks. The Act limits the liability of public authorities, volunteers and persons performing duties in an emergency to enhance public safety. It limits the ability of criminals and intoxicated persons to recover damages. Personal injury damages claims are made subject to caps on awards of economic loss and general damages are awarded according to a scale of 100 points, capped at $250,000. Courts may make structured settlement orders and expressions of regret are inadmissible in civil proceedings.
September The Civil Liability Regulation 2003 sets out the ranges of injury scale values for the general damages scale prescribed by the Act. The Regulations also list the prescribed entities providing services to enhance public safety for the protection of those entities from liability under the Act.

December The Civil Liability Act 2003 is amended so that, in the event of a failure to warn about or perform a sterilisation or contraceptive procedure, if a child is born despite the procedure a court cannot award to either parent damages for economic loss arising from the costs ordinarily associated with raising a child.

Pending The proportionate liability provisions contained in the Civil Liability Act 2003 have not yet commenced. Unlike other jurisdictions, the Act proposes not to apply proportionate liability to any claim for damages below $500,000.

South Australia

March The Law Reform (Delay in Resolution of Personal Injury Claims) Act 2002 amends the Wrongs Act 1936 to enable a court to award exemplary damages to dependants or the estate of a deceased person whose personal injury claim was unreasonably delayed by the defendant or someone with an interest in the defence of the claim.

July The Recreational Services (Limitation of Liability) Act 2002 provides protection from liability for recreational service providers who subscribe to approved codes of practice. A registered code can allow for a modified duty of care for those who undertake to comply with the code where a prescribed form of notice is given. The Recreational Services (Limitation of Liability) Regulations 2002 prescribe the process by which a person may have a code of practice registered, including the payment of fees. The regulations also prescribe the form of notice to participants. As at 31 December 2003, no codes of practice had been recorded as registered, approved or refused, according to the Office of Consumer Affairs for South Australia website.

Pending The cap applied by the Wrongs Act 1936 to awards of general damages for personal injury arising from accidents in 2004 is adjusted to $250,280.

The Law Reform (Ipp Recommendations) Bill, introduced in April and passed by the Legislative Council in October, proposes to rename the Wrongs Act 1936 as the Civil Liability Act 1936 and to prescribe principles for determining the existence of a duty of care, causation, assumption of risk, the standard of care expected of professionals, liability of road authorities, the effect of criminal conduct and contributory negligence. The Bill also proposes to prevent a court awarding damages for the ordinary costs of raising a child in actions
for negligence, innocent misrepresentation and breach of implied warranties relating to unintended births and conceptions.

The Professional Standards Bill, introduced in November, is intended to enable the creation of schemes to limit the civil liability of professionals and improve occupational standards, and to establish the Professional Standards Council to supervise the preparation and approval of such schemes.

Tasmania

January The Civil Liability Act 2002 commences, limiting the recovery of damages by criminals and intoxicated persons, rendering apologies inadmissible and enabling courts to order structured settlements.

July The Civil Liability Act 2002 is amended to prescribe principles of standard of care, causation, mental harm, obvious risk, professional negligence, non-delegable duties and vicarious liability. The liability of public authorities and volunteers is limited. Personal injury and death claims are subject to a general damages threshold of $4,001 and a sliding scale applies to general damages assessed up to $20,000. Damages for economic loss are capped.

Victoria

February The Wrongs Act 1958 is amended to allow courts to order structured settlements.

March The Wrongs Act 1958 is amended to protect volunteers from civil liability.

May The Goods Act 1958 is amended to protect recreational service providers from liability by the use of forms prescribed by regulation.

Amendments to the Wrongs Act 1958 impose threshold levels of impairment in relation to the recovery of damages for non-economic loss at more than 10 per cent for psychiatric injury and more than five per cent for any other injury. The recovery of damages for gratuitous attendant care services is also capped and subject to threshold levels of care, below which no damages for care will be awarded. Procedures for assessing impairment are introduced, including certification by a medical panel and the imposition of time restrictions on claimants and respondents. The Act also amends the Limitation of Actions Act 1958 for actions concerning death or personal injury.

July The cap applied by the Wrongs Act 1958 on awards of general damages in personal injuries claims is adjusted to $382,950.

December The Wrongs and Other Acts (Law of Negligence) Act 2003 introduces into the Wrongs Act 1958 principles of duty of care, causation, awareness of risk, professional negligence, vicarious liability and contributory negligence. It limits damages recoverable for mental...
harm and protects public authorities from civil liability. Amendments are also made to the procedures for the assessment of impairment, in order to determine entitlements to non-economic loss.

By proclamation, the Wrongs Act 1958 is amended so that, from 1 January 2004, proportionate liability provisions apply to claims for economic loss and property damage arising from a failure to take reasonable care. Specific exceptions apply, including claims that arise out of an injury.

Pending Amendments to the Fair Trading Act 1999, which have been passed but have not yet begun, will imply conditions and warranties in contracts for supply of services, with a carve-out for recreational services. Equivalent provisions currently contained in the Goods Act 1958 will be repealed.

The Professional Standards Act 2003 received assent on 2 December 2003 but has not yet commenced. It is intended to enable the creation of schemes to limit the civil liability of professionals; to improve occupational standards; and to establish the Professional Standards Council to supervise the preparation and approval of such schemes.

Western Australia

January The Volunteers (Protection from Liability) Act 2002 provides volunteers with protection from civil liability.

The Civil Liability Act 2002 introduces a threshold of $12,001 on awards of general damages in personal injury claims. A formula applies on general damages awards up to $48,500 and a cap applies to damages for economic loss. The Act also allows courts to order structured settlements and restricts the advertising of personal injury legal services.

July The threshold applied by the Civil Liability Act 2002 on awards of general damages in personal injuries claims is adjusted to $12,500. The threshold for gratuitous care awards was also adjusted but, after rounding off, remains unchanged.

December The Civil Liability Act 2002 is amended to allow limited contracting out from its provisions, to prescribe principles of duty of care, causation, contributory negligence and assumption of risk. The Act now limits the damages recoverable for mental harm and protects public authorities and good Samaritans from liability. Apologies are inadmissible.

Pending Amendments to the Civil Liability Act 2002 introducing proportionate liability to economic loss and property damage claims have been passed but not yet commenced.
Background

In the 2001 and 2002 editions of the Annual Review of Insurance Law, we set out an overview of the Financial Services Reform (FSR) legislation, which commenced on 11 March 2002. It amended the Corporations Act 2001 (Cth) (Corporations Act) to introduce a uniform licensing, conduct and disclosure regime for financial service providers. The introduction of most of the FSR provisions is subject to a two-year transitional relief period, which expires on 10 March 2004.

To recap, an entity that carries on a financial services business in Australia (which includes entities issuing or arranging most types of general and life insurance products) must obtain an Australian financial services (AFS) licence; alternatively, it must establish that it is able to rely on one of the licensing exceptions contained within the regime. An entity will carry on a financial services business for FSR purposes if it carries out certain activities (eg issuing, advising on or dealing in financial products).

Most life and general insurance products are specifically designated as financial products under FSR. However, reinsurance, health insurance and Commonwealth, State and Northern Territory insurance are specifically excluded from the regime.

The following FSR-related issues arose in 2003 and affect the insurance industry.

Legislation

FSR Amendment Act 2003

The Financial Services Reform Amendment Act 2003 (FSRAA) was introduced into Commonwealth Parliament in June, passed with amendments by both Houses on 5 December 2003 and received Assent on 17 December 2003. The purpose of the FSRAA is to clarify and amend various aspects of the FSR regulatory framework.

The amendments of particular relevance to the insurance industry are summarised below. References to sections are to the sections of the Corporations Act as amended or inserted by FSRAA.

(a) Bundled insurance contracts

The FSRAA provides a consistent basis for determining when general insurance products are financial products, irrespective of whether the products are provided individually in separate contracts of insurance or provided in a bundled contract of insurance. To the extent that one component of a bundled product would be taken to be a financial product under FSR, then the obligations that relate to that product (for example, if that product is taken to be provided to retail clients) are applied only to that component of the product. In other words, bundled products are
divisible between their retail components and wholesale components for product disclosure and other purposes (section 764A).

(b) Exceptions to the provision of a custodial or depository service

A person provides a financial service if, among other things, they provide a custodial or depository service. The FSRAA provides that the operation of a statutory fund by a life company is not the provision of a custodial or depository service (s766E(3)(ca)).

(c) ASIC’s exemption and modification powers

Powers to provide exemptions from, or make modifications to, the application of certain provisions of the Act (exemption and modification powers) are given to the Australian Securities and Investments Commission (ASIC) (sections 951B, 992B, 1020F, 1075A, 1437 and 1442). ASIC uses its exemption and modification powers to provide administrative ‘relief’ from the operation of various provisions of the legislation in circumstances where it judges that application of those provisions is not warranted, or that they should apply in a modified way.

Usually, the exemption and modification powers are exercised in response to requests for relief from parties who are experiencing difficulties complying with a particular provision of the legislation or where the application of the provisions is not appropriate to particular circumstances. Prior to FSRAA, ASIC’s exemption and modification powers were subject to the limitation that they could not be exercised by ASIC to declare that provisions be modified such that they would apply in relation to persons and/or financial products to which they would not otherwise apply. For example, insurance brokers who failed to renew their registration in accordance with the Insurance (Agents and Brokers) Act 1984 (Cth) (IABA) are effectively denied the benefit of the transition period to the FSR regime. ASIC could not modify the FSR provisions to provide relief to brokers who did not renew in time, regardless of the reason.

ASIC’s view was that the limitation referred to above presented a substantial impediment to their effective use of the exemption and modification powers. Therefore, the FSRAA repeals sections 951B(2), 992B(2), 1020F(3) and amends sections 1437(3) and 1442(3) to remove the limitation referred to above. However, the amendment does not limit ASIC’s power only to situations where relief has been requested.

(d) Notification of the appointment of authorised representatives

The FSRAA provides that the appointment of certain individual representatives by a corporate authorised representative does not have to be notified to ASIC if certain conditions are met, including that the individuals are employees of the authorised representative and that they provide only general advice or deal in financial products prescribed by the regulations.

It is also extends the time for notification to ASIC of the appointment of an authorised representative (and to an AFS licensee of the appointment of an individual representative) from 10 business days to 15 business days (s916F).
(e) Defective Financial Services Guide

Amendments provide greater certainty in relation to the requirement that a Financial Services Guide (FSG) must be up-to-date when given to a client, and up-to-date on the meaning of the term defective within the criminal and civil liability provisions of the Corporations Act. The inclusion in a FSG of information that is not up-to-date (or an omission of information relating to new circumstances) is deemed to constitute a misleading statement for the purposes of determining whether an FSG is defective (s941E).

(f) Combined FSG and PDS

An FSG and a Product Disclosure Statement (PDS) may be combined in a single document in the circumstances set out in the regulations (s942DA).

(g) Anti-hawking provisions

The prohibition on making an offer to issue financial products in the course of, or because of, an unsolicited meeting or telephone call is extended to prohibit an invitation to issue or an invitation to offer financial products (s992A).

(h) Providing a PDS later

If a risk insurance or investment life insurance product is issued or recommended to a retail client who expressly instructs that they require the financial product immediately and it is not reasonably practical to provide the client with a PDS within the time required, the regulated person need only communicate the prescribed information orally, rather than read a prepared statement (s1012G).

(i) Extension of transition period

ASIC may declare that the transitional provisions of the legislation extend to a person or class of persons beyond 10 March 2004 (ss1437 and 1442).

Corporations Amendment Regulations

A total of 11 tranches of amendments were made to the Corporations Regulations during 2003. Those amending regulations of particular relevance to the insurance industry are set out below, by reference to their commencement dates.

11 March 2003

Reg 7.1.07C Insurance provided by an overseas student health insurance contract is not a financial product.

Reg 7.1.07D A funeral expenses policy is not a financial product.

Reg 7.8.20A Risk insurance products are exempt from the prohibition on AFS licensees and their employees jointly acquiring financial products.

Reg 7.8.22 The limitations on making contact with customers as set out in anti-hawking provisions are extended to include an additional five public holidays.

Reg 7.9.07D A PDS is not required for a general insurance product offered as part of a contract of insurance that offers more than one kind of insurance cover and
which the regulated person reasonably believes that the client does not intend to acquire.

Reg 10.2.38 The transitional provisions have been amended to apply to certain insurance brokers whose licences have expired but who applied for re-registration, and to life and general insurers.

Reg 10.2.87A A document or statement that contains information given in accordance with Insurance and Superannuation Commission Circular GI1 is an exempt document or statement.

8 May 2003

Reg 7.1.33D A person is taken not to provide a financial service if they are an issuer of a financial product for which they make a market and where the product is an investment-linked life insurance policy under an investment-linked contract.

Reg 7.7.05B An FSG provided by an individual authorised by a corporate licensee or authorised representative does not need to include the name and contact details of the individual in certain circumstances.

1 July 2003

Reg 7.1.17A Medical indemnity insurance products are taken to be provided to retail clients (see our separate section on Medical Indemnity Reforms).

Reg 7.6.01 Advising in relation to, or dealing in, a medical indemnity insurance product does not require an AFS licence until 11 March 2004 or the date on which the person obtains an AFS licence for the product, whichever is earlier.

Reg 7.9.95 Medical indemnity insurance products are exempt from the FSR product disclosure provisions until 11 March 2004, or earlier, if the issuer of the product opts-in to the new regime.

6 August 2003

Reg 7.7.02 An FSG does not need to be provided in certain circumstances in respect of general advice given in a telephone call during which there is no issue of a product (or where the call is to an existing client); however, the providing entity must tell the client that an FSG exists and must offer to send out an FSG on request.

13 November 2003

Reg 7.6.01 A financial service provided to a wholesale client by the Export Finance and Insurance Corporation is exempt from the AFS licensing requirement.

Regs 7.7.01/02A An FSG, PDS or a Statement of Advice (SOA) may be given to a person or their agent in any way agreed to by them if the regulated person is satisfied that they received it.

Reg 7.9.07E No PDS need be given to a client who informs the regulated person explicitly that they do not wish to acquire the financial product and where no issue
results from the offer (for example, where a client terminates a telephone call due to lack of interest in acquiring the product).

Reg 7.9.07F In certain circumstances, no PDS need be given to a client who is not contactable for as long as they are not contactable.

23 December 2003

Reg 7.6.01 An AFS licence is not required for financial services provided to wholesale clients by bodies established and regulated for the provision of insurance under a law of the Commonwealth or of a State or Territory that is required under a law to carry on any business of insurance or to undertake liability under a contract of insurance.


Reg 7.6.04A The appointment of an authorised representative does not have to be notified to ASIC if the representative is only authorised to provide general advice that relates to, or deals in, general insurance products.

Reg 7.7.08A Sets out the circumstances in which a Combined Financial Services Guide and Product Disclosure Statement may be issued for a general insurance or life risk insurance product.

Reg 7.8.22A The provisions relating to offers during unsolicited telephone calls are modified by removing the requirement of offering to read out the information in the PDS and instead providing the details of the provider, indicating the nature of the information in the PDS and offering to provide any of the information contained in the PDS.

Regs 7.9.80C/80D In an issue situation, in certain circumstances if the client so elects (and is not influenced by the regulated person), where a PDS is to be provided later, the regulated person need not state the essential features, significant risks and dispute resolution system relating to a financial product. In a recommendation situation, the regulated person may also be exempted from the need to state the costs, fees and charges associated with the product.

1 July 2004

Regs 7.7.11-13 Where an SOA must disclose a charge, benefit or remuneration, it must be stated as a dollar amount or, if that is not possible, as a percentage of a specified matter, or if neither of those are possible, as a description of a method of calculating the charge, benefit or remuneration.

Reg 7.9.15A Where a PDS must disclose a benefit, cost or payment, it must be stated as a dollar amount or, if that is not possible, as a percentage of a specified matter or, if neither of those are possible, as a description of a method of calculating the benefit, cost or payment.

In December, Treasury also released draft regulations for consultation, some of which have particular application to insurance products and services. It is proposed
that providing advice in relation to, or dealing in, general insurance, investment life insurance or life risk insurance products will each represent a separate class of financial service. Treasury believes this clarification is necessary because of a perceived reluctance of licensees to ‘cross-endorse’ representatives because of the potential for liability from activities relating to other classes of financial services.

The draft regulations also propose to treat insurance provided by the Australian Capital Territory in the same way as other States and the Northern Territory (the legislation does not currently refer to ACT insurance). It is also proposed that Reg 7.7.05B, referred to above, be extended to corporate authorised representatives. Finally, the draft regulations propose to extend the circumstances in which a PDS is not required to include situations where the client has been given a policy document and other information prescribed by the Insurance Contracts Act 1984.

ASIC publications and statements

Information release

ASIC’s information release of 10 June 2003 contained its interim position on the circumstances in which ASIC will permit excesses or deductibles on professional indemnity insurance cover to exceed the level prescribed by the IABA. Under current compensation arrangements, acceptable indemnity insurance must be maintained by insurance brokers registered under IABA and these arrangements will continue to apply until 10 March 2004, after which time it is anticipated that new compensation arrangements will come into effect. Under IABA, an acceptable contract of insurance is prescribed as one where any deductible does not exceed $10,000 or 2.5 per cent of the insurance brokerage income for the previous financial year (whichever is greater). Under the interim arrangements, ASIC will permit a deductible to exceed the IABA requirements, provided the deductible does not exceed $18,750, or 20 per cent of the surplus liquid funds of the insurance broker or AFS licence holder, whichever is greater. In order to qualify, an insurance broker or licensee needs to apply to ASIC in writing. Where the deductible is greater than $18,750 but does not exceed 20 per cent of surplus liquid funds, applicants must also provide a supporting letter from a registered company auditor confirming the current amount of surplus liquid funds.

An information release on 15 July 2003 announced ASIC’s interim position3 on to the regulation of mutual risk products (MRPs), which generally involve participation in a ‘mutual’ scheme based around particular professions, small business associations, franchise operations or community groups. ASIC’s stated view is that MRPs are financial products for the purposes of the Corporations Act because they represent both facilities for managing financial risk and interests in a managed investment scheme. As such, ASIC generally expects MRP providers to comply with the managed investment scheme and licensing provisions of the Corporations Act but will consider granting relief in limited circumstances.

---

Class orders

In June 2003, ASIC released Class Order 03/448 to provide relief to permit an FSG and a PDS to be combined in one document in certain circumstances. As noted above, this has since been the subject of legislative amendment.

In July, ASIC issued Class Order 03/645 to ensure that an applicant, who is able to streamline an application for a product that forms part of one of the specified financial products (deposit products and insurance products respectively), is able to be authorised to provide financial services for all of the relevant specified products under the streamlined application procedure.

In October, ASIC issued Class Order 03/824, which exempts persons from the need to hold a licence where they are dealing with wholesale clients and the only reason the person is carrying on a financial services business in Australia is as a result of engaging in conduct that is:

(a) intended to induce people in this jurisdiction to use the financial services the person provides; or
(b) is likely to have that effect

(that is, conduct deemed by s911D to be carried on in Australia) whether or not the conduct is intended, or likely, to have that effect in other places as well.

Note that persons who are carrying on a business of providing services to wholesale clients in Australia under the more general tests used to determine whether a person carries on a business in Australia (elsewhere in the Corporations Act and under the common law) still require an AFS licence (unless otherwise exempted).

Licensing guides

In July 2003, ASIC released a licensing guide Responsible officers: Demonstrating compliance with organisational competency obligations, which explains how applicants for an AFS licence can demonstrate that they comply with ASIC’s competency obligations in Policy Statement 164 Licensing: Organisational capacities (PS 164). PS 164 outlines five alternative methods of demonstrating the competency of an applicant’s responsible officers. The guide addresses questions raised by different industry groups about how each of these five alternatives is applied during assessment of licence applications.

In September, ASIC released an updated version of its industry guide about life and general insurance brokers. The guide is designed to assist industry participants in the process of applying for a licence.
In October, ASIC released a new licensing guide, *Meeting the financial requirements for your AFS licence: Compliance with Policy Statement 166*. The guide is designed to provide practical guidance about how to meet obligations under *Policy Statement 166: Licensing: Financial requirements*. Later that month, ASIC released version 4 of the eLicensing system and an updated version of the AFS Licensing Kit.

**Policy statements**

In June 2003, ASIC released *Policy Statement 175: Licensing: Financial product advisers – Conduct and disclosure (PS 175)*, setting out how ASIC proposes to administer conduct and disclosure obligations under the *Corporations Act* relating to the provision of financial product advice to retail clients.

In September, ASIC released *Policy Statement 176: Licensing: Discretionary powers – Wholesale foreign financial services providers*[^7], which sets out the two-pronged test by which ASIC may grant relief from the licensing requirements to a wholesale foreign financial service provider where:

(a) the provider’s overseas regulatory authority delivers sufficiently equivalent regulatory outcomes to the Australian regulatory regime; and

(b) there is effective cooperation arrangements between ASIC and that overseas regulatory authority.

ASIC also amended *Policy Statement 167: Licensing: Discretionary powers and transition*[^8] and *Policy Statement 169: Disclosure: discretionary powers and transition*[^9] in October to provide additional guidance on the factors ASIC considers when assessing applications for relief from the licensing or disclosure provisions of the FSR regime.

**Revised pro forma**

Also in October 2003, ASIC re-issued *Pro Forma 209: Australian financial services licence conditions*. The amendments take into account ASIC policy changes, including PS 175. *Authorisation Condition 1* includes new authorisations to cover licensees who provide financial services in relation to consumer credit insurance only. In addition, the life insurance product authorisations were expanded to include any products issued by a registered life insurance company that are backed by one or more of its statutory funds.

**Frequently asked questions (FAQs)**

ASIC’s answers to FAQs, which are published on its web site, are not definitive statements of the law or of ASIC policy but reflect ASIC’s view on topical issues as at the date of posting. Some answers published in 2003 of particular interest to the insurance industry are set out below, adopting ASIC’s question references.

QFS 16 Reinsurance brokers will need to consider whether they ‘advise’ or ‘deal’ in relation to ‘financial products’ as those terms are defined under the regime. Reinsurance is specifically excluded from the definition of financial products (s765A(1)(g)); however, advice about reinsurance together with advice about a financial product may be covered. Reinsurance brokers should also consider whether they provide incidental advice about financial products (i.e., insurance) or deal in, issue, vary, acquire, or dispose of financial products.

QFS 36 In order to take advantage of the wholesale client licensing exemption set out in s911A(2)(g), the financial service must be one in relation to which the Australian Prudential Regulation Authority (APRA) has regulatory or supervisory responsibility. APRA’s responsibility does not arise merely where the service is provided by an insurance company or a bank. Rather, the service must properly form part of an insurance business, a life insurance business, or a banking business.

QFS 37 Persons who provide financial services under a Corporations Act binder given by an insurer that holds an AFS licence need to be an authorised representative of the insurer or have an AFS licence with the appropriate authorisations (s911B(1)(b) and (d)). AFS licensees can be authorised representatives of other AFS licensees if acting under a Corporations Act binder but only in relation to dealing in risk insurance products (including entering into, renewing, extending or reinstating insurance contracts and dealing with and settling claims). An insurer cannot authorise a person to give financial product advice, including general advice, about the products for which the person acts under the binder. If a person intends to provide financial product advice, they must do so outside the binder arrangement, either as an authorised representative of an insurer (only if they are not licensed) or under their own AFS licence, or as a representative of another licensee that is authorised to provide that service.

Where an AFS licensed insurer has a binder with a corporate entity, this does not operate to automatically make representatives or directors of that corporate entity authorised representatives of the insurer. The process in s916B that relates to sub-authorisation must be followed.

QFS 46 Most insurance brokers will need to either become a representative of an AFS licence holder or obtain an AFS licence in their own right.

QFS 47 The FSR regime will apply to certain conduct (such as arranging and advising) in relation to financial products that include travel insurance. People who advise, arrange or deal in travel insurance will need to either obtain a licence themselves or be the representative of a licensee.

QFS 51 General insurance products are in the main caught by the FSR regime. However, certain insurance products (e.g., those that provide for funeral benefits) are exempt from the definition of a financial product. Each insurer will need to consider whether the products it provides are financial products for FSR purposes and whether the insurers’ activities are covered by relevant exemptions.

QFS 53 Under the current law, it is possible to continue as an agent for more than one insurance company before those companies obtain an AFS licence. During that
period an agent will continue to be regulated by the IABA. Once the insurers obtain AFS licences, the agent may be appointed an authorised representative of more than one licensee and will be subject to the FSR requirements. Insurance multi-agents who obtained qualified licences may operate under them until 11 March 2004. From that date, a qualified licensee intending to continue operating as a licensee (rather than as a representative) must do so under a standard AFS licence.

**QFS 56** A PDS for an insurance product is not required prior to a superannuation fund member becoming covered by a group insurance policy because the insurance product is issued to the trustee, not the member. No benefits are provided directly under the insurance product by the insurer to the member.

**QFS 57** Community groups and non-profit organisations are probably retail (as opposed to wholesale) clients, as they fall within the definition of ‘small business’. That is, they are not necessarily designed to make a profit (but involve ‘system, repetition and continuity’) and pursue the purpose of fulfilling a social obligation. The product disclosure obligations that apply to financial services to retail clients are therefore relevant.

**QFS 62** Although a person may be exempt from the requirement to hold an AFS licence under Part 7.6 of the FSR Act, they may still be required to provide a PDS to retail clients.

**QFS 70** The provision of consumer credit insurance that includes a contract of general insurance is a financial product and is subject to the FSR regime.

**QFS 74** Training for all general insurance products, except personal sickness and accident insurance, may be provided at Tier 2 level. As the personal accident cover provided within a travel policy is generally limited in terms of coverage, this is not considered to fall within the category of ‘personal sickness and accident insurance’ for the purposes of PS 146 compliance. As such, advisers in travel insurance products will generally only need to achieve Tier 2 educational standards. Note that all life product advisers must be trained to Tier 1 level.

**QFS 100** Licence holders who provide services to retail clients are obliged to maintain compensation arrangements but, during the two-year transitional period, the existing arrangements will continue to apply to licensees. The professional indemnity requirements of the IABA will continue to apply to insurance brokers during the transition period.

**QFS 109** An AFS licensee may be the authorised representative of a second AFS licensee who is an insurer, if the first licensee acts under a binder given by the insurer. However, a licensee acting under a binder need not necessarily be an authorised representative of the insurer. For example, the first licensee could provide the financial services that are the subject of the binder under its own licence.

**QFS 110** In general, a licensee cannot be the authorised representative of a second licensee. However, s916E specifically provides for the situation where a licensee may be the authorised representative of a second financial services licensee who is an insurer, if the first licensee acts under a binder given by the insurer.
QFS 125 Whether a person’s activities constitute arranging is a question of degree. In ASIC’s view, an intermediary is more likely to arrange for another person to deal in a financial product (and therefore provide a financial service), where there is a sufficient degree of connection between the intermediary’s actions and the completion of a transaction for a financial product. This may occur where:

(a) the intermediary plays an important role for the consumer in relation to the particular financial product, and the transaction probably would not have proceeded without the intermediary’s involvement; or
(b) the intermediary adds value for one or more of the parties to the transaction.

Generally, the more active the intermediary is in facilitating the transaction between a consumer and a product issuer, the more likely their activity is to be arranging.

The collection and transmission of money and the receipt of benefits based on sales are also indicators that particular conduct may amount to arranging, especially when performed in conjunction with other activities (ordinarily, one of these indicators alone would not amount to arranging, however).

Dealing as an agent, including applying for, acquiring or disposing of a financial product in a second person’s name where you have power to bind that second person, is not arranging.

ASIC provides the following example:

- a consumer appoints a real estate professional (the agent) to manage a rental property on the consumer’s behalf; and
- as part of this arrangement the agent has the power to bind the consumer in relation to a number of transactions including acquiring insurance for loss of income should the rental property become vacant (usually by organising the insurance cover and paying the premium out of the rent account managed by the real estate agent).

Here, the agent has acquired a financial product (general insurance) as agent for the consumer, and the agent would need a licence with an authorisation to deal (by acquiring a financial product) on behalf of another, or be authorised to provide that service on behalf of a licensee with the relevant authorisation.

Also, where, in addition to displaying advertising material relating to the insurance product, an intermediary receives the premium for an insurance product and transmits that premium to the relevant insurance company, this conduct, when viewed as a whole, is highly likely to amount to arranging. In contrast, the mere collection of money from a consumer and transmission of that money to a product issuer is not likely to be arranging.
Medical indemnity reform

Background
In the 2002 edition of the *AAR Annual Review of Insurance Law*, we set out an overview of the first tranche of the Federal Government's medical indemnity reform package, which commenced on 1 January 2003. The second tranche commenced on 1 July 2003, regulating medical defence organisations (MDOs) and applying minimum product standards to the medical indemnity insurance policies they offer. More recently, in response to intensive lobbying by doctors' groups, the Commonwealth has undertaken to provide additional benefits to doctors, which substantially alter the reforms initially proposed.

Legislative reforms
Responding to medical practitioners' widely publicised concerns relating to rising medical indemnity insurance premiums and the viability of the medical indemnity insurance market, the Prime Minister announced legislation in October 2002 to address these issues.

The *Medical Indemnity Act 2002* and related legislation commenced on 1 January 2003, but readers should note that the legislation has since been substantially amended as a result of the lobbying discussed below. The original reforms implemented the following schemes:

**Medical indemnity premium subsidy scheme**

The Commonwealth subsidises premiums payable by bulk-billing obstetricians, neurosurgeons and procedural general practitioners, calculated by reference to the premiums paid in more claims-averse areas of practice.

**High-cost claims indemnity scheme**

The Commonwealth subsidises medical indemnity insurers for 50 per cent of the cost of that portion of claims that exceeds $2 million, subject to the relevant policy limit.

**The IBNR (Incurred But Not Reported) indemnity scheme**

The Commonwealth funds the unfunded IBNR liabilities of MDOs and recoups the cost by imposing a levy on members of MDOs that have benefited from the scheme.

The Federal Government concurrently announced its intention to apply Australian Prudential Regulation Authority (APRA) regulatory and prudential requirements to general insurers offering medical indemnity cover after 1 July 2003. The *Medical
Indemnity (Prudential Supervision and Product Standards) Act 2003, which commenced on 1 July 2003, introduced the following reforms.

Provision of medical indemnity cover

Since 1 July 2003, it is an offence for a person to arrange, offer or renew medical indemnity cover other than:

(a) by a general insurer; and
(b) by means of an insurance contract.

The penalty provisions in the Act extend to intermediaries.

Prudential requirements

New general insurers providing medical indemnity cover have the benefit of a transition period, ending on 30 June 2008, within which to meet the minimum capital requirements imposed by a prudential standard. Accordingly, APRA may approve an application by a new insurer for authorisation under the Insurance Act 1973 in circumstances where the corporate applicant would not otherwise meet the minimum capital requirements.

New insurers that wish to take advantage of the transition period must apply (by June 2005) for a determination from APRA, which must grant the application if the applicant lodges a funding plan in the approved form. Failure to meet that funding plan entitles APRA to revoke the determination that grants the transition period.

Regulations also extend the transition period to some existing general insurers.

Minimum product standards

Insurance that offers medical indemnity cover for medical practitioners and registered health care professionals must have a minimum limit of liability of $5 million. Failure to provide at least the minimum level of cover is an offence.

If an insurance contract provides cover of less than $5 million for a single claim, the Act nevertheless requires the insurer to indemnify the insured up to a maximum of $5 million.

Since 1 July 2003, when a claims-made medical indemnity insurance policy is entered into, takes effect or is renewed, the insurer must also offer, on reasonable terms, to cover the health care professional for claims made during the policy period arising from prior incidents for which the professional would otherwise not be insured. This will prevent the practice of insurers restricting cover by the insertion of a retroactive date. The regulations provide that the offer must be made in writing and remain open for acceptance for 28 days. The insurer must not enter into a medical indemnity insurance contract before receiving a written response to the offer. Evidence of the making of the offer and the response must be retained by the insurer for five years.
Anti-avoidance measures

The legislation contains provisions intended to prevent insurers from circumventing the operation of the legislation and which apply to medical indemnity cover arranged before 1 July 2003 for the dominant purpose of avoiding the operation of the legislation.

Exceptions

These reforms do not apply to medical indemnity cover provided by the Commonwealth, States and Territories and their public authorities and instrumentalities. Accordingly, indemnities provided to health care professionals by public hospitals are excluded from the operation of the Act. The Act also carves out indemnities provided by employers to employees who are health care professionals. This carve-out also extends to indemnities that an employer gives to a contractor who is engaged to provide health care services to the employer’s staff.

Regulations

Regulations made under the legislation:

(a) exempt medical indemnity cover provided to oral and maxillo-facial surgeons;

(b) prescribe certain forms required to be submitted to APRA; and

(c) provide that when a medical practitioner:

(i) dies;

(ii) retires permanently from providing health care at or after age 60; or

(iii) is permanently disabled so that they cannot continue to practise as a health care professional of the same kind

the insurer must, within 28 days, make an offer to provide medical indemnity insurance covering the medical practitioner’s otherwise uncovered prior incidents. The offer must be for cover that the insurer is obliged to offer to renew annually for at least six years from the end of the first claims period. The insurer may offer to include any special terms and conditions attaching to the original cover but must otherwise offer the terms and conditions that are standard at the time of each offer for practitioners in the same practice category.

Complementing the prudential reform of the way in which medical indemnity cover is permitted to be issued, new regulations under the Corporations Act 2001 commenced on 1 July 2003 for the purpose of clarifying how the new financial services regime applies to medical indemnity cover. The regulations provide that:

(a) medical indemnity insurance products are included as a class of general insurance products in s 761G(5) Corporations Act which, if provided to an individual or small business, are deemed to have been provided to a retail client, within the meaning of the legislation;
(b) advising in relation to, or dealing in, a medical indemnity insurance product is added as a new exemption to the need to obtain an Australian financial services licence; however, this exemption applies only until 11 March 2004 (or earlier if the issuer obtains a licence in respect of the product); and

(c) medical indemnity insurance products are exempt from the product disclosure provisions contained in Part 7.9 Corporations Act but only until 11 March 2004 (or earlier if the product issuer opts in to the new regime).

The significance of these reforms is that some medical indemnity insurance providers, in some cases providing medical indemnity cover by way of an insurance contract for the first time, have the benefit of a transition period within which to apply for and obtain a licence to issue medical indemnity insurance products and also to prepare the appropriate disclosure documentation required by the legislation. Since medical indemnity insurance is deemed to be provided to retail clients, medical indemnity insurers will need to provide product disclosure statements and other disclosure documents to insured individuals from 11 March 2004. They will also need to comply with the numerous other obligations that apply to financial services provided to retail clients, including cooling-off periods and dispute resolution mechanisms.

Announcements and reaction to reform

Doctors’ groups were quick to express dissatisfaction with the proposed IBNR indemnity levy and certain other aspects of the reforms. After several doctors stated their intention to resign from the public health care system, the Federal Government announced a review into its reforms, including the IBNR indemnity levy. Details of the principal announcements and releases during 2003 are set out below.

May

When the final form of the above reforms had been settled, the Federal Government announced that the requirements contained in the regulations that apply to offers of retirement cover are intended to apply to doctors retiring in 2003-04 and that a longer-term approach to retirement cover would be in place by 1 July 2004.

At the same time, the Federal Government also announced details of a ‘blue sky’ claims scheme that it would establish to assume all of the liability for any damages payable against a medical practitioner over a specified level of cover provided by the insurer (subject to the same terms as the underlying contract). The threshold for the scheme was announced to be $15 million for claims notified between 1 January 2003 and 30 June 2003, covered solely by an insurance contract and $20 million for claims notified under insurance contracts after 1 July 2003. Full details of the scheme were to be announced at a later date but the Federal Government has stated that it would be funded by a charge levied on medical indemnity providers and would be reviewed after three years.
July The Australian Medical Association (AMA) formally withdraws its support for the imposition of an IBNR indemnity levy, citing an absence of full reforms to support doctors’ liabilities.

August The Government announces the final details of the IBNR indemnity scheme. It is proposed that in 2003-04 the IBNR indemnity levy will be payable only by doctors who were members of United Medical Protection Limited (UMP) as at 30 June 2000. Unless exempted, doctors must pay tax-deductible annual contributions equal to one half of the annual subscription they paid to UMP in 2000-01 (or earlier in some cases).

The Government also announces additional premium subsidies for GP registrars undertaking procedural training.

Levy notices are mailed to doctors by the Health Insurance Commission. The AMA re-states its opposition to the levy and states that medical indemnity premiums are causing many surgeons to consider retirement.

September Numerous press releases and media statements by the AMA and the Federal Government about the IBNR indemnity levy. AMA and other doctors’ groups announce an intention by some member doctors to resign from public practice. Doctors’ rallies are held in some state capitals.

October The Federal Government announces that taxpayers cannot be expected to meet the cost of all negligence claims against doctors who are former members of UMP.

President of the AMA meets with incoming Federal Minister for Health. Agreement reached on an action plan that AMA says ‘should put an end to the crisis.’

The Government announces a policy review. In the interim, it undertakes to extend the high-cost claims scheme to cover half of all medical negligence claims above $500,000 (previously $2 million), to provide additional exemptions from the IBNR indemnity levy and to implement further measures as soon as possible.

The AMA undertakes not to make any further claims for financial assistance until completion of the policy review in December.

The review panel is appointed, comprising the Health Minister, Assistant Treasurer, a lawyer, a financial expert and four representatives of doctors’ groups. The terms of reference of the panel are:

- to consider the impact of all current and proposed reforms and measures (including tort law reforms, new prudential measures and the Government’s announced medical indemnity schemes);
• to identify barriers to ensuring that doctors can continue to treat their patients with certainty and confidence and that the medical indemnity arrangements provide secure and affordable cover;
• to consider any relevant overseas experience or options; and
• to make recommendations regarding the IBNR indemnity levy.

November Legislation is introduced that delays and reduces the IBNR indemnity levies for 2003-04 and that indemnifies doctors for their liability for health care claims above the limit of their medical indemnity insurance.

UMP and its associated insurer, AMIL, exit provisional liquidation. It has been stated that this is the first time in Australian corporate history that a company in provisional liquidation has been successfully restructured.

December The Federal Government announces that it has largely adopted the recommendations of the review panel.

Outcomes
The Commonwealth has undertaken to:

• extend the high-cost claims scheme to cover half of all health care claims against doctors above $300,000;
• establish a Commonwealth Run-Off Reinsurance Vehicle to meet claims against retired doctors and others and will assume the IBNR indemnity levy payable by those doctors;
• pay 80 per cent of that part of doctors’ premiums that are above 7.5 per cent of their gross private medical income;
• replace the IBNR indemnity levy with UMP support arrangements, capping the amount payable by doctors at $5,000 for each year (up to six years) that the doctor was a member of UMP; and
• establish, within 18 months, a working group to consider the effectiveness of the reforms.

The Government states that the total cost to the Commonwealth of its reforms is now $619 million over four years.

The AMA has announced its intention to allow 18 months to assess whether the package of reforms has successfully addressed its stated concerns about the affordability of medical indemnity insurance.

Legislation proposing to amend the IBNR indemnity scheme was introduced in November 2003. The Medical Indemnity Amendment Act 2003 and the Medical Indemnity (IBNR Indemnity) Contribution Amendment Act 2003 each received Assent on 5 December 2003 and together provide that:
the IBNR indemnity levy for the year beginning 1 July 2003 is capped at $1,000 and doctors have until 1 March 2004 to pay it. In the following year, the levy will be capped at $500 above half of the doctor’s annual subscription fees paid to UMP in 2000-01 and will be payable on 1 August 2004. Thereafter, the levy will be capped at half of the doctor’s annual subscription fees paid to UMP;

- there are additional available exemptions from the IBNR indemnity levy, including all doctors over 65; and

- the ‘blue sky’ claims scheme, now renamed the ‘exceptional claims indemnity scheme’, is established, providing doctors with an indemnity from the Commonwealth for all of their liability for health care claims above the limit of their medical indemnity policies. The legislation sets out all the procedural matters relating to the application of the scheme and enables a protocol to be established by which insurers may be paid for handling claims subject to the scheme.
Terrorism Insurance Act 2003

Background
The Terrorism Insurance Act 2003 (Cth) (the Act) is the Commonwealth government’s legislative response to the widespread withdrawal of terrorism cover that occurred post-September 11 2001. The Terrorism Insurance Regulations 2003 (Cth) (the Regulations) were gazetted on 26 June 2003 and subsequently amended on 24 September 2003.

Framework
The effect of the Act, which commenced on 1 July 2003, is that terrorism exclusion clauses in non-residential property and business interruption insurance policies relating to Australian property and certain liability covers will not operate if there is a declared terrorist incident in Australia.

For eligible insurance contracts in force at 1 July 2003, or which begin after that date, if there is a declared terrorist incident, then any terrorism exclusion becomes inoperative and cover is provided for eligible terrorism losses in accordance with the other terms and conditions of the policy. The cover is triggered by a declaration by the Minister that a terrorist incident has occurred.

Eligible insurance contracts are contracts in relation to:

- loss or damage to eligible property owned by the insured (or in which an insured has an insurable interest);
- business interruption covers relating to the ownership or occupation of such property; and
- liability covers to the extent that they relate to liability arising from the insured’s ownership or occupation of such property.

The Regulations prescribe a large number of contracts that are excluded from the coverage provided by the legislation. In sum, these include:

- a contract of insurance that provides cover for the destruction of, or damage to, a home building;
- a contract of insurance that provides cover for the loss of, or damage to, the contents of a residential building;
- travel insurance;
- certain personal property insurances;
- farm insurances where there is no cover for business interruption (other than increased cost of working covers provided under farm packs or similar policies);
- Commonwealth, State and Territory insurances;
• cover provided to the Commonwealth, a State or a Territory other than instrumentalities or agencies of those bodies that carry on business;
• motor vehicle policies;
• marine and aviation insurance;
• various types of liability covers such as professional indemnity, directors’ and officers’ liability, trade credit, trade indemnity, and trustee insurance; and
• various other covers (set out in detail in the Regulations).

The effect of the Regulations is that the Act primarily operates on commercial property insurance and business interruption insurance.

Insurers affected by this arrangement are fully indemnified for claims and claims settlement costs arising from policies in force on 1 July 2003, or begun between 1 July 2003 and prior to 1 October 2003. Since 1 October 2003, insurers have been able to reinsure with the statutory authority, the Australian Reinsurance Pool Corporation (ARPC), under arrangements whereby insurers bear a small portion of the liability. The balance of the liability, together with claims settlement costs, will be borne by the ARPC. The ARPC is funded by reinsurance premiums, a bank facility of A$1 billion and a Commonwealth government guarantee.

The Commonwealth government is able to manage its exposure in the event of a terrorist attack by establishing a reduction percentage that reduces the liability of the insurer, the ARPC, and the Commonwealth for that event. It is anticipated that the Commonwealth would use this to manage its liability within a limit of A$10 billion.

Issues under the Act

General

Insureds, in particular insureds who have previously sought terrorism cover, need to fully understand this legislation and consider whether or not any existing cover or other covers they may have sought for a terrorism liability need to be adjusted. Insureds also need to know which policies are covered by the Act and which policies are not covered, because they may have a continuing need in some areas to purchase terrorism cover from the insurance market.

Insurers are potentially caught by the Act if they issue an eligible insurance contract. It does not matter whether the insurer is a locally authorised insurer or an offshore insurer. Insurers that are affected need to have in place reinsurance with the ARPC or, alternatively, they must have taken a decision to take the liability on their own balance sheet or to seek alternative reinsurance arrangements.

The government’s objective is to operate the scheme only while terrorism insurance cover is unavailable commercially on reasonable terms.

What is residential?

The Insurance Council of Australia (ICA) has had discussions with the ARPC in respect of the determination as to whether or not a building is a residential building and, as a consequence, whether it is excluded from the ambit of the Act under the Regulations. As a result, the ICA has agreed a protocol with the ARPC as
to the approach to be taken by an insurer in determining whether or not a building is residential and whether or not the policy of insurance in relation to that building is reinsured under the reinsurance arrangements with the ARPC.

Is a sub-limit an exclusion?

There is a question over the situation where a particular sub-limit is applied for a terrorism liability: does that mean the policy is intended to cover terrorism subject to the sub-limit? If that is the case, then the legislation will not apply. If, however, what is intended is that there be a sub-limit in the event of a write-back that operates by reason of the Act, it seems that there may be a problem in that the sub-limit itself is a terrorism exclusion and will therefore be subject to the write-back.

The write-back is expressed in the Act at section 8(1), where it provides that a terrorism exclusion has no effect in relation to a loss or liability to the extent to which the loss or liability is an eligible terrorism loss. A terrorism exclusion is defined as being an exclusion or exception for acts that are described using the word terrorism or terrorist or words of similar effect or other acts (however described) that are substantially similar to terrorist acts as defined in the Act. If the sub-limit is directly related to a terrorist act, then it seems that, in itself, it may be seen to be a terrorist exclusion.

Event insurance

Note the situation where a policy indemnifies the organiser of, for example, a sporting event or a cultural event against financial loss caused by a terrorist attack on key participants and/or the intended venue. It would seem that the event organiser may only have terrorism cover under the Act if it can be said that the organiser is unable to use eligible property (ie buildings, works and structures or things within or on buildings, works or structures) where that property is owned or occupied by the actual insured. Many organisers may not qualify as owners or occupiers in this context and, therefore, the policy may not be an eligible insurance contract, or may only be subject to the Act where the declared terrorist incident occurs after the insured has gone into occupation of a stadium, hall, etc, where the event is held.
Review of discretionary mutual funds & direct offshore foreign insurers

**HIH Royal Commission**

Under Australia’s regulatory framework, all providers of financial services are subject to market conduct and disclosure regulation. In addition, entities involved in the business of providing insurance are also subject to prudential regulation.

In the HIH Royal Commission’s final report (the *report*), Justice Owen recommended that the Commonwealth government amend the *Insurance Act 1973 (Cth)* (the *Insurance Act*) to extend prudential regulation to all discretionary insurance-like products (to the extent that it is possible to do so within constitutional limits). Justice Owen also raised some issues associated with direct offshore foreign insurers (*DOFIs*), but made no specific recommendation.

**Discretionary mutual funds**

Discretionary cover is an insurance-like product that involves no legal obligation by the provider to meet the costs of an ‘insured’ event. The provider of such cover merely accepts that it will, at its discretion, consider meeting such costs.

Most discretionary schemes have grown out of mutual-type arrangements based around particular professions. In these schemes, a group of professionals may jointly agree to meet the costs of certain risks that members face in the course of their professional duties.

The discretionary nature of the products provided by these mutual funds means that the funds are not subject to the provisions of the *Insurance Act* as they do not meet the definition of insurance business in section 3 of the *Insurance Act*.

**Direct offshore foreign insurers**

Foreign insurers wishing to conduct insurance business in Australia must establish a subsidiary or a branch in Australia and apply to APRA for authorisation under the provisions of the *Insurance Act*. Alternatively, foreign insurers can sell insurance to Australians via an insurance agent or broker licensed in Australia without establishing a subsidiary or branch in Australia. Both of these types of foreign insurers are called DOFIs. They are not subject to the provisions of the *Insurance Act*.

**Review**

On 12 September 2003, Treasurer Peter Costello announced the Federal Government’s response to the report. The government considered that a review was required to determine whether it is necessary and possible to provide the same level of protection to consumers (and third parties) of products supplied by discretionary mutual funds (*DMFs*) and DOFIs as is provided to consumers of
products supplied by insurers subject to prudential regulation under the provisions of the *Insurance Act*.

Headed by Mr Gary Potts, the Review will consider the role of DMFs and DOFIs in the Australian insurance market and their contribution to overall insurance capacity. The review will be taking submissions from interested parties (interested parties are requested to provide any input by 30 November 2003), and will provide a report to the government on options for ensuring appropriate levels of consumer protection. The review is expected to report to the government by 30 January 2004. The review will provide the information necessary for the government to make decisions on these issues.

**Scope of the review**

The review will look at DMF and DOFI operations in Australia and their contribution to overall insurance capacity.

In undertaking this examination, the review is to consider:

- the reasons why DMFs and DOFIs choose to do business in the manner they do; and
- the level of financial and organisational resources available to DMFs and DOFIs operating in Australia.

It will also consider the systemic risk associated with the failure of a DMF or DOFI to meet its obligations; the adequacy of existing protection arrangements for consumers of products supplied by DMFs and DOFIs; and provide options for improving protection arrangements. In providing options, the review will have regard to the different characteristics of DMFs and DOFIs.
Prudential supervision of general insurance: APRA stage two reforms

Background
On 20 November 2003, the Australian Prudential Regulatory Authority (APRA) issued its proposed second round of reforms to the prudential and regulatory framework for the supervision of the Australian general insurance industry.

APRA's proposals follow amendments to the prudential and regulatory framework set out in the Insurance Act 1973 (Cth) (Insurance Act), which became effective on 1 July 2002.

The current proposals are APRA's response to the various findings and recommendations of Justice Owen (Commissioner of the HIH Royal Commission), which were handed down in April 2003. The Federal Government supports those findings and recommendations and has referred them to APRA for consideration. These recommendations reflect APRA's view that further work is required to strengthen the prudential supervision framework for general insurance in Australia.

In particular, APRA believes that the current prudential requirements made under the Act need to be extended to cover consolidated groups, to improve disclosure and to strengthen the actuarial supervisory governance and audit arrangements of general insurers.

APRA intends to release a separate consultation paper in 2004, which will set out APRA's proposals for the development of a regime of consolidated supervision to minimise the risk that adverse developments in other parts of a corporate group, which includes an authorised general insurer, may damage the soundness of the insurer.

Further, APRA also intends to release a separate consultation paper and a draft prudential standard to deal with the fit and proper requirements for directors and senior management in the general insurance, life insurance and authorised deposit-taking industries.

In broad terms, the current APRA proposals fall into two main categories.

The first category involves the revision of existing, and the development of new, prudential standards and guidance notes to further strengthen the regulatory framework for general insurance.

The second category contains proposals to increase and expand the disclosures to be given by general insurers about their activities – with the intention of promoting market discipline.

Some of the significant proposals canvassed in the APRA discussion paper are explained further in this article.
**Capital management**

APRA proposes that insurers be required to strengthen their capital management processes by putting in place a capital management plan (CMP). The CMP should set out the insurer’s strategy for setting and monitoring capital resources over time and the processes and controls that the insurer will put in place to monitor and ensure continual compliance with its minimum capital requirement under the Act.

The CMP should be set for a minimum of three years and should be kept under regular review by the board and senior management. The board will be required to approve the CMP and the document will also need to be submitted to APRA annually or whenever a material change to the CMP is made.

**Reinsurance recoveries**

APRA is concerned that many reinsurance arrangements are entered into without appropriate formal, legally binding documentation being executed in a timely manner. APRA therefore proposes not to permit reinsurance recoveries to be deducted from gross liabilities for the purposes of calculating the insurer’s minimum capital requirement unless and until a fully documented, executed and enforceable reinsurance contract is in place.

**Securitisation**

Although insurance securitisations are still relatively uncommon, APRA considers it appropriate to address this issue. It proposes to prohibit insurers entering into securitisation arrangements without the prior approval of APRA.

**Governance**

Governance requirements are currently set out in prudential standards GPS220 and 230. GPS220 is proposed to be retained but streamlined to deal only with risk management. APRA is also proposing to make three new prudential standards dealing with the governance issues, the fit and proper requirement, and the audit requirements. These proposals would remove existing provisions from GPS220 and place them into new prudential standards – this is intended to ensure clarity in the prudential standards and to assist APRA to ensure consistency and harmonisation across APRA-related industries.

**Directors**

GPS220 currently requires the board of a general insurer to consist of a majority of non-executive directors within the meaning of the Corporations Act 2001 (Cth). The meaning of a non-executive director for prudential standard purposes is proposed to be redefined to include directors who are not in the employment of the insurer or any of its related entities, either directly or indirectly.

Further, the board of a locally incorporated general insurer is proposed to consist of a majority of independent non-executive directors. An independent director is proposed by APRA to be one who is independent of the management of the insurer and any of its related entities and is free from any business or other relationship with those entities that could, or could reasonably be perceived to, materially affect their independent judgment.
Separately, it is proposed that a director should not serve as a director of another general insurer (or parent company) outside the group to which the insurer belongs. In addition, APRA also proposes to require that an insurer must provide written advice to APRA of the resignation or removal of a director, setting out the reasons for the director’s resignation or removal.

**Board audit committees**
APRA is concerned that the independent role of the Board Audit Committee may be compromised by allowing executive directors to be on the committee. APRA therefore proposes that the Board Audit Committee comprise at least three members, all of whom must be non-executive directors and a majority of whom must also be *independent* (within the meaning of the proposed new definition of that term).

**Board risk committee**
In APRA's view, risk management and control is critical to the safety and soundness of the operation of an insurer. APRA proposes to mandate the establishment of a Board Risk Committee. The committee's responsibility would be to develop, set and monitor adherence with risk management strategies.

**Board/senior management performance**
Currently there are no requirements for an insurer to have procedures in place to assess the performance of the board and senior management. APRA therefore proposes to require an insurer to have in place procedures for assessing the performance of the board, individual directors and senior management. APRA views this assessment as critical to ensuring that senior management discharge their duties effectively and efficiently.

APRA proposes to require that each director be elected for a fixed period, preferably not more than three years. Although directors may seek re-election, APRA is concerned to ensure that independent non-executive directors remain truly independent so as to be free from conflicts of interest. APRA believes that the maximum term for independent non-executive directors should not exceed 10 years – it is implicit from this proposal that APRA believes there is an inherent tension between independence and length of service.

**Auditors and actuaries**
APRA proposes to require an insurer to advise APRA when the insurer’s approved auditor and/or approved actuary do not continue to meet eligibility, and fit and proper criteria.

In order to promote the continued independence of approved auditors and approved actuaries, APRA is proposing that rotation of audit partners and firms may be beneficial. Separately, APRA proposes to restrict the services that audit firms provide to the insurer: that neither the auditor nor its related companies should provide services to the insurer including accountancy, preparation of financial statements, actuarial services, information technology design, senior managerial functions, legal services, taxation services or human resource functions.
Although peer review practices currently exist in both the auditing and actuarial professions, APRA is presently considering formalising the requirement. Further, APRA also proposes powers that would entitle it to review processes that exist in approved audit and actuarial firms to assess their independence.

Risk management strategy
An insurer is presently required to submit a copy of the insurer’s risk management strategy to APRA within 14 days of its approval by the Board. This must also happen whenever a material change to the risk management strategy is made. To strengthen the monitoring of the risk management strategy, APRA is proposing to require insurers to submit the risk management strategy to APRA on an annual basis.

Outsourcing
Given the increasing prevalence of outsourcing, APRA is proposing to strengthen the requirements in this area. The proposed further requirements would be set out in an existing APRA prudential standard applicable to authorised depositing institutions: namely, prudential standard APS231 – outsourcing.

Business continuity planning
Similarly, APRA is proposing to strengthen requirements for business continuity planning. APRA intends to consult separately on this issue in 2004, with proposals applicable to all APRA-regulated industries.

Non-risk transfer products
APRA has expressed concerns about the use of these products, particularly where arrangements do not involve an adequate transfer of insurance risk. Such arrangements may be structured in a complex way that makes them difficult to account for and/or difficult for a full risk assessment and understanding to be achieved. APRA therefore proposes to require that insurers seek APRA’s prior approval before entering into non-risk transfer arrangements.

There is also a range of issues discussed in connection with APRA’s proposals for greater disclosure within, and by, the Australian general insurance industry. The HIH Royal Commission recommended that all information provided to APRA in the statistical returns of general insurers should be made public. Although APRA strongly supports disclosure, it recognises the need to obtain a balance in the level and detail of disclosure and is presently considering the scope and frequency of financial information on an individual insurer and aggregate insurance industry basis, which should be publicly disclosed. A copy of the discussion paper is available from the APRA website at www.apra.gov.au.

There is clearly a range of very significant issues in the discussion paper that need to be considered and addressed by the industry. APRA has called for public comment on the discussion paper. It is important that the industry considers the proposals very carefully, as they are likely to form the basis of the next round of amendments to the Insurance Act and the Prudential Standards and Guidance Notes issued under the Act, and will have a significant impact on the regulatory, reporting, disclosure and compliance framework within which the general insurance industry in Australia will operate.
The Senate is currently debating the Age Discrimination Bill 2003 (Cth) (the Bill). The Bill prohibits discrimination on the basis of age, subject to certain exemptions, including an exemption for the terms or conditions on which a policy of insurance is offered or may be obtained.

Content of the Bill
The Bill prohibits discrimination on the basis of age in key areas of public life, including the following areas:

- work, including recruitment, training, promotion, redundancy and retirement;
- access to goods, services and facilities;
- access to premises, including places and transport, discrimination when allowing or refusing access, when providing such access, or in the imposition of terms and conditions on access;
- Commonwealth laws and programs, such as the performance of functions or exercise of power under Commonwealth law or for the purposes of the Commonwealth program;
- education such as discrimination by educational authorities in relation to admission of students, access to benefits, or expulsion of students;
- accommodation, such as discrimination in providing, renewing or refusing access to accommodation, limiting access to benefits or evicting from accommodation; and
- land, including discrimination in refusing or failing to dispose of an estate or interest in land, or the terms or conditions on which an estate or interest in land is offered.

Exemption for insurance
The Bill proposes certain exemptions to the prohibition on age discrimination. The exemptions include: positive discrimination; inherent requirements of the job; youth wages; superannuation, insurance and credit; health; acts done under statutory or other legal authority; compliance with Commonwealth legislation; and compliance with other legislation where the age discrimination has an identifiable, beneficial purpose.

Section 37 sets out the exemption in relation to insurance (it also deals with superannuation and credit) as follows:

(1) Subsections (2) and (3) apply to the following:
   (a) an annuity;
   (b) a life insurance policy;
(c) a policy of insurance against accident or any other policy of insurance;
(d) membership of a superannuation or provident fund;
(e) membership of a superannuation or provident scheme.

(2) This Part does not make it unlawful for a person to discriminate against another person, on the ground of the other person’s age:

(a) in respect of the terms or conditions on which the annuity, policy or membership is offered to, or may be obtained by, the other person; or
(b) by refusing to offer the annuity, policy or membership to the other person;

if the condition in subsection (3) is satisfied.

(3) The condition is satisfied if:

(a) the discrimination:

(i) is based upon actuarial or statistical data on which it is reasonable for the first-mentioned person to rely; and

(ii) is reasonable having regard to the matter of the data and other relevant factors; or

Note: The Commission and the President can require the disclosure of the source of the actuarial or statistical data (see section 54).

(b) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the discrimination is reasonable having regard to any other relevant factors.

Section 54 sets out the right of the Human Rights and Equal Opportunity Commission (HREOC) to call on the source of data as follows:

(1) Subsection (2) applies if a person has acted in a way that would, apart from paragraph 37(3)(a) or subsection 37(5) [concerns credit only], be unlawful under Part 4.

(2) The President or the Commission may give the person a notice in writing, as prescribed, requiring the person to disclose to the President or to the Commission, as the case may be, the source of the actuarial or statistical data on which the act of discrimination was based.

Note: Failure to comply with the requirement is an offence under section 52.

The Explanatory Memorandum to the Bill explains why an exemption has been proposed for age discrimination in respect of the terms or conditions on which an insurance policy may be offered or refused. It acknowledges that the development of commercially viable insurance products involves the assessment of risks for particular groups of people and that this assessment includes age, where relevant. Insurance providers would suffer increased costs if these age factors could not be included in the provision of insurance, and those costs would be passed on to consumers. For this reason, distinctions based on age in respect of the terms and conditions on which insurance policies may be offered and/or refused should be exempted from the prohibition on age discrimination.

However, the exemption will apply only where the age discrimination is based on actuarial or statistical data on which, in all of the circumstances, it is reasonable to
rely and where the different treatment is reasonable in light of that data and other relevant factors. HREOC, the body that would handle any complaints of unlawful discrimination in the context of insurance, can require that the source of actuarial or statistical data be disclosed under s54, above. A failure to provide actuarial or statistical data at the request of HREOC is an offence in accordance with s52.

When there is no actuarial statistical data available to an insurer and such data cannot be reasonably obtained, age discrimination in relation to the terms and conditions on which the insurance is offered or refused is permitted where the discrimination is reasonable, having regard to any relevant factors.

**Passage**

The Bill, with a proposal paper, was introduced into the House of Representatives by the then Attorney General Daryl Williams on 26 June 2003. The proposal paper recommended the insurance exemption as set out above. The Bill was referred to the Senate Legal and Constitutional Legislation Committee. The committee provided its report on 18 September 2003, and accepted the proposed insurance exemption.

Discussion of the Bill resumed in the House of Representatives on 3 November 2003 and it was passed by the House on 26 November 2003. Certain amendments were made; however, none of these concerned insurance.

The Bill was introduced into the Senate on 1 December 2003 and remained under debate as at the adjournment of the session on 4 December 2003.
Insurance legal framework and industry background in Hong Kong

An industry overview

Insurance is a rapidly growing industry in Hong Kong and, although the market is still small, foreign operators have been shoring up their existing offices or opening up new ones. While the region has undoubtedly suffered as a result of the Asian financial crisis, 11 September 2001, and the fallout from SARS, the economy appears to be recovering well. When compared to its neighbours, Hong Kong is a leader in insurance industry development and reform.

Insurance laws in Hong Kong are comparatively progressive and favour an open market. Unlike mainland China, Hong Kong has placed few restrictions on domestic and foreign insurers. In 2003, however, a number of new schemes and agreements were implemented.

Foreign insurers’ participation

The Office of the Commissioner of Insurance (OCI) has reported that 190 insurers (approximately 66 per cent general business insurers, 24 per cent long-term business (or life) insurers and 10 per cent composite insurers) were authorised to operate in Hong Kong as at 30 September 2003. Of these insurers, 94 were companies incorporated in Hong Kong, while the balance came from 24 different regions or countries.10

Unlike other legislative frameworks throughout Asia, Hong Kong does not distinguish between foreign and domestic insurers: the same set of rules and requirements applies to both. Foreign insurers can also be authorised to maintain accounts in relation to their Hong Kong businesses.11

Not surprisingly, Hong Kong is viewed as the gateway into mainland China. As a result, the number of foreign insurers present in the region is steadily increasing.

The nature of the market

There are two classes of insurers: general and life insurance. Within each class, various types of policies provide protection for different situations.12 Insurance products are primarily distributed by insurance agents. It is predicted that the industry will eventually become a mix of banking, security and insurance business, as a result of cross-selling by banks and insurance companies.13

10 The Office of the Commissioner of Insurance, Hong Kong.
11 Insurance Companies Ordinance, Cap 41, section 22 A.
12 Doing Business in Asia, Hong Kong: CCH Asia PTE Limited, Volume 1 pp 19,001 – 22,364.
After Japan, Hong Kong has the most developed insurance market in the region, in terms of per capita insurance premium. Total gross premiums of insurance business in 2002 amounted to approximately HK$89 billion. For the first half of 2003, the gross and net premiums of general insurance business grew by 3.1 per cent to HK$12.682 million and by 3.6 per cent to HK$8,610 million respectively, as compared with the corresponding period in 2002. The overall underwriting profit of general insurance business improved from HK$332 million to HK$810 million.

**Legislative and regulatory environment**

The Insurance Companies Ordinance Cap 41 (the *Ordinance*) provides a comprehensive regulatory regime for the prudential supervision of insurers, agents and brokers. Among other things, the Ordinance specifies the minimum requirements for insurers wishing to obtain authorisation to carry out an insurance business. It is supplemented by subordinate legislation, as well as by guidance notes.

The Office of the Commissioner of Insurance (*OCI*) administers the Ordinance and is responsible for granting licences. It operates autonomously under the Financial Services and the Treasury Bureau within the structure of the Government Secretariat. The Office is headed by the Commissioner of Insurance, who is appointed as the Insurance Authority (*IA*).

The principal functions of the IA are to ensure that the interests of policyholders or prospective policyholders are protected and to promote the general stability of the insurance industry. The IA also has a monitoring role and examines the audited financial statements, actuarial reports and business returns that are submitted annually by insurers. The IA is designed to encourage greater transparency and is empowered to act against an insurer where solvency is in issue.

Other important regulators include the Securities and Futures Commission, and the Hong Kong Monetary Authority (*HKMA*), which is the government body responsible for maintaining monetary and banking stability.

In addition to statutory regulation, the industry also self-regulates through the Hong Kong Federation of Insurers (*HKFI*), the Insurance Claims Complaints Bureau, and a Code of Conduct for Insurers.

---

14 Hong Kong Trade and Development Council, TDC Trade.
15 Office of the Commissioner of Insurance, Hong Kong (Website).
17 Ibid.
18 Ibid.
19 Insurance Companies Ordinance, Cap 41, sections 27-35.
Insurance licences

An insurer who intends to carry on insurance business in or from Hong Kong must be authorised to do so. Authorisation can be granted by the IA, Lloyds of London, or an association of underwriters approved by the IA.20 To gain authorisation, an insurer must meet the minimum requirements.21 These are:

**Paid-up capital requirements**

- An insurer carrying on solely general business or long-term business must have paid-up capital of $10 million. Where the insurer’s business is a combination of general and long-term business, or if it carries on any class of compulsory insurance business, the minimum paid-up capital requirement is $20 million. For a captive insurer, the minimum paid-up capital is $2 million.22

**Fit and proper persons**

- Directors and controllers of the insurer must be fit and proper persons. Prior approval of the IA is also required for the appointment of certain controllers.23

**Solvency margins**

- The insurer must maintain an excess of assets over liabilities of not less than a required solvency margin. An insurer carrying on general business must maintain a solvency margin determined on the ‘premium income basis’ or the ‘claims outstanding basis’, whichever is the greater, and subject to a minimum of HK$10 million (or HK$20 million if the insurer is authorised to carry on a compulsory insurance business).

**Reinsurance**

- The insurer must have adequate reinsurance arrangements in force for the risks it underwrites.

Other requirements include:

**Assets**

- An insurer carrying on general business, other than a professional reinsurer and a captive insurer, must maintain assets in Hong Kong of an amount not less than the aggregate of 80 per cent of its net liabilities and the solvency margin applicable to its Hong Kong general business.

**Submission of financial statements**

- An insurer must submit its financial statements annually to the IA. General insurers are also required to submit an audited General Business Return and audited Statement of Assets and Liabilities. This latter requirement does not apply to reinsurers or captive insurers.24

21 Ibid, section 8.
22 Ibid section 8.
23 Ibid section 13 A & B.
24 Ibid section 17.
The requirements for agents and brokers (intermediaries) are also covered by the Ordinance.

**Major developments in 2003**

During 2003, several new agreements, legislative schemes, reviews and guidance notes have been released and implemented. Major developments include:

**Bancassurance**

A memorandum of understanding was executed on 19 September 2003 between the HKMA and the IA as a result of the growing trend in Bancassurance. The agreement is aimed at promoting mutual assistance and the sharing of information between the two bodies.²⁵ In particular, it recognises the need to ensure that no gaps exist in the supervision of entities that are subject to the regulation of both authorities.

**Closer Economic Partnership Arrangement**

The Closer Economic Partnership Arrangement (CEPA) was executed on 29 June 2003.²⁶ The arrangement is a cross-border, free trading agreement between Hong Kong and mainland China. From the start of January 2004, mainland China will confer the following concessions upon Hong Kong insurance service suppliers:

- Allow individual entities or groups formed by Hong Kong insurance companies through strategic mergers to enter the mainland insurance market subject to established market access conditions (global assets above US$5 billion; more than 30 years of establishment experience by one of the Hong Kong insurance companies in the group; and a representative office established in the mainland for more than two years by one of the Hong Kong insurance companies in the group).
- Set the maximum limit of capital participation in a mainland insurance company at 24.9 per cent for a Hong Kong insurance company.
- Allow Hong Kong residents with Chinese citizenship to practise in the mainland without prior approval, after they have obtained the mainland’s professional qualifications in actuarial science.
- Allow Hong Kong residents to engage in insurance business as employees of a mainland insurance institution, after they have obtained the mainland’s insurance qualifications.

²⁶ The annexures to the agreement were signed on 29 September 2003. These prescribe details of the main agreement, as well as the application procedure for CEPA concessions.
Employees Compensation Assistance Fund & Employees Compensation Insurer Insolvency Scheme

To relieve the financial burden borne by the Employees Compensation Assistance Fund (ECAF) in dealing with insolvency of insurers writing employees' compensation business, the Employees Compensation Insurer Insolvency Scheme (ECIIS) was established on 1 April 2003. The scheme will become fully operational to provide coverage for the insolvency of employers with effect from 1 April 2004.

Review of the OCI

The OCI structure is under review by the Hong Kong Government. In short, it is proposed that the OCI be converted to an independent, non-governmental regulatory agency on the basis that it may lead to greater operational and financial flexibility. No change has been made to the OCI functions to date, but the government is consulting with stakeholders.

Guidance notes

Several new guidance notes were released during 2003. These include:

- Guidance Note on Reinsurance with Related Companies (GN12), issued on 30 June 2003;
- Supplement to the Guidance Note on Money Laundering, issued 25 June 2003;
- Guidance Note on the Combat of Terrorist Financing, issued 25 June 2003; and
- Guidance Note on the Corporate Governance of Authorised Insurers, effective 1 September 2003.

New guidelines for corporate governance

The Hong Kong Society of Accountants is set to release new guidelines in early 2004, to help prevent and report fraudulent activities undertaken by companies in the jurisdiction. It is likely that these guidelines will apply to domestic and foreign insurance companies.

Barriers to market development

Increased premium rates and reinsurance

The increasing amounts of damages awarded by courts for personal injury has, in turn, lifted the operating costs of insurers' core underwriting activities. As a result, insurers in Hong Kong (as in other countries) have increased their premium rates and tightened underwriting measures. Notably, the OCI is not permitted to interfere with premium-setting by insurers.27 The lack of capacity among reinsurers is also placing additional pressure on insurance companies.

---

27 Insurance Companies Ordinance, Cap 41, section 23 A.
ED5

On 25 August 2003, the Society of Accountants released for comment the exposure draft of a proposed new accounting standard for insurance contracts, ED5. It has also been argued by various commentators that ED5 would change revenue recognition for many Hong Kong insurers. Specifically, contracts that are currently defined as ‘insurance’ and included in revenue, may be reclassified as financial instruments or service contracts. Thus, they would disappear from premium income, which is traditionally a measure followed very closely by the industry.28

Review of the OCI

Potentially, the cost for insurance firms and policyholders could increase if the structure of the OCI is amended. Currently, the IA costs around HK$100 million per annum to operate. The government pays around 60 per cent of this sum, while the remaining 40 per cent is paid by licence fees from insurance firms.

Conclusion

It is expected that the Hong Kong insurance sector will experience some major changes in 2004. While the market in mainland China remains underdeveloped, the impact of CEPA will become apparent after the agreement becomes effective on 1 January 2004. Although the market is small in comparative terms, Hong Kong is certainly not averse to industry review and legislative reform.

Obligation to notify insurers of relevant events connected to claims

Case Name: Harbourfield Engineering Co. Limited v Falcon Insurance Co. (Hong Kong) Limited

Citation: [2003] Court of First Instance of Hong Kong per Suffiad J

Date of Judgment: 28 July 2003

Issues:
- Public liability insurance
- Failure to notify

Notification of matters relevant to a potential claim would arise only on some ‘objectively foreseeable’ connection to a claim that eventually materialises. In the case of third-party claims, this would be evident only after a writ relevant to a claim had been served upon the insured.

Harbourfield Engineering Co. Limited was contracted to provide maintenance and service to water systems for a particular building. An arson attack resulted in the death of an occupant whose estate subsequently brought an action against a number of defendants, including Harbourfield, for breach of statutory duty and negligence. Harbourfield claimed under its public liability insurance policy with Falcon Insurance Co. (Hong Kong) Limited.

Under the policy terms, Harbourfield was obliged to give immediate notice to Falcon ‘on the happening of any event which may give rise to a claim’ and immediately forward any claim, writ or summons connected with such event upon receipt. It was not permitted to make any ‘admission’ without Falcon’s consent, but required to take all reasonable precautions to comply with statutory requirements and give ‘immediate notice of any alterations which materially affects the risk’ covered by the policy.

Falcon declined liability under the policy and sought to repudiate it because of Harbourfield’s alleged failure to disclose, when Falcon discovered that Harbourfield had pleaded guilty for breaching certain regulations after the arson attack.

The court found for Harbourfield, taking the view that it was not objectively foreseeable that the guilty plea was related to the death arising out of the arson attack, despite being made after the attack. Harbourfield’s duty to disclose the statutory breach arose out of the allegations and the claim by the deceased.

Further, given that it was not directly involved, Harbourfield was under no obligation to report the arson attack, even if it had knowledge of the attack because of some indirect means, such as newspaper reports after the event. Its disclosure obligations for that particular event arose only upon receipt of the summons by the deceased’s estate.

This case demonstrates a relatively lenient attitude by the courts towards an insured’s disclosure and notification obligations, particularly in liability policies.
Can an insurer withhold an extension of time unreasonably?

Case Name:
Fong Wing Shing Construction Co Ltd v Assurances Generales de France (HK) Ltd

Citation:
[2003] Court of First Instance of Hong Kong per Gill J

Date of Judgment:
28 May 2003

Issues:
- Circumstances-notified clauses
- Failure to notify
- Withholding an extension of time unreasonably

The Hong Kong Court of First Instance considered whether an insurer can deny indemnity on the basis that the insured failed to notify of an occurrence under the policy terms. In this case, the court held that, where an insured is diligent but does not know about an occurrence giving rise to the claim, an insurer cannot withhold a time extension unreasonably, if notification is given as soon as possible after the insured becomes so aware.

In October 1997, the insured entered an agreement to perform construction works. The work was scheduled to begin in November 1997 and was to be completed by June 2000.

Under the policy terms, the insured was covered from 5 November 1997 to 4 January 2000. It provided cover for any liability resulting from bodily injury to any person arising from the performance of the contract.

The relevant clauses were as follows:

5.3 ... the terms... and conditions... herein... are incorporated in and form part of this contract... and are... conditions precedent to any liability on the part of the Insurers...

5.8 In the event of any occurrence which might give rise to a claim... the Insured shall:

5.8.1 notify the Insurers as soon as possible and... give an indication as to the nature and extent of the damage...

5.8.4 submit a formal claim and furnish all such information and... evidence as the Insurers may require within six months of the occurrence or such further time as the Insurers may... agree, such agreement not to be unreasonably withheld...

The work was completed by February 1999.

On 7 June 2000, the insured received a letter from a worker, Mr Lau, stating that he had been injured on site on 31 July 1998. Mr Lau claimed that the accident was attributable to the insured’s negligence and gave notice of his intention to sue. The letter was copied to the insurer.

The next day, the insured gave notice of this letter to the insurer.

The insurer denied liability, on the basis that the plaintiff failed to give notification according to the terms of the policy.

However, the court held that, as the insured provided notification to the insurer as soon as it became aware of the circumstances, it would be unreasonable if the insurer was permitted to deny an extension of time to allow the plaintiff to file its claim.
This case suggests that, where an insured is diligent and has no knowledge of an occurrence giving rise to the claim, an insurer cannot withhold an extension of time unreasonably if notification is given as soon as possible after the insured becomes so aware.
Insurer cannot avoid cargo insurance policy on
grounds of material non-disclosure, breach of
warranty and lack of insurable interest

Case Name:
Hong Kong Enterprises Ltd &
Ors v QBE Insurance (Hong
Kong) Ltd

Citation:
[2003] HKCFI 52, Court of
First Instance of Hong Kong
per Stone J

Date of Judgment:
17 January 2003

Issues:
• Material non-disclosure
• Breach of warranty
• Lack of insurable interest

This case concerns the interpretation of cargo insurance policies
and the plaintiffs’ attempt to recover under these policies.

The facts
In 1997, Hong Kong Nylon Enterprises Ltd (HK Nylon) exhibited a plastic-bottle
moulding machine (the machine) at a Shanghai exhibition. The machine was an
‘exhibition machine’, as it had been removed from its packaging to be displayed.
HK Nylon subsequently sold this machine and, in 1998, shipped it and its
auxiliaries from Hong Kong to Xiamen. On arrival in Xiamen, the machine and
auxiliaries were transported to the consignee’s warehouse by truck. During this leg
of the journey, the truck swerved to avoid a taxi and a large wooden box containing
part of the machine fell off the truck and onto the middle of the road. The machine
was damaged considerably. After repair, the machine was resold to another buyer
for much less than the original sale price. A claim for the cost of repair and loss on
resale was submitted to the insurer, QBE Insurance (Hong Kong) Ltd (QBE). QBE
rejected the claim because it said:

• HK Nylon had not disclosed that the machine had been exhibited and was not
  new;
• notwithstanding lack of knowledge by HK Nylon, it had not been disclosed that
  there was prior damage to the wooden boxes housing the machine;
• there had been a breach of promissory warranty ‘that this is a container load
  shipment’ by the unloading of the containers and the carrying of the auxiliaries
  break bulk (that is, not containerised) by the forwarder, Dragon Form Holdings
  (Dragon Form); and
• HK Nylon ceased to be interested in the goods by the time of the loss and that
  only the buyer had an insurable interest at this time.

Material non-disclosure
HK Nylon’s case was that it had told QBE that the machine was not new. QBE
maintained that it had not received this information. Justice Stone ultimately
accepted HK Nylon’s evidence that it had told QBE that the machine was
exhibition machinery prior to, and at the time of, placing the risk. Had it been
necessary, Justice Stone would have also accepted that, in any event, non-
disclosure of this fact would not have impacted on QBE’s underwriting decision
because:

• in the absence of evidence from the specific underwriter involved, it would have
  been reasonable to infer so; and
by insuring on terms excluding the risk of denting, chipping, cracking and scratching, QBE had adequately protected itself against pre-existing damage anyway.

**Breach of warranty**

Section 33 of the *Marine Insurance Act 1906* (the *1906 Act*) provides that a promissory warranty ‘is a condition which must be exactly complied with’ and that non-compliance discharges the insurer from liability as from the date of the breach.

Justice Stone found that discharge from liability for less than exact compliance was to be ‘subject to any express provision in the policy’. The policies in question contained Clause 8.3 of the Institute Cargo Clauses (A) *(ICC(A))* which provides that the insurance shall remain in force ‘during any variation of the adventure arising from the exercise of a liberty granted to shipowners or charterers under the contract of affreightment.’

Accordingly, by unloading the two containers before loading, and shipping the auxiliaries’ break bulk, Dragon Form purported to exercise the liberty contained in Clause 7(a) of its bill of lading to carry the goods ‘in any commercially reasonable manner and by any reasonable means… including the right to transship Goods using other… conveyances or containers’. Justice Stone therefore accepted that the breach of warranty was within the parameters contemplated by Clause 8.3 of the ICC(A).

**Lack of insurable interest**

According to section 6 of the 1906 Act, the assured must be interested in the goods, the subject matter of the insurance, at the time of the loss.

Justice Stone found that, although the sale price was expressed as a CIF (cost plus insurance and freight) price, this was not a normal CIF sale in that, within 90 days after delivery at Xiamen, there was to be an inspection of the machine, which was to be final and binding. If the machine failed that inspection, HK Nylon was to take it back. Accordingly, at the time the machine fell onto the road, HK Nylon had not been paid the full price, and there had been no inspection. HK Nylon stood to benefit from the safe arrival of the machine, and to suffer detriment if the machine was lost or damaged.

Accordingly, Justice Stone found for HK Nylon.

This case highlights the importance of cargo insurances, and that particular attention should be paid to the issues of material disclosure, warranty clauses and insurable interest.
Marine cargo policies, which were issued subject to a pre-existing arrangement to insure, contained broader warranties than previously agreed. The insurer argued that the policies were outside the terms of the existing contractual relationship, and declined indemnity because the warranty had not been complied with. The court found it was ‘commercial nonsense’ to construe the policies as outside the bounds of the pre-existing arrangement to insure.

On 26 November 2000, the vessel, Rui Xiang, sank with all its cargo. The cargo was insured with the defendant underwriters, Bank of China Group Insurance Co Ltd (the bank) under three marine-cargo policies. However, the bank refused to pay on the basis of a breach of warranty appearing in the policies, which read: ‘Warranted the carrying vessels must be ISM Code compliant’.

At issue was whether these policies should have been regarded as operating under an ‘open cover’ policy for the year 2000, or whether these policies should be considered as free-standing policies issued outside the open cover. The warranty in the open cover policy contained a similar but qualified warranty, requiring that only bulk-carrying vessels be ISM Code compliant. The Rui Xiang was not ISM Code compliant, nor was it a bulk-carrying vessel.

The open cover system is used by merchants who regularly engage in overseas trade, and generally applies for 12 months. The assured is obliged to declare all shipments falling within the terms of the open cover, and the underwriter must accept and issue policies for all declared shipments.

Following the issuing of the 2000 open cover, the plaintiff, BC Enterprise Sdn Bhd Nagasaki International Limited Cofcotianding International Trading Co Ltd (BC), insured 26 cargoes with the bank. However, instead of including an ISM Code warranty in the terms of the 2000 open cover (limiting its application to bulk carriers), the 26 policies contained the unqualified warranty.

On 18 November 2000, BC notified the bank by fax of the intended shipment and requested a cover note and three sets of policies.

Immediately after the Rui Xiang sank, BC notified the bank and claimed under the policies. The claims were declined, on the grounds of the breach of the ISM Code warranty.
The bank submitted that the three policies were free-standing policies issued independently of the open cover, and that the parties had chosen to act outside the terms of their existing contractual relationship. As such, the bank was free to impose a warranty in those policies inconsistent with the terms of the 2000 open cover.

BC argued that the 18 November 2000 fax plainly satisfied the notice requirements of the 2000 open cover. To construe the fax as being a request for insurance ‘outwith’ the 2000 open cover would be to construe it as a request for double insurance, which would be ‘commercial nonsense’.

Justice Stone agreed. His Honour found that it was never the parties’ intention to enter into an ad hoc arrangement for this voyage, which would remove the pre-existing insurance from the ambit of the established 2000 open cover, rendering the assured subject to a more onerous term than that which existed under the cover.

His Honour found that the 18 November 2000 fax was a declaration properly made under the 2000 open cover, and the bank was obliged to insure the declared shipment in accordance with the terms of the existing insurance. The bank was not entitled to issue policies at variance with the provisions of the existing cover, including the imposition of a more onerous warranty.

The case should serve as a warning to insurers and insureds alike to ensure that the contractual terms they have agreed are accurately reflected in policy documents. However, where a dispute arises, the courts will ultimately look to the parties’ intentions in order to determine the prevailing terms.
Duty of care of solicitors not acting in a professional capacity

Case Name: Yiu & Ors v Chow

Citation: [2003] Court of First Instance of Hong Kong per Muttrie J

Date of Judgment: 14 July 2003

Issues:
- Scope of duty of care of solicitors

Solicitors owe no heightened duty of care to third parties by virtue of their professional status. They do not voluntarily assume any responsibility merely by providing advice of a legal nature or witnessing a signing in the absence of a retainer.

The plaintiffs, comprising of Mr Yiu and his associates, entered into a series of loan transactions with the borrower Chapol Ltd (Chapol) secured by units in a building said to be owned by Chapol. Chapol defaulted on the loans. Subsequently, it was discovered that the security was worthless, as the property was encumbered by mortgages and not wholly owned by Chapol.

Mr Chow, a solicitor and personal friend of Chapol’s representative, Mr Yau, witnessed the signing of the various loan agreements as a personal favour.

At the signing of the loan documents, Mr Chow responded, in passing, to queries by the plaintiffs on some minor legal issues. Mr Chow had not prepared the documentation himself, although this was wrongly assumed by the plaintiffs.

The court confirmed previous authority that a solicitor who witnesses a legal document does not have a duty of care to explain it, correct any defect or advise any party to seek independent legal advice, unless that solicitor has in fact been retained by a party. No ‘special relationship’ arose warranting a higher duty of care merely because the witness happened to be a solicitor, nor would Mr Chow’s conduct constitute a voluntary assumption of responsibility.

This decision illustrates a reluctance to impose higher duties of care on professionals where they are clearly not acting in their professional capacity.
When is a financial adviser liable for losses suffered by a client?

Case Name:
Field v Barber Asia Ltd

Citation:
[2003] HKCFI 548, Hong Kong Court of First Instance per Barma J

Date of Judgment:
17 June 2003

Issues:
- Duty of care and standard of care owed by financial adviser
- Contributory negligence

The High Court of Hong Kong has confirmed that a financial adviser must take account of the individual circumstances of a client when offering financial advice, and that the client is justified in relying on the advice given.

A Hong Kong businesswoman (the client) who had accumulated some £150,000 in personal savings, approached the principal of Barber Asia Ltd, (the adviser) seeking ‘conservative’ investment opportunities. After persuading the client to invest her savings in a managed investments scheme, the adviser later suggested that the client gear her existing investments by taking a loan in Japanese yen and investing it in pounds sterling, with the original investment to act as security. The client accepted the suggestion without seeking any legal or other advice.

Due to a sharp appreciation of the yen against the sterling, the lending bank demanded additional security and later switched the loan to sterling, resulting in a loss to the client of more than £200,000. The client sued the adviser, alleging negligent misstatement.

His Honour had little hesitation in concluding that the adviser owed a duty of care to the client in tort. The adviser had assumed responsibility for providing advice to the client in circumstances where he possessed special knowledge and ought to have realised that the client would rely on the advice. Further, His Honour found that the gearing strategy involving differential currencies was a ‘high risk’ investment that did not accord with the client’s stated desire for a conservative approach. A reasonably competent adviser would have had regard to the client’s circumstances and intentions in recommending a suitable investment. In addition, His Honour declined to make a finding of contributory negligence, holding that the client was entitled to rely upon the advice of a financial expert without seeking a second opinion.

This case re-asserts the important principle that financial advisers must select investment opportunities that are suitable to the situation of the client, and take full account of the client’s willingness to accept the level of risk associated with the investment.
Vicarious liability: what amounts to a sufficiently close connection with employment?

Case Name: The Ming An Insurance Company (HK) Limited v The Ritz-Carlton Limited

Citation: [2003] 1HKC 225, Court of Final Appeal of Hong Kong per Bokhary and Chan PJJ, Litton, Mortimer and Lord Cooke of Thorndon NPJJ

Date of Judgment: 4 December 2002

Issues:
- Vicarious liability: what is within the scope of employment?

Hong Kong employers are vicariously liable for the negligent acts of their employees, even when they are engaged in conduct not specifically authorised, if the employer is aware of and does not disapprove of the relevant conduct.

Mr Lo Sin Tak (Mr Lo), an employee of the Ritz-Carlton (the hotel) negligently drove a hotel limousine and injured two pedestrians. Mr Lo was expressly authorised to park limousines to decrease congestion, when the chauffer was off duty. However, the lower courts found that, at the time of the accident, Mr Lo was actually driving the bell boy to the market to collect food for his colleagues and other staff members. This practice had developed among the staff and was not disapproved by the hotel.

The judges of the Court of Final Appeal of the Hong Kong Special Administration Region (the court), unanimously agreed that the test for vicarious liability is whether the employee's tort is so closely connected with his or her employment, that it would be fair and just to hold the employer vicariously liable (close connection test).

The court then found that the collection of food was closely connected to the employment of the hotel staff involved in the accident because it was the then prevailing practice known by the employer to exist (and not disapproved), and it was in the hotel's business interest that its staff be adequately fed. Also of relevance was that:
- the employee was in uniform at the relevant time;
- the accident occurred during working hours;
- the employee had set out from the place of employment;
- the employee had legitimate access to the keys of the limousine; and
- it was an inherent risk that the employee would drive in the circumstances.

All of the judges found the close connection between Mr Lo's employment and the negligent driving so obvious, that it was clearly fair and just to hold the hotel vicariously liable.

This case confirms that when Hong Kong courts consider vicarious liability, the close connection test will be applicable, broadening the scope of employment. It also sounds a warning to employers that practices that develop of which they have knowledge and do not expressly disapprove are likely to be considered to be within the scope of employment for the purposes of vicarious liability. This is so, particularly where that practice is both in the employee's and employer's interest.
**Case Name:**

Au Ka Ying & Ors v Guandong (HK) Tours Company Limited

**Citation:**

[2003] HKCFI 88, Court of First Instance of Hong Kong per Seagroatt J

**Date of Judgment:**

27 January 2003

**Issues:**

- Non-delegable duty of care

This case is an appeal against a decision that interim damages be paid to the second and third Plaintiffs in the sums of HK$1.3 million and HK$1.1 million respectively.

The plaintiffs were on a holiday tour provided by Guandong (HK) Tours Company Limited (Guandong). Their coach was travelling through a mountainous region of China when the driver negligently lost control of the coach. It struck a hillside and rolled down a slope, seriously injuring the second and third plaintiffs.

The driver was not directly employed by Guandong, but by CYTS, a separate company that operates tours. Guandong argued that it was not the provider of the tour but arranged for services to be provided by CYTS, and was therefore not liable for the driver’s negligence.

The sole issue was whether the plaintiffs, while bound to succeed against the driver and his employers, could succeed against Guandong.

The primary document for consideration was the Justice Guandong travellers’ application form. Taking the contract as a whole, Justice Seagroatt concluded that Guandong undertook to provide, with reasonable skill and care, and not merely arrange, all the services included in the programs, even if some activities were to be carried out by others. His Honour found that:

- there were no clear terms that Guandong was doing no more than arranging the tour as an agent for the travellers;
- terms providing that Guandong ‘shall not be liable for any accidental injury or death’ or ‘in case of accidental injury or death… nothing thereof shall concern [Guandong]’ were not disclaimers of liability for negligence;
- the statement that ‘all means of transportation are not owned by [Guandong]’ was not sufficient as a term to unequivocally indicate agency and an exclusion from liability; and
- there were specific references to the ‘tour provided by [Guandong]’.

While under no obligation to provide absolute safety, Justice Seagroatt found that Guandong had a non-delegable duty of care.

His Honour dismissed the appeal.

This case demonstrates the significance of companies considering the nature of their obligations, and their legal relationships with other service providers involved in the chain of supply.
Insurance legal framework and industry background in Singapore

An industry overview
Most industries in Singapore are open to foreign investors. Businesses, for the most part, operate in a free-market economy. Multinational corporations are seen as valuable contributors to economic growth, with the Monetary Authority of Singapore (MAS) publicly encouraging such corporations to use Singapore as an international business centre. MAS is responsible for supervising and developing the insurance industry, with the dual objectives of fostering a sound insurance industry and developing a competitive and progressive insurance market.

The insurance industry in Singapore has responded to the outbreak of SARS and general economic uncertainty, as have most insurance industries in developing countries, by introducing a raft of regulatory changes that aim to improve the management of the industry and the protection of policyholders. The result in Singapore, which has a reputation for being responsive to change, is the introduction of a regulatory framework that reflects relevant risks faced by insurance companies and allows sufficient capital to absorb fluctuations in asset and liability values.

Legislative and regulatory environment
Singapore's Insurance Act 1966 (the Act) provides an integrated regulatory framework for persons engaging in insurance business and acting as insurance intermediaries in Singapore. In April 1977, the Act came under the supervisory umbrella of the MAS, which is governed by the Monetary Authority of Singapore Act (the MAS Act). The MAS Act gives MAS the authority to regulate all elements of monetary, banking and financial aspects of Singapore. This includes the power to act as a banker and financial agent of the Government. Enjoying considerable operational autonomy, the MAS Board of Directors is appointed by the President and ultimately accountable to the Parliament of Singapore.

Under the Act, a Singapore resident must insure against a risk that is within Singapore's jurisdiction, either with a locally authorised insurer or a foreign insurer that has been empowered by MAS to carry on insurance business in Singapore. Currently the law requires companies engaged in the insurance business to be established and authorised by the MAS.

Another important figure in the insurance industry in Singapore is the General Insurance Association (GIA), which was formed when Singapore become an independent republic. It is the industry representative of all non-life insurance companies transacting business in Singapore.

29 www.mas.gov.sg
In 2002, the GIA focused on wide-ranging industry reform through the creation of the Motor Insurance Task Force and the Committee for Enhancement of Standards in General Insurances (CESGI). The CESGI, comprising members of GIA, the Singapore Insurance Brokers' Association and MAS, developed a Code of Practice that sets out the minimum standards regulating the sales, advisory and service standards of general insurers, insurance intermediaries and anyone acting for general insurers. It also developed training and competency requirements that set out the minimum qualification and continuous professional development required of all personnel engaged in sales and/or providing insurance advisory services and/or handling claims.

On the recommendation of CESGI and MAS, GIA established and funds the Insurance Disputes Resolution Organisation (IDRO), an independent body set up in February 2003 to resolve individual policyholder and insurance company disputes in a low-cost, efficient and impartial way.

As part of an ongoing effort to improve the insurance industry and its regulatory framework, the Insurance (Amendment) Bill 2003 (the Bill) has been introduced (at the time of writing).

The Bill seeks to build a risk-based capital framework that reflects relevant risks faced by the insurance companies so that capital will serve as an effective buffer to absorb fluctuations in asset and liability values. It will also provide clear information on the financial strength of insurance companies and facilitate early progressive prudential intervention by MAS.

In order to establish the risk-based capital framework, the Bill amends section 17 of the Act, to clarify how insurance funds are to be set up and maintained. Section 18 of the Act is also amended to replace the existing margin of solvency requirements with fund solvency and capital adequacy requirements. These requirements will govern the adequacy of capital at the insurance fund and company-wide level respectively.

Specifically, s17(6) introduces the ‘surplus account’ to the participating fund of direct life insurers. The surplus account aims to add greater clarity to the treatment of capital support and allocations to shareholders in relation to participating funds. Any allocation of participating fund monies made to shareholders will be credited into this account, which is separately maintained. Shareholders may withdraw the balances in the surplus account if they are not required to meet capital requirements. This account will also keep track of any future capital support that shareholders may provide to satisfy the fund’s capital needs.31

The Bill shifts the responsibility of approving bonus distribution from the appointed actuary to the directors, reflecting the current market practice, while emphasising the need to strengthen the corporate governance of insurers in Singapore. Accordingly, directors will need to take into consideration the written recommendation of the appointed actuary before approving any bonus distribution.32

Section 18(4) empowers MAS to direct registered insurers to satisfy fund solvency requirements or capital adequacy requirements other than those required under s18, having regard to ‘risks arising from the activities of the insurer and such other factors as MAS considers relevant’. Examples of such risks include operational risk, quality of governance and internal control, and accessibility to capital. MAS will assess the need for, and the quantum of, additional capital for specific insurers via its risk-based supervisory process.

Currently, no provision in the Act specifically applies to health insurance, although there are provisions under the current legislation for general insurance that apply to health insurance. The Bill proposes a framework that governs both the underwriting and distribution of policies that contain ‘accident and health benefits’. The key proposed health insurance legislative amendments in the Bill include:

- Stand-alone policies that will be divided into two categories: long-term and short-term. Health insurance products deemed to be of a long-term nature (that is, of a duration exceeding five years and not unilaterally cancellable by the insurer) must only be underwritten by life insurance companies, while short-term health insurance products may be underwritten by both life and general insurance companies.
- Intermediaries are prohibited from advising or arranging health insurance products, unless they have attained the required qualification.
- The level of disclosure is enhanced, especially the disclosure of information that allows consumers to make an informed buying decision that suits their needs. This includes disclosure for products where contract terms may change over time, for example, where premium rates are not guaranteed, continual disclosure will be necessary. Additionally, the advice must be considered reasonable, taking into account the client’s objectives, financial situation and particular needs, as well as how these factors relate to the products being recommended.33

There are also minor policy changes and technical modifications to clarify MAS’s administration of the Act.

**Foreign insurers participation**

Currently, non-resident insurers may carry on certain prescribed insurance business in Singapore if authorised by MAS under a foreign insurer scheme. Essentially, where a foreign insurer scheme is established, each member of the class, society or association of foreign insurers specified in the scheme may, according to the terms of the scheme, carry on such insurance business in Singapore as may be prescribed. Under the Act, only the cross-border supply of reinsurance is allowed. The cross-border supply of other types of insurance business is prohibited.

---

However, from 1 January 2004, the Insurance Act (Chapter 142) Insurance (Authorised Reinsurers) Regulations 2003 (Reinsurance Regulations) introduces an authorisation framework for the cross-border supply of reinsurance. Overseas reinsurers who are currently providing reinsurance to Singapore, or who would like to in the future, must obtain authorisation.

This ‘authorisation framework’ differs from the approval framework that will be required under the Insurance Act (Chapter 142) Insurance (Approved Marine, Aviation and Transit Insurers) Regulations 2003 (MAT Regulations) from 1 January 2004 for the cross-border supply of marine, aviation and transit (MAT) insurance, direct broking of MAT insurance and reinsurance broking to Singapore.34

Under the MAT Regulations, the approval framework is more restrictive and only insurers and insurance brokers licensed in the United States can apply for approval35. Authorised reinsurers and approved insurers and insurance brokers will be allowed to conduct only limited activities in Singapore; these are mainly solicitation and collection of premiums.

Authorised reinsurers and approved MAT insurers will also be required to:

- maintain a reinsurance and insurance deposit with MAS;
- make certain disclosures in their dealings, including their authorised or approved status; and
- lodge annual returns with the MAS.

The nature of the market

After three years of rapid growth, the insurance industry experienced a moderate decline in activity, reflecting economic uncertainties and the effects of the SARS outbreak. In the first quarter of 2003, single premium life insurance business decreased by 50.9 per cent over the corresponding period in 2002 to S$0.8 billion36. The general insurance industry is now focused on returning to fundamentals and achieving positive underwriting results. The reinsurance sector remains cautiously optimistic about prospects for general reinsurance, as the general increase in premium rates is likely to be sustained.37

Licensing

The admission criteria for insurance licensing in Singapore is regulated by the Act and Insurance Regulations, Revised Edition 2002 (the Regulations). They can be summarised in the following categories.

---

34 Insurance Act (Chapter 142) Insurance (Approved Marine, Aviation and transit Brokers and Approved Reinsurance Brokers) Regulations 2003 (Approved MAT Regulations).
35 Only those licensed in countries listed in the schedules to the regulations can apply. Currently only the US is designated under the Free Trade Agreement between the two countries.
37 Seizing the Opportunities, address by Deputy Prime Minister Lee Hsien Loong, Chairman, Monetary Authority of Singapore, at the MAS Staff Seminar, 18 November 2003.
Admission criteria for direct insurers

MAS applies the same admission criteria to applicants for direct life and/or general insurance licences. In assessing an application, the following factors are taken into consideration:

(a) domestic and international rankings;
(b) present and past credit ratings;
(c) track record and reputation, with regard to compliance with regulations and the strength of internal control systems; and
(d) commitment to contribute to Singapore’s development as a regional insurance hub and an international financial centre.

They have identified that it is important that the insurance industry develops in areas of product innovation and the use of alternative distribution channels. Applicants with a strong record in these areas, or in specialist and niche fields, will receive favourable consideration.

Admission criteria for reinsurers

In assessing an application for life and/or general reinsurance licences, MAS takes into consideration the following factors:

- world ranking;
- credit rating;
- reputation, financial soundness and track records; and
- commitment to contribute to the development of Singapore as an important reinsurance centre.

Applicants with commitment to develop a significant portfolio of offshore business from Singapore will receive favourable consideration.

Admission criteria for captive insurers

MAS takes into consideration the following admission criteria in assessing an application for a captive insurance licence:

- reputation, financial soundness and track records of the applicant; and
- long-term commitment of the applicant in the use of a captive insurer as a risk-management vehicle.

The business of captive insurers should consist principally of the risks of its related companies. Proposals to set up ‘rent-a-captive’ operations in Singapore will also be considered. All captive insurers are required to establish their operations in Singapore as subsidiaries.

Admission criteria for insurance brokers

In assessing an application for registration as an insurance broker, MAS takes into consideration the following broad criteria:

- reputation, financial soundness and track record of the applicant;
- world ranking (for general insurance brokers);
• business plans and projections;
• commitment and ability to contribute to Singapore's development of Singapore as an international insurance centre; and
• details on the minimum paid-up capital, professional indemnity insurance and net asset value, which are in Regulations 27B, 27C and 27D.

Application procedures for all insurers and insurance brokers

Prospective insurance and insurance broker applicants are encouraged to meet with the Insurance Department or the Market & Business Conduct Department of MAS to discuss their business plans before submitting a formal application. All applications are to be submitted on prescribed forms.

Conclusion

The regulatory initiatives undertaken in Singapore are intended to improve the general insurance industry by protecting policyholders and creating a better-managed industry. Focusing on a return to fundamentals and achieving positive underwriting results, Singapore's position in Asia shows signs of a vibrant cross-border trade flow, which is generating a strong demand for insurers specialising in credit and political risk insurance.
A case of rushed cover: a lack of detailed instructions from the insured led to a lack of coverage

Case Name: 
Wan Teck Chian Machinery (PTE) Ltd v CGU International Insurance PLC (formerly known as Commercial Union Assurance Co PLC)

Citation: 
[2003] SGDC 18, Singapore Subordinate Courts per Sim, District Judge

Date of Judgment: 
5 February 2003

Issues: 
- Inland transit clauses 
- Damaged goods in transit

Insurance cover for goods during ‘the ordinary course of transit’ does not extend to damage associated with putting the goods into the premises of the consignee.

The insured had a contract to sell, set up and install embroidery machinery. The insured required insurance quickly, to cover the machinery’s transit and delivery to the consignee. Instructions were forwarded by the insured to the insurer’s agent, requesting cover for the two-day period in which delivery was to take place. The insured assumed that the agent would ensure that the insurance obtained would cover damage to the machinery over the specified period. The insurer issued a standard policy including an ‘Inland Transit Clause’ that covered all risks of loss of, or damage to, the machinery, while in the ordinary or customary course of transit. The cover:

- included the risks of loading and unloading; and
- excluded the risks of denting, bending, scratching and chipping for unprotected cargoes.

The machinery was delivered, unloaded and unpacked at its destination. The machine was then damaged, while being prepared for hoisting in the plaintiff’s warehouse. The insured made a claim under its insurance policy on the ground that the machinery was rendered a total loss. The insurer denied liability on the ground that the policy did not cover the loss in question.

The court was asked to look at the construction of the insurance policy with regard to:

- whether the inclusion of the risks of ‘loading and unloading’ included the risks of putting the machinery into the premises of the consignee itself, or whether it only included the risks of unloading the machinery from its named conveyance; and
- whether the insurer’s liability was, in any event, excluded by the exclusion against the risks of denting, bending, scratching and chipping for unprotected cargoes.
The court found in favour the insurer. Upon construction of the policy, the insured’s machinery was only covered up to the time it was delivered. If the insured had wanted further ‘warehouse to warehouse’ cover they should have specified this and paid the associated premium. According to Justice Sim, to insist on cover being present throughout the unpacking process up until the accident would have extended the insurer’s exposure to include risks they were expressly not willing to insure against. Justice Sim refused to read down the terms used in the exclusion. Justice Sim also noted that the insured must be aware of the fact that the agent has no authority to accept risk on the insurer’s behalf.

Insurers are not expected to presume anything when issuing policies to the insured, even if the insurer and insured have had past dealings. If the insured wants to be covered for something in particular, even something obvious (as in this case), the insured must specify the cover and pay the additional premium.
Insurance legal framework and industry background in China

Since its World Trade Organisation (WTO) entry, China’s insurance industry has experienced significant changes. It has gone from being a predominantly closed market in the early 1990s, to one in which foreign insurers now account for more than half of all insurance companies. The market has grown significantly, encouraged by legislative reform, restructuring of the social security system, high levels of saving and low penetration rates. However, in comparison to Western countries, the actual market size remains small and is a fairly low source of revenue.

An industry overview

China’s insurance industry was nationalised in the 1950s and virtually closed for a decade during the Cultural Revolution. When it reopened in 1978, the state-owned People’s Insurance Company of China (PICC) monopolised the industry. The PICC’s dominance began to break down in 1988 when two domestic insurance companies, Ping An Insurance Company of China Ltd (PAIC) and China Pacific Insurance Company (CPIC), were granted regional licences. Today, there are a number of these regional domestic insurance companies competing for market share.

In 1990, China’s Government, keen to participate in the General Agreement on Tariffs and Trade (GATT) announced it would open its insurance market to foreigners. AIG was the first to benefit, with a licence issued in 1992. From then on, foreign insurers continued to be licensed in limited numbers; however, the process of getting a licence was slow, and foreign insurers were permitted only to establish branches or joint ventures in specific regions.

The reinsurance field was also dominated by a state-owned insurer, the China Reinsurance Company, which held its monopoly until as late as mid-2002, when a foreign insurer was licensed.

Foreign insurers participation

Although foreign insurers now account for more than half of all insurers in China, they take up only a small market share. Their growth has been hindered by geographic and product restrictions, as well as the requirement that each branch be capitalised at RMB200 million (US$24 million). This capital requirement has been a particular issue, because it reduces operational efficiencies in comparison to domestic insurers, who are able to get a nationwide licence with a one-off capital payment. Foreign insurers are restricted to regional licences and must individually apply for each licence and capitalise each regional operation to the levels required by law.
Even with China’s commitment to market opening, the fact remains that the current legal framework restricts foreign insurers’ rights to underwrite in particular areas. This is all part of the phasing-in process of reform, which should be complete by 2004. However, at present, the legal framework contributes to protecting state and domestic companies’ respective positions in the market.

The nature of the market

China’s insurance market is currently small. It is underdeveloped, not only in terms of size but also in terms of products offered and basic infrastructure, with many places in China not even having insurance institutions.

Insurance generally is not a concept largely understood or adopted by the Chinese people, which explains the low insurance depth. However, in comparison to broader China, trends in urban centres are promising, with Shanghai enjoying an increase of around 42 per cent for insurance premium income in the year 2001 to 2002. Foreign insurers play an increasingly important role in Shanghai’s insurance industry, in 2001 taking up 13.6 per cent of the city’s total premium and 12 per cent of the life insurance premium.

Legislative and regulatory environment

On 18 November 1998, the State Council established the China Insurance Regulatory Commission (CIRC). Directly under the State Council, the CIRC is the sole regulator of China’s insurance industry and meets China’s WTO commitment to provide separate regulation for each service sector. The Insurance Association of China was established at the end of 2000 in Beijing. Although its strength as an industry association is still uncertain, its intended purpose is to coordinate and discipline the insurance sector.

The main legislative contribution to insurance reform in China is the Insurance Law 1995. The Law provides a broad legal framework that is intended to foster growth by providing rules relating to the formation and operation of insurance companies on the mainland. It was updated in October 2002, with amendments effective January 2003 (the Amendment), which marks a significant step forward to fully opening the market.

The Insurance Law focuses on two primary areas: contract and regulatory control. The contract aspect of the law details the rights and privileges of the consumer and insurer. The regulatory control aspect details the powers, responsibilities and accountability of insurers and industry bodies.

The Insurance Law Amendment creates a more market-oriented and policy-based legal environment, and is intended to increase protection for consumers, strengthen industry regulation, and develop the domestic insurance industry in the face of increased foreign competition.

The Amendment now enables companies to write their own clauses and set their own premiums, whereas, in the past, CIRC dictated these conditions. It also enables CIRC to monitor the solvency capability of companies according to set standards. These standards are detailed in CIRC’s Administrative Rules on Solvency Margin and Regulatory Benchmarks of Insurance Companies (Solvency Rules),
released 24 March 2003. The Amendment also provides better protection for the insured by placing legal obligations on companies to train and administer their agents and not mislead them into improper behaviour.

With the Amendment, wholly foreign-owned enterprises were added as the third type of foreign invested enterprise recognised under the Insurance Law. The original law recognised only sino-foreign joint venture companies and foreign insurance company branches. On WTO entry, however, China committed to all three forms of foreign investment being permitted.

The Insurance Law 1995 and the Amendment to it does not deal with foreign insurers in a substantial manner. The Law does, however, apply to them, with article 148 stipulating that the establishment of foreign insurance companies will be governed by the Insurance Law, except where specifically provided for in other laws and regulations.

To complement and provide detail for the Insurance Law, various regulations have been promulgated, including rules for the absorption of foreign equity by domestic companies, insurance brokers, insurance agents and foreign-invested insurance companies.

The Regulations of the People’s Republic of China on Administration of Foreign-Invested Insurance Companies (the Regulations), effective 2 February 2002, are the primary regulations that foreign investors should look to when establishing an insurance company in China.

The Regulations set out the criteria for foreign insurers seeking to operate in China and empower the CIRC to supervise, administer and grant licences for insurance companies.

Under the Regulations, a foreign insurer who intends to set up a joint venture, wholly foreign-owned enterprise or branch of an insurance company should have:

- at least 30 years of experience in the insurance industry;
- established a representative office in China for at least two years preceding the application; and
- at least US$5 billion in assets in the year preceding its application.

The minimum registered capital for a joint venture or wholly foreign-owned enterprise is RMB200 million (US$24 million) or the equivalent in a freely convertible currency. This minimum amount must be actually paid in, and 20 per cent of it placed in a Chinese bank as a ‘guarantee fund’ that can be used only to pay off debts during liquidation proceedings. Branches of foreign-invested insurance companies have the same minimum operating capital requirements of at least RMB200 million, or the equivalent amount in a freely convertible currency for the parent company. These capital requirements are costly by international standards, effectively limiting the market in China to large, well-established international companies. Reinsurance companies have even steeper capital requirements, needing RMB300 million or approximately US$35 million in capital.
Foreign-invested insurance companies are prohibited from operating both property and life insurance businesses at the same time in China. However, an exception to this rule has been created by the recent Amendment, which allows property insurance companies to engage in cross-class operations in short-term health and casualty insurance products if permitted by the CIRC.

Recent legal developments

Two important draft rules were released in mid- to late-2003. Firstly, on 31 July, CIRC published the Implementing Rules for the People’s Republic of China Administrative Regulations on Foreign-Invested Insurance Companies (Draft Foreign Implementing Rules). These draft rules clarify some outstanding issues in the Regulations described above. Secondly, on 18 August, CIRC published the Administrative Rules on Insurance Companies (Draft Revised Insurance Company Rules), which have substantially revised various rules governing the administration of insurance companies. The draft rules are not in force until they are issued in final form, and the effective date specified by CIRC, is reached.

Some major provisions of the Draft Foreign Implementing Rules include:

- Foreign insurers are allowed to establish life insurance joint ventures with Chinese companies and enterprises. However, the foreign equity in such joint ventures cannot indirectly or directly exceed 50 per cent of the total registered capital.
- Branches of foreign property insurance companies may apply to convert into wholly foreign-owned enterprises. The Draft Foreign Implementing Rules set out the conditions, documentation and procedures for such a conversion. Three months after converting, the wholly foreign-owned property insurance company can apply to open additional branches.
- After being established, a foreign insurer is permitted to set up one branch per year. It must have a minimum working capital of RMB200 million and is required to increase its registered capital by RMB20 million for each additional branch it applies to set up. When the total registered capital reaches RMB500 million (US$60 million) a foreign insurer will not be required to further increase its registered capital before setting up new branches, provided that it meets certain solvency standards. A foreign insurer that was approved before the implementation of this legislation must have RMB200 million in registered or operating capital within two years, or it will not be permitted to open branches.
- A foreign insurer must directly establish its own representative company in order to operate in China. If the representative office is established by a foreign insurance holding company or its subsidiary, which operates reinsurance, property and life insurance concurrently, the representative office can be used only to apply for an insurance company in China engaging in one of those three businesses.
- Foreign investors may not hold more than 50 per cent of the shares in a life insurance company. The Draft Foreign Implementing Rules also set foreign equity investment levels for equity joint ventures, cooperative joint ventures, and enterprises with a minority of foreign equity invested.
The following summarises the major features of the *Draft Revised Insurance Company Rules*:

- The *Draft Revised Insurance Company Rules* significantly lower the capitalisation requirements for Chinese insurance companies and their branches, so that Chinese and foreign-funded insurance companies are treated equally.
- Previously, Chinese nationwide insurance companies had a minimum registered capital requirement of RMB500 million and regional insurance companies had a minimum registered capital requirement of RMB200 million.
- In the *Draft Revised Insurance Company Rules*, there is no distinction between Chinese nationwide and regional insurance companies, with the minimum registered capital requirement being unified at RMB200 million. The additional capital required for a Chinese insurance company to establish a branch is RMB20 million per branch until the total capital hits RMB500 million. These capitalisation rates are the same as those imposed on foreign-invested insurance companies and reflect CIRC’s intention to facilitate the development of Chinese insurance companies in the face of foreign competition.
- The *Draft Revised Insurance Company Rules* also allow for natural persons to invest in insurance companies. This change paves the way for the potential public listing of insurance companies; however, a single individual investor cannot own more than 5 per cent of the issued capital of an insurance company, and the total equity held by all individual investors in an insurance company cannot exceed 15 per cent. The *Draft Revised Insurance Company Rules* are ambiguous as to whether ‘individual’ includes foreign individuals; however, in the rules, the total foreign shareholding remains unchanged at less than 25 per cent.
- The *Draft Revised Insurance Company Rules* confirm two new investment options, allowing insurance companies to trade enterprise bonds rated AA and securities funds. Restrictions on investing capital outside China are removed; however, no guidance is given on which overseas areas insurance companies are allowed to invest in. These capital relaxation rules also allow insurance companies to set up asset management firms to manage their funds.
- Finally, the *Draft Revised Insurance Company Rules* provide insurance companies with greater flexibility in setting their own clauses and rates. Generally, insurance companies are permitted to formulate their own clauses and rates; however, CIRC still must approve clauses and rates for compulsory forms of insurance, new types of life-insurance products and investment protection insurance, as well as other types of insurance that CIRC deems it necessary to approve.

**Insurance licences**

In addition to the substantial capital and experience requirements described above, a foreign insurer must also:

- be from a country or region with a sound insurance regulatory system and where the company is already subject to effective regulation by the authorities of that country or region;
- meet the solvency standards of the country or region where it is located;
• have evidence that the authorities of its home country or region have agreed to its licence application in the People’s Republic of China; and
• meet other prudential conditions required by CIRC.

The application process to gain an insurance licence is lengthy, usually taking about two years, and has a number of stages. Initially, a preliminary examination of the application is undertaken, with CIRC deciding to accept or deny it within six months of receipt. If the preliminary application is accepted, a formal application form will be issued, which the applicant must complete and submit within one year, together with relevant documents. Once the formal application is submitted, it will be assessed and approved or denied within 60 days. If it is approved, a permit is issued. If either the preliminary or formal application is denied, CIRC must notify the applicant in writing and provide reasons for the denial.

Once the formal application is approved, the applicant must then register with the industry and commerce administration for a business licence. If the application is denied, however, an applicant may not reapply for six months.

For both foreign and domestic insurers, China’s entry into the WTO has had a significant impact on CIRC’s licensing practices. Recent licensing trends reflect China’s commitment to opening up the insurance sector; however, the significant increase in the number of licences being granted has left some insurers unsettled. For foreign insurers, the primary concern is market saturation by their domestic counterparts whose establishment costs are less, despite capitalisation rates having been made equal.

Chinese insurance companies continue to benefit from a licensing system that allows them to receive several branch licences in one application, in comparison to foreign-invested insurance companies that are restricted to one application for each city.

At present, a total of 36 foreign insurance companies have received approval to operate in China: 20 are life insurers, 14 are non-life insurers and two are reinsurance companies.

**Barriers to market development**

• Until recently, insurance companies were only allowed to channel their funds into severely restricted investment options, choking off sustainable growth. These restrictions have resulted in a significant proportion of insurance premiums being invested in either cash or bank savings. This is in comparison to the West, where funds are commonly invested in stocks that generate the returns necessary to cover pay-outs on premiums, costs and profits. In an attempt to rectify this problem, the China Security Regulatory Committee (CSRC) has taken steps to allow insurance funds to enter the sharemarkets. However, these markets are unsophisticated and volatile, with few solid companies in which to invest. Their attractiveness to insurers is, therefore, limited. Draft rules flag the potential for insurance companies to invest overseas; however, no guidance has been provided as to what areas investment will be permitted in.
Company solvency is a major issue in China’s insurance industry, with a low level of capital funds being held currently by domestic insurers. The lack of solvency has been exacerbated by insurers’ restricted investment options. Recent changes in the law require greater transparency in regard to holdings and permit greater diversity of investment.

As competition in the market increased, domestic insurers quickly expanded their market share without much regard to quality. A lack of insurance professionals with knowledge and experience in insurance markets has further contributed to the problem; as has the history of state company monopoly, which has left a legacy of non-competitive services. However, as foreign insurers and their customer-driven services enter the market, domestic insurers are being forced to lift their standards.

The low quality of services and lack of understanding by the general population of the role of insurance has led to a credibility crisis for China’s insurance industry. Many people have been reluctant to purchase policies, their scepticism encouraged by damaging news reports on the difficulty of receiving reimbursement. This reputation potentially affects foreign insurers, both positively and negatively: positively, in that they may be differentiated by their reliability, and negatively, if they are perceived as being the same as domestic insurers.

Also hindering market growth has been the delay in the development of a comprehensive legal environment for insurers. The drafting of insurance laws and regulations has lagged behind, with the Regulations of the PRC on Administration of Foreign-Invested Insurance Companies only released in 2002. Prior to this, the Insurance Law 1995 was the primary legislation regulating the industry. However, it does not deal comprehensively with foreign insurers, and was not updated until 2002.

Conclusion

China’s commitment to comply with its WTO obligations is genuine, with many insurance industry reforms having taken place since its accession. However, despite these reforms, the market remains underdeveloped and insufficiently regulated. It remains dominated by state and domestic companies that have the advantage of fewer restrictions on their operation.

Regardless of these challenges, foreign insurers continue to enter the market with the knowledge that reform is ongoing and industry growth presents opportunities.

Insurance Law Amendments allowing insurers more freedom to enter and conduct business in the market, and allowing property insurance companies to offer short-term health and casualty insurance products are an indication that the sector is moving towards international operating practices. Some foreign insurers, however, may prefer these practices to be implemented and realised before investing in China.
Insurance legal framework and industry background in Thailand

Since the Asian economic crisis in 1997, Thailand’s insurance industry has undergone significant change. Prior to 1997, the industry was largely closed, with only limited investment by foreign insurers. In response to the financial crisis, Thailand’s insurance regulators actively encouraged investment by foreign insurers who offered much-needed capital and increased technical expertise. Because of the need for consolidation and the weak financial position of a number of Thai insurers, opportunities still exist for foreign investors. As Thailand emerges from the financial crisis, the insurance industry is experiencing significant growth, with the trend expected to continue as public awareness of the need for insurance increases.

An industry overview

Thailand’s general insurance industry grew dramatically during the early- to mid-1990s. Owing to strong growth rates in the industry, especially in the motor vehicle insurance business, which averaged 25 per cent growth between 1992 and 1996, the number of general insurers increased as new participants sought to profit from the boom.

After six years of double-digit underwriting profits, the Asian economic crisis reversed the industry’s fortunes, with two years of underwriting losses in 1998 and 1999. The dramatic impact of the crisis hastened reform of the previously closed industry. As part of the financial bail-out offered by the World Bank and other multilateral agencies, Thailand was required to engage in extensive financial sector reform, including meeting its commitments to the World Trade Organisation to liberalise the insurance sector.

Since the turmoil of the crisis, the industry has staged a recovery, with premium levels growing each year since 2000, despite the impact of the events of September 11, 2001. By last year, premium levels had regained those reached prior to the crisis and now continue to grow steadily on the back of continued economic growth, proposed tax incentives and a government drive for complete coverage by compulsory motor insurance.

Foreign insurers participation

While the influx of foreign investment into the industry was encouraged in the wake of the economic crisis, foreign insurers remain subject to both geographic and equity participation restrictions within the Thai market.

Foreign insurers may operate either as a foreign branch office or as a joint venture partner in a Thai insurance company. Holders of a foreign branch office licence are restricted to operating from a single location in Thailand. Foreign investment in a Thai insurance company is limited at present to 25 per cent of shares.
Despite these restrictions, foreign insurers currently play a significant role in the market. This is most prominent in the life insurance sector, where it is estimated that 15 of the 26 life insurance companies have joint venture partners and the sole foreign branch licensee, American International Assurance, is the market leader with more than 50 per cent market share. High loss ratios in the years since 1997 have meant that foreign investment in the general insurance sector has not been as pronounced. There are currently five foreign branch licencees, with some 27 of the 78 general insurers having joint venture partners.

While foreign insurers are limited by law to holding a 25 per cent stake in Thai insurance companies, foreign investors have been able to obtain effective control through management agreements or complex shareholding structures. It is expected that the 25 per cent shareholding limit will be increased over time, initially to 49 per cent for a period of ten years, before the market is fully opened prior to a WTO deadline of 2020.

The nature of the market
The influx of foreign investment into the sector has led to a maturing of the Thailand insurance industry, with a wider range of products now being offered, and improvements in basic infrastructure.

The general insurance sector is characterised by a large number of small- to mid-size insurers, with more than half of the 77 general insurers holding less than one per cent market share. This has resulted in overcrowding and intense competition. There will be continuing pressure towards consolidation of small- to mid-size general insurers as the Department of Insurance seeks to reduce the numbers of players in the industry. This is expected to occur partly because of proposed amendments raising the minimum paid-up capital requirement of general insurers from the present figure of THB30 million to THB300 million. It is currently estimated by industry sources that more than half of Thailand's general insurers hold less than THB300 million in capital funds. These measures, while tough for small insurers, should ultimately prove beneficial for the overall strength of the industry by improving capitalisation and strengthening the overall structure of the sector.

Because many Thai insurers lack reinsurance expertise, there is a significant reliance upon international insurers and an outflow of reinsurance premiums from Thailand. At present, only one pure reinsurance company operates in Thailand.

Legislative and regulatory environment
Thailand's general insurance and life insurance sectors are governed by separate legislation: namely, the Insurance Against Loss Act 1992 and the Life Insurance Act 1992. The legislative structure is similar for both types of insurance business. This legislation deals with both the contractual relationship between insurer and consumer and the regulation of the insurance industry.

The insurance sector is regulated by the Department of Insurance, under the control of Thailand's Ministry of Commerce. This body is charged with reviewing the financial standing of insurers operating within the Thai market, particularly
their compliance with capital requirements. In addition to the proposed increases in capital funds already discussed, the Department has moved, in the past few years, to introduce new monitoring systems similar to those employed by Thailand’s Securities and Exchange Commission to scrutinise listed companies. These steps impose more-stringent reporting requirements and greater public disclosure obligations on company executives in respect of information about the financial performance of insurers.

The Department also plays an important role in the development of the industry as a whole. It directly controls the number of insurers, the type of product and policy wordings that insurers may offer to consumers, and the premiums that insurers may charge. The use of non-approved policy documentation can result in policyholders having the option to terminate the policy with a full refund of premiums paid or to benefit under the policy as written or amended by the requirements of the Department of Insurance. These tight controls mean that the introduction of new insurance products – such as unit-linked life insurance, which has been the subject of much discussion within the industry recently after the Department of Insurance and the Securities and Exchange Commission finalised regulations on the investment of premiums for the direct benefit of policyholders – can be a protracted process.

**Insurance licences**

Two classes of person are permitted to hold licences to engage in the provision of insurance in either the general insurance or the life insurance sectors:

- Thai companies incorporated for the purpose of engaging in the relevant insurance business; and
- foreign insurers who may apply for a foreign branch office licence.

The holder of an insurance licence or a foreign branch licence in either the general insurance or life insurance sector may not conduct business within the other sector.

The specific requirements for persons wishing to apply for new licences are set out in notifications issued by the Ministry of Commerce as and when it wishes to increase the number of existing licences. In practice, new sets of conditions are issued for each round of licence applications. No application for a licence may be made until a notification has been issued. At present, the official position of the Department of Insurance is that no licences will be issued in the near future because of the need for further consolidation within the insurance industry.

While unable currently to apply for foreign branch licences, foreign insurers can still seek to enter the Thai market through an investment in one of the numerous Thai insurers. As referred to above, the limit on foreign investment is presently set at 25 per cent; however, that figure is expected to be raised to 49 per cent in the near future. In addition to this restriction on foreign investment, 75 per cent of the directors of Thai insurers must be Thai nationals.
Barriers to market development

In addition to the need for industry consolidation, several issues continue to restrict development of the industry as a whole, including:

- limited public awareness of the need for insurance;
- excessive dependence within the general insurance sector on motor vehicle insurance, which presently accounts for more than 40 per cent of premiums written;
- limited corporate governance, risk management and internal control systems, particularly among smaller insurers;
- inadequate service levels in the areas of insurance agency conduct and claims management;
- regulatory difficulties affecting the developments of new channels of distribution;
- the need for increased training for Thai insurance staff, to improve their skills; and
- insufficient investment in information technology systems.

The Department of Insurance has recognised the need to address these issues and has developed a strategic plan aimed at strengthening the position of Thai insurers, before the admission of further foreign competition. Key features of the plan to be implemented between 2001 and 2006 include:

- The achievement of steady growth in a competitive insurance industry by:
  - enhancing systems used to monitor the financial position of insurers;
  - promoting the merger of local insurers;
  - amending regulations to limit restrictions on competition within the market;
  - emphasising the importance of good corporate governance through the development of Codes of Best Practice, in conjunction with the General Insurance Association and Thai Life Insurance Association; and
  - raising service levels within the local industry to international standards.

- Efforts to increase public awareness of the insurance industry and the benefits it can offer consumers by:
  - creating a public relations office to promote the concept of insurance to the public; and
  - strict enforcement of the compulsory motor insurance scheme.

- Improvements in the Department’s regulatory functions to be achieved by:
  - transforming the Department into a fully independent regulatory authority and amending its organisational structure;
  - revising the Department’s working practices to improve both the efficiency and transparency of its operations;
– strengthening regulatory and monitoring skills of Insurance Department staff;
– improving the IT infrastructure within the Insurance Department to allow for efficient and effective monitoring of the industry; and
– enhancing consumer protection mechanisms.

• Development of the regulatory framework to meet the changing needs of the industry and the promotion of these developments within the Department, the insurance industry and to the wider public.

Conclusion
Improvements in insurance industry regulation and in the skills base and service levels offered to the public by insurers should work together to further develop the recovering industry, although the pace at which these changes are being implemented remains slow.

While the changes made since the Asian financial crisis have been significant, there is still financial weakness in parts of the insurance sector. Further consolidation must occur, particularly in the general insurance market, before the full potential of the industry can be realised. Opportunities for foreign insurers still exist, as further investment and technical expertise are required to strengthen the market. While the number of policyholders in Thailand is currently low compared with western countries, this represents great potential for continued growth in the coming years if the strategic goals identified by the Department can be met.
Introduction
Papua New Guinea (PNG) is a small, open economy, characterised by a large subsistence sector and with primary exports of agricultural and mineral commodities.

During the past decade, the economic performance of PNG has been erratic and vulnerable to external shocks. Such shocks have included a severe drought and the Asian economic crisis. PNG has also been affected by macroeconomic governance issues.

The financial sector of PNG (which includes insurance, banking, superannuation, etc) has recently undergone significant structural reforms aimed at improving financial viability, increasing transparency and strengthening relations with international financial institutions. These reforms include the regulation of the previously unregulated life insurance industry.

An industry overview
The financial sector accounts for approximately six per cent of PNG’s non-mining GDP.38

Separate legislation governs general insurance, life insurance, marine insurance, workers’ compensation and third-party motor vehicle insurance. The administration of these different types of insurance is also distinct, with the Insurance Commissioner, the Bank of Papua New Guinea and the Independent Consumer and Competition Commission all being charged with responsibility for the administration of particular aspects of the insurance industry.

The nature of the market and the participation of foreign insurers
Although participants in the insurance industry are usually required to be licensed, foreign companies are able to enter the PNG insurance market.

The participation of foreign insurers in PNG is moderate. The Asia Insurance Review Directory currently lists 13 insurance companies as operating in PNG.39 Most of these companies, if not all, are subsidiaries of large, multinational organisations. The number has risen only slightly from 1998, when 12 insurance companies operated in PNG.40

---

All risks situated in PNG are required to be insured with a PNG corporation that is licensed under PNG law, unless an exemption is granted by the Insurance Commissioner. In 1997, approximately 20 per cent of gross non-life insurance premiums were placed abroad.  

**Legislative and regulatory environment**

The principal legislation governing the insurance industry in PNG is the Insurance Act 1995 (the *Act*). This legislation regulates the activities of insurers, brokers and loss adjustors. In addition, the Act:

- requires all risks situated in PNG, for which insurance (and reinsurance) is required, to be insured with a PNG licensed insurer;
- provides a mechanism for the licensing of industry participants; and
- establishes the office of Insurance Commissioner and the Insurance Complaints Tribunal.

As referred to above, the Insurance Commission may waive the requirement that all risks situated in PNG be insured with a licensed insurer. This exemption may be granted if the existing facilities and available capacity of licensed insurers are fully utilised. Even where sufficient available capacity exists, the Act requires an exemption to be granted where the cost of insuring a risk with a licensed insurer is more than 17.5 per cent greater than the cost of insuring that risk with an offshore insurer. The Insurance Commissioner, however, maintains the discretion to refuse an exemption if, in his or her opinion, there are exceptional circumstances or the refusal is in the national interest.

The licensing, regulation and supervision of companies involved in providing life insurance is governed by the Life Insurance Act 2000. The Bank of Papua New Guinea is responsible for administering this legislation.

Third-party motor vehicle insurance is compulsory for the owners of registered motor vehicles. The provision of third-party motor vehicle insurance has been declared to be a regulated industry. This means that the Independent Consumer and Competition Commission is responsible for economic regulation of third-party motor vehicle insurance (ie the cost of premiums and annual adjustments to them). Technical regulation of the provision of third-party motor vehicle insurance is the responsibility of the Insurance Commissioner. Motor Vehicles Insurance Ltd, a state-owned company, is currently the exclusive provider of this type of insurance. However, there remains a mechanism under which other companies able and willing to carry on the business of third-party motor vehicle insurance may be nominated to do so.

All employers are required to take out workers’ compensation insurance for their employees.
Insurers and reinsurers must also be aware of other legislative instruments affecting all foreign enterprises intending to do business in PNG. These instruments require all foreign-owned or controlled enterprises to obtain a certificate to carry on business within PNG (including the business of insurance and reinsurance). A certification application requires the disclosure of all agreements relating to the management of the enterprise and can take up to 35 days to process. PNG is also subject to foreign exchange controls administered by the Bank of Papua New Guinea (that is, the Central Bank). Central Bank authority is generally required for payments by PNG residents to persons outside of PNG and for all agreements that contemplate such payments being made.

Insurance licences
It is an offence under PNG law to carry on general insurance business without the necessary licence. The licensing of insurers, brokers and loss adjusters is primarily governed by the Insurance Act 1995.

Only those corporations incorporated under PNG laws may be granted a licence to carry on general insurance business. Licensed insurers must maintain within PNG an amount of capital as prescribed by the Commissioner. An amount of money, to be determined by the responsible Minister, must also be deposited with his or her Department as security for certain liabilities that may arise. The Government has also issued guidelines regulating the categories of investment in which insurers may hold their premium income.

The Workers’ Compensation Act (Chapter 179) requires that insurers who provide workers’ compensation must also be licensed under the Insurance Act 1995.

A corporation must also be incorporated under PNG law to be eligible for a licence to operate a life insurance business. The Bank of Papua New Guinea must be satisfied that potential licence holders and their officers meet specified criteria so as to be considered ‘fit and proper’. Licence holders will also be required to comply with a prescribed minimum capital requirement of at least K4 million (as at 1 July 2003).

In the event that a PNG corporation other than Motor Vehicle Insurance Ltd is allowed to provide third-party motor vehicle insurance, that corporation will be required to maintain a minimum amount of K4 million with a licensed bank in PNG, as well as to maintain with the Bank of Papua New Guinea a deposit of the greater of K100,000 or 10 per cent of its net premium income for the previous financial year.

Barriers to market development
There remain a number of barriers to the development of the insurance industry in PNG.
The principal barrier relates to law-and-order and the cost of security. These problems have been described as the largest obstacle to private sector development in PNG, with more than 90 per cent of respondents to a 1999 survey agreeing that theft and crime were serious problems that substantially increased the costs of doing business in PNG. In addition to these barriers making the operations of insurance companies more difficult, they also have the effect of increasing the number of claims made.

Another barrier to the development of the insurance market is the PNG economy. In 2002, PNG experienced its third consecutive year of recession, with mining and petroleum revenue decreasing as many mining and oil operations encountered a decline in their production profiles. Finally, the proportion of the population that participates in the formal economy, and which may therefore be in the market for insurance products, is very low by Western standards.

**Conclusion**

The insurance industry in PNG appears to be relatively open, with minimal barriers to entry. However, the ability of the market to grow in the short- to medium-term is limited by the erratic nature of the economy. It remains too early to assess whether the recent reforms of the financial sector will have a significant effect on the viability of the insurance industry in PNG.