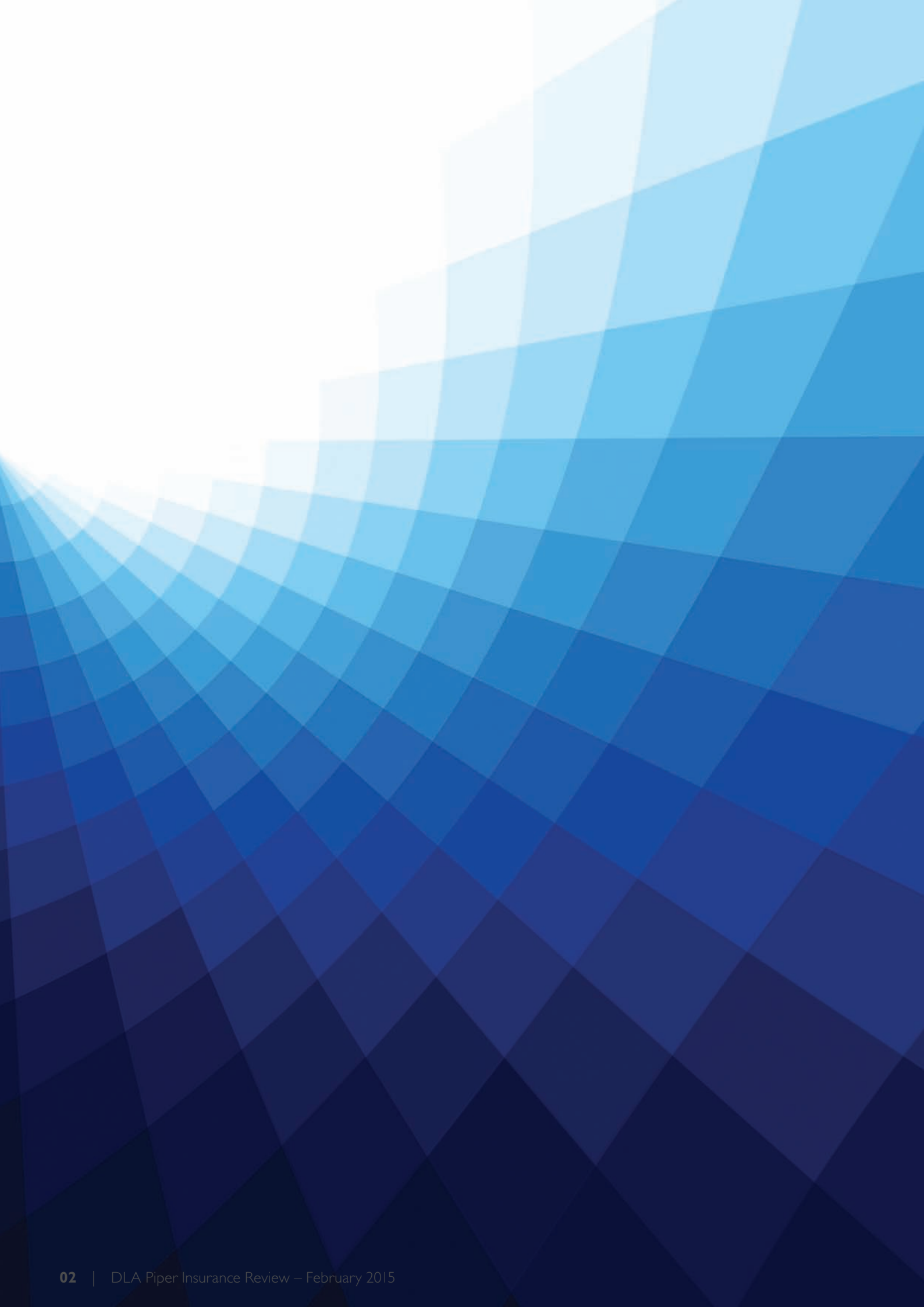
INSURANCE REVIEW

FEBRUARY 2015

DLA PIPER



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DLA PIPER

INSURANCE FLASHLIGHT

SHINING THE LIGHT ON INSURANCE

The forces of globalisation and regulation make insurance ever more complex and international in nature.

We have been advising clients on insurance and risk for more than 100 years. With a team of more than 200 lawyers, we offer our clients an enormous depth of knowledge across all areas of insurance, from corporate and regulatory advice through to claims management.

We deliver:

- A tailored, global service – whether you need one lawyer or a team from around the globe.
- Depth of experience – we have one of the largest and most experienced insurance and risk management teams in Australasia.
- Faster, cost-effective claims management – we've pioneered new technology to support claims management service delivery. So claims are resolved faster, with the best outcome in the most cost-effective way.

Our insurance clients include Australia's leading listed insurers, international insurers and reinsurers, underwriting agencies and specialist insurers in areas such as aviation, trade and transport.

Check out our blog, **Insurance Flashlight**, where we illuminate business and legal issues important to insurers, reinsurers, brokers, and other insurance sector professionals.

www.insuranceflashlight.com

INTRODUCTION

We remain excited and grateful that at the ANZIIF Insurance Awards in August 2014 we were named "Insurance Law Firm of the Year". It is a great recognition of the hard work that our team has put in recent times. Our teams in New Zealand and the United Kingdom have also been recognised as leading teams by winning "Insurance Law Firm of the Year" at the Legal 500 UK awards and also at the New Zealand Insurance Industry awards. The insurance sector continues to be a major focus of the firm locally and globally and will be into the future.

To make the awards evening even better, our insurance elder statesman, Michael Gill, received the ANZIIF "Lifetime Achievement Award". The many of you who know Michael and are aware of his achievements over his long career, will know the award is richly deserved. For newcomers to the industry, read partner James Berg's interview with Michael on page 17. We have had a number of partners across the Asia Pacific recognised in 2014 as leading practitioners in insurance by various also directories such as Chambers and Best Lawyers.

2014 was a relatively stable year for the insurance industry in both the financial and regulatory spheres. Total industry net profit and investment income remained at 2013 levels. As usual, the devil is in the detail. In fact, gross incurred claims for long tail classes were up 25.3 percent from the previous year – but this was primarily due to the decrease in government bond yields rather than any inherent problems in the industry.

As for regulation, insurers can understandably suffer occasionally from compliance fatigue after the constant regulatory changes over the past 10 to 15 years. So it was with a sigh of relief when we read the Financial System Inquiry, delivered to the Treasurer on 7 December 2014, concluded that there was not a "compelling case" for further changes to the "stability settings" in insurance at this time. Sophie Devitt discusses the report on page 5. Sophie and her team also look at the long awaited insurance reforms in the UK, see page 9. The Bill was introduced to parliament in 2014 and if it is adopted, many of the features of Australian insurance law, enshrined in the *Insurance Contracts Act 1984* (ICA), will be UK law. However the bill falls short of adopting all of the consumer protections contained in the ICA.

If you only read one article in Insurance Review 2015, read Alec Christie's predictions on privacy and cyber – if you "get creepy" this year, don't blame us!

Insurers, as ever, have been keeping Australian courts busy over the past year. Carmen Elder reports on some interesting judicial decisions on broker's negligence, which provide some guidance on the scope of a broker's duty of care. See page 23.

Australian lawyers continue to enjoy protection from professional negligence claims thanks to advocates' immunity. There has been a flurry of cases concerning negligent advice on prospects and settlement going to trial. In the past, these cases tended to be settled. Proportionate liability and causation also continue to limit the exposure of insurers. These topics are addressed in pages 21 – 26.

The High Court decision of Brookfield confined the scope of the duty of care to subsequent owners of, in this case, a commercial building. However, as an apartment building can be a commercial building, the decision was the cause of much consumer complaint at the time, with calls for legislative reform. For further discussion, see David Leggatt and James Baird's article on 39.

Our insurance blog, Insurance Flashlight, continues to flourish. If you haven't bookmarked or subscribed to it yet, we recommend it.

We wish all our clients and readers all the best for 2015.

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THE FINANCIAL SYSTEM INQUIRY
What does it mean for the insurance industry?

The Financial System Inquiry (Inquiry) delivered its final report on 7 December 2014. The terms of reference, released by the Treasurer, the Honourable. Joe Hockey MP on 20 December 2013, required the independent committee, chaired by former Commonwealth Bank chief executive David Murray, to examine how to best position the financial system to meet Australia's evolving needs and support sustainable economic growth.

In recommending policy options, the Inquiry were asked to consider how the financial system had changed since the Wallis Inquiry (completed in March 1997), as well as considering emerging opportunities and challenges.

In preparing its interim and final reports, the Inquiry consulted extensively, both domestically and internationally, with regulators, industry participants and consumer groups.

INTERIM REPORT

The Interim Report released on 15 July 2014, made an initial assessment, based on submissions that "many areas of the financial system are operating effectively and do not require substantial change." The Interim report identified areas of potential change and improvement for consideration by stakeholders rather than making recommendations.

The Interim Report identified nine priority issues facing the Australian financial system and put forward a range of possible policy questions for consideration:

THEMES	PRIORITY ISSUES
Growth and consolidations	1. Competition and contestability 2. Funding Australia's economic activity 3. Superannuation efficiency and policy settings
Post-GFC regulatory response	4. Stability and the prudential framework 5. Consumer outcomes and conduct regulation 6. Regulatory architecture
Emerging trends	7. Ageing and retirement incomes 8. Technology opportunities and risks 9. International integration

In relation to insurance, the Interim Report's preliminary assessment was that the insurance sector has similar levels of concentration and profitability to the banking sector. However, by in large the Interim Report submissions did not raise concerns regarding competition in the insurance industry.

The Interim Report addressed the following issues for the insurance sector:

- **Aggregators** – their use, the industry's concern about the complexity of aggregating insurance products, access to sensitive pricing models and the continuing risk of over emphasis of pricing leading to underinsurance.
- **Statutory insurance schemes** – the possibility of opening statutory schemes to private sector competition.
- **Underinsurance** – the submissions raised a range of issues including affordability, availability and the impact of State taxes.
- **Life insurance** – observations that underinsurance for life and disability insurance is significant.

The Interim Report sought submissions as to whether Australia has a problem with underinsurance that warrants some form of policy response. Specifically:

- How does Australia compare internationally on adequacy of insurance coverage?
- Has the issue of underinsurance been increasing over time?
- What evidence and data are available to support a conclusion about our level of underinsurance?
- What evidence and data are available to assess whether more granular risk-based pricing will lead to exclusion or further underinsurance?

FINAL REPORT

The Final Report was the product of an extensive consultation period, including 6,800 submissions and hundreds of stakeholder meetings, as well as the incorporation of the observations made in the Interim Report.

In his address to the Committee for Economic Development of Australia releasing the Final Report, Mr Murray AO, emphasised the importance in undertaking the Inquiry for sustaining confidence in the Australian financial system, and funding the sustainable economic growth of Australia.

The report makes 44 recommendations "to improve the efficiency, resilience and fairness of Australia's financial system." The recommendations are based around two general themes: funding Australia's economy and boosting competition. The Final Report presents its recommendations within five specific themes:

- **Resilience**: Strengthen the economy by making the financial system more resilient.
- **Superannuation and retirement incomes**: Lift the value of the superannuation system and retirement incomes.
- **Innovation**: Drive economic growth and productivity through settings that promote innovation.
- **Consumer outcomes**: Enhance confidence and trust by creating an environment in which financial firms treat customers fairly.
- **Regulatory system**: Enhance the independence and accountability of regulators and minimise the need for future regulatory intervention.

The majority of the final recommendations relate to capital adequacy in the banking sector and the underperformance of the superannuation industry. Even so there were some significant recommendations relevant to the insurance industry.

In a nod to the strength of the insurance industry, the submission observed the reforms that took place following the collapse of HIH Insurance Limited in 2001 and concluded that there was not a "compelling case" for further changes to the "stability settings" in insurance at this time.

The recommendations specific to insurance are discussed below.

CONSUMER OUTCOMES

Recommendation 21: Product Issuer Accountability for Design and Distribution

The Final Report recommends laws to introduce "a principle-based product design and distribution obligation." This obligation would require product issuers and distributors to take into account a range of factors in the product design stage and the distribution avenues. The Inquiry concluded that issuers and distributors would need to consider the financial needs of the consumer best suited to the particular product and the distribution method. The relevant standards would depend on the product class. This recommendation is in part a response to the challenges that have arisen with consumer credit insurance (CCI) and the Storm financial matter and similar matters. The proposed obligation would cover:

PHASE	OBLIGATIONS
Product Design	Identifying the target and non-target markets, how the product may affect consumers and testing the features are clear and easy to understand.
Product Distribution Process	The issuer should direct how the product should be distributed.
After the Sale of a Product	There should be periodic reviews to test the product still meets the needs of the target market.

The purpose of this recommendation is to ensure consumers are not sold financial services that they don't understand or that don't meet their needs. The Inquiry noted that disclosure can be ineffective due to a number of reasons including financial literacy and poor advice or no advice. This recommendation puts the onus back on the issuer and distributor to control the purchasing of the product to protect the consumer. The recommendation (if adopted) presents some challenges to issuers and distributors.

Recommendation 22: Production Intervention Power

Currently Australian Securities and Investment Commission (ASIC) can only take action after a breach of the law. The product issuer's responsibilities will be backed by a recommendation that ASIC have the power to prevent the issue or distribution of a financial product (or a class of financial products) where there is a "risk of significant consumer detriment." This proposal represents a notable increase in ASIC's powers.

Recommendation 24: Align The Interests Of Financial Firms And Consumers

This recommendation is focused on fostering confidence and trust in the financial system. The Inquiry wants a shift in the culture and conduct of financial firms' management so the focus is on consumer interests. This includes addressing the commission structures for life insurance.

The Inquiry concludes that "better aligning the interests of financial firms with consumer interests, combined with stronger and better resourced regulators with access to higher penalties, should lead to better consumer outcomes."

Recommendation 26: Improve Guidance And Disclosure In General Insurance

The Inquiry also makes a recommendation to improve transparency, guidance and disclosure in general insurance with a particular focus of home insurance.

This recommendation seeks to address underinsurance and improving consumers understanding of the features of the policy so they can make informed decisions.

The recommendations says that increased guidance (in the form of tools and calculators) is recommended for consumers on the likely replacement costs of their home and contents. There are also recommendations regarding more reasonable timeframes for industry to implement any significant regulatory changes. The report recommends that "[i]f significant progress is not made by the industry within a short timeframe, the Government should consider introducing a regulatory requirement to provide this guidance at the point of renewal or on entering into a contract with a new insurer."

There is also some general commentary on insurance and natural disasters. The Inquiry believes this issue should be primarily handled by risk mitigation efforts rather than direct government intervention. Interestingly, the Australian Government Actuary has confirmed in its investigation that the pricing adopted by insurers in North Queensland is reasonable because of the risk in that area. The Final Report cautioned that if the use of unauthorised foreign insurers (UFI) became widespread, the impact on the stability of the market should be revisited. Allowing UFIs into the domestic market may result in Australians being exposed should their insurers fail.

INSURANCE COUNCIL OF AUSTRALIA'S RESPONSE

On 8 December 2014, the Insurance Council of Australia (ICA) issued a response to the Financial System Inquiry report.

The ICA commended the Inquiry's focus on investing in mitigation to reduce the impact of natural disasters rather than direct government intervention, which risks distorting price signals. The ICA considers that the findings pave the way for the Australian Government to work with state and local governments to prioritise investments in mitigation and examining improvements to building standards.

The ICA supported the Inquiry's promotion of competitive neutrality particularly the calls for an examination of the stability implications caused by any increase in access by UFI's. The ICA considers that the Australian Government's recent promotion of the use of UFI's as a competition tool in the already highly competitive domestic insurance market, is contradictory to competitive neutrality, especially without the UFI's facing the same cost impositions.

In relation to disclosure and consumer empowerment, the ICA noted that the Inquiry's recommendations for improvements to advice and disclosure regimes to improve consumers' ability to make well-informed discussions, reflected the ICA's position.

Finally, the ICA endorsed the Inquiry's recommendations that taxes on insurance should be reduced or removed to enhance affordability.

WHAT NEXT?

The Inquiry makes bold recommendations in relation to the banking sector and superannuation industry. The Final Report's focus on the insurance sector is brief with a number of the queries raised in the Interim Report, not receiving further consideration. It remains to be seen whether the Government will take steps to implement the recommendations and if they do, whether these recommendations will suffer the same fate in the Senate as the recent unsuccessful Future of Financial Advice reforms.

Submissions on the Final report remain open until March 2015.

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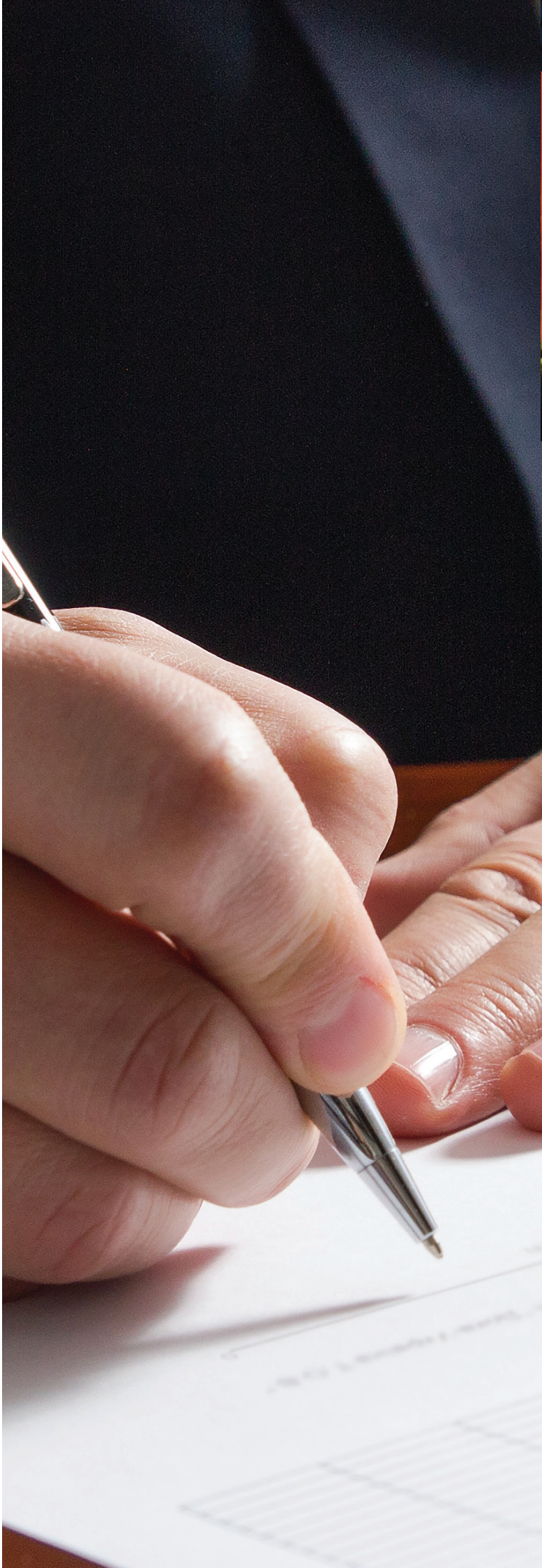

INSURANCE REFORM IN THE UK
Adopting the Australian Approach?

The Insurance Bill 2014, if passed, will mark the end of a protracted period of insurance law reform in the United Kingdom. The reforms are clearly aimed at modernising and simplifying a century-old regulatory system and bear a strong resemblance to some of the key features of the Australian approach to insurance contracts law.

BACKGROUND

It has now been 30 years since the *Insurance Contracts Act 1984* (Cth) (ICA), was introduced into Australian Parliament. The ICA re-defined disclosure obligations and remedies available to parties to an insurance contract and created broad protections for policy holders in the Australian market. The ICA was and, in some respects still is, regarded as market leading.

In January 2006, the Law Commission and the Scottish Law Commission (the Commission) commenced a joint review of insurance contract law in the United Kingdom and invited submissions on what areas of insurance contract law required reform. As part of the project, the Commission had specific regard to the impact of the ICA on the insurance market in Australia and the successes and failures of the Australian legislation. Following a period of review and consultation with key stakeholders, the Commission adopted a phased approach to insurance contract reform.

The first phase culminated in the enactment of the *Consumer Insurance (Disclosure and Representations) Act 2012* (the 2012 Act) which came into effect on 6 April 2013 and related specifically to consumer insurance contracts.

The next and final phase was the introduction of the *Insurance Bill 2014* (the Bill) on 17 July 2014. The Bill deals with disclosure in business insurance, warranties and insurer's remedies for fraudulent claims. The Bill will need to receive Royal Assent before the end of the current parliamentary session in March 2015. If it is not passed in this timeframe, it cannot be passed over to the next session due to the UK general election in May 2015.

If passed, it will come into force from 18 months from the date it is passed to allow time for policy wordings to be amended where necessary.

We discuss below the key features of the Bill in comparison to the provisions of the ICA.

DUTY OF DISCLOSURE

Clause 3 of the Bill requires the insured under a business insurance contract to make a "*fair presentation of the risk*" to the insurer before entering into the contract.

This duty of disclosure requires the insured to:

- disclose every material circumstance which the insured knows or ought to know; or alternatively
- disclose sufficient information to put a *prudent insurer on notice that it needs to make further enquiries* for the purposes of revealing those material circumstances.

In circumstances of misrepresentation or non-disclosure, the Bill allows the insurer to avoid a claim in circumstances where it can demonstrate that, but for the breach it would not have entered into the contract or alternatively, it would have entered into the contract on different terms.

The disclosure requirements adopted by the 2012 Act and the Bill are similar to the position under the ICA.

The UK Act and the Bill also adopt the Australian approach of varying an insurer's remedies for an insured's non-disclosure. For instance, in the ICA:

- where an innocent misrepresentation has occurred, an insurer cannot avoid the contract, but liability is reduced to what would put the insurer in the same position as it would have been had the non-disclosure not occurred (s 28(1)); and

- where there is a fraudulent breach of the duty to disclose, the insurer may avoid the contract (s 28(2)). However, the court may disregard the avoidance 'in the interests of justice' (s 31).

There are similar features in the UK Act and Bill which take a subjective approach to misrepresentations from the insured and allow the insurer to terminate a contract in the event of a deliberate or reckless breach.

The principal difference is that a contract of insurance can only be avoided in Australia in circumstances of fraudulent misrepresentation or non-disclosure whereas the proposal under the UK Bill is that the insurer can avoid the contract in circumstances of both fraudulent and negligent or innocent non-disclosure.

WARRANTIES

The Bill prohibits "basis of the contract" clauses on proposal forms which convert statements made on the proposal form to a warranty.

This is similar to the effect of section 24 of the ICA which provides that statements made by an insured in connection with a contract of insurance are viewed as being made during negotiations before the contract was entered into and do not form part of the contract itself.

In addition to this, clause 10 of the Bill suspends (rather than completely discharges) an insurer's liability from the time of the breach until the time the breach is remedied.

CONTRACTING OUT

Much like the 2012 Act and the ICA, the Bill also prevents an insurer from contracting out of the Bill to the detriment of the insured. A policy term that puts the consumer in a worse position than under the Bill will be rendered void.

Curiously however, the parties to a business or non-consumer policy are nonetheless able to contract out of most provisions of the bill. The exceptions include the prohibition on basis of contract provisions and deliberate or reckless breaches of a duty.

CONCLUSION

The Commission's work in reforming the UK's insurance industry is understandably vast – a full contemplation of which, would take many pages. Nonetheless, the Commission's work has been reflected in two concise statutory instruments.

Clearly, while the UK reforms have sought to re-balance the law in relation to insurance contracts, the reforms have not shifted the scales as far toward the insured as the ICA. The high-water mark of the ICA is section 54 which limits an insurer's remedy for breach of a policy term to the extent to which it is prejudiced by the insured's act or omission. No equivalent provision exists in either the 2012 Act or the Bill.

The Commission has nevertheless acknowledged that many of its proposed reforms are in line with those introduced in Australia in 1984, particularly around non-disclosure and warranties/representations. The Commission requested a report from Professor Robert Merkin of Southampton University to highlight the Australian regulatory experience. For a full copy of Professor Merkin's detailed report see here.

We consider that the full ambit of insurance reform (if passed) will take a number of years to settle as the courts seek to determine disputes in accordance with these new laws. Thirty years of Australian case law may well be called upon to assist in settling the UK position on the rights and remedies of parties to an insurance contract. For now though, we wait to see the UK legislature's response to the Bill and whether a split legislative scheme for consumers and businesses will emerge.

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TOP FIVE PRIVACY & CYBER PREDICTIONS, TRENDS AND ISSUES IMPACTING INSURERS IN 2015 AND BEYOND

This time last year, we looked forward to the APPs coming into effect (from 12 March 2014) and highlighted the "Top 10 Things You Think You Know About Privacy But Don't!." In September this year, after six months of the operation of the APPs, we highlighted the "Issues and Concerns With The New APPs" that our clients had encountered in practice.

At this time, as we reflect on 2014, we thought it appropriate to give you our top five privacy predictions, trends and issues that we see impacting insurers and the industry in 2015 and beyond!

1. IMPACTS OF THE EU DATA PROTECTION REGULATION – THE RIPPLE EFFECT!

Even before it has been passed one of the cornerstones of the new EU Data Protection Regulation (**Regulation**), the right to be forgotten, has already caused significant concern and discussion around the world. The Regulation will be passed during 2015 and its main principles (including the right to be forgotten) and tougher stance on privacy protection and security will be also felt outside of the EU.

We expect that the Regulation will have a ripple effect across the Asia-Pacific, including in Australia and New Zealand. The Regulation will "*up the ante*", "*raise the bar*" and will embolden privacy regulators across the region to (i) interpret and apply their privacy laws more onerously and/or (ii) seek new enhanced privacy rules, heavier fines and more administrative and investigative weapons to be available to them. We will not be surprised to see the first privacy related jail sentence somewhere in the region in 2015.

The Regulation and increasing discussion of it throughout the region will also have an unconscious impact (which we believe we have already seen in part in the Murray Report) on any inquiries in the financial services industry, including in relation to any aspects of customer information, privacy or Big Data analytics. Those involved in the inquiries cannot help but be caught up in the renewed focus on privacy and security that the Regulation will promote across the region.

2. INTERNET OF THINGS (IOT) – COMING FASTER THAN YOU THINK!

For a few years now many of us have been thinking about and discussing the IoT in a light-hearted manner, imagining a world where our toaster is telling our insurer that we have a bad diet or have insomnia and therefore are a bad risk for health and/or car insurance! However, giant strides have been made in 2014 and even larger strides will be made in 2015 in terms of making IoT a reality.

The implications of IoT for the insurance industry and insurers generally cannot be over-estimated. The information that can be obtained from the multitude (and ever increasing number) of remote sensors in/on everything from our cars, household appliances and wearable fitness devices (if not other wearables), to name but a few, is potentially of enormous benefit to insurers, including in relation to assessing insurance risks and setting premiums.

In 2015 the IoT will become much more "real." Of course, the challenge for insurers is to understand not only what data is available to them but also how they can and should be using it and, in relation to 1 below, how they will secure the information collected. Together with the Big Data analytics discussed below care must be taken, from a privacy compliance perspective, to understand what an insurers' privacy obligations are and, above all else, to start a conversation with customers about what information will be collected and how, what it will be used for and the "bargain" offered in return (i.e. what will customers get for allowing insurers to access the personal information from their devices?).

3. MOBILE/APP COMPLIANCE – IN THE COMMISSIONER'S CROSSHAIRS

In the last couple of years the delivery of services and products by insurers via mobile devices and Apps has increased significantly. In 2015 we expect significant further growth in the use of the mobile and App environment by insurers to deliver services and products. It is therefore timely to note the Privacy Commissioner's warning (given at an Australian privacy conference in late November 2014) that investigating and ensuring compliance in the mobile and App environment is one of his top two priorities in 2015.

There is, of course, a twist here. Compliance in the mobile and App environment is not simply dumping a five page website privacy policy on to a smart phone. The Commissioner has made it very clear that this is unlikely to be acceptable or compliant. Insurers will need to carefully consider how they deliver privacy compliance across their mobile and App environment. In particular, developing innovative ways to transparently and concisely inform customers of the key aspects of their privacy compliance and to resist the temptation to over-reach (for example, collecting location data from the mobile devices where it is not really necessary for the insurer's functions/business), just because they can.

4. BIG DATA ANALYTICS – DON'T GET CREEPY

A number of our insurance clients are already well advanced in the planning and development of a number of Big Data analytics projects. We expect these projects to be deployed from now and to generally develop apace during 2015, with a significant number of Big Data analytics projects to be deployed across all insurers.

While we are excited that the insurance industry is at the forefront of the Big Data analytics (after the big retailers), care must be taken to navigate the privacy obligations and, in particular, to always be alert and aware of the relationship with your customers and whether what you are doing could be considered to be "creepy" (e.g. upsetting to your customers). There was a lot of press in 2014 about the creepy aspects of Big Data analytics and, in each case, it is underpinned by a lack of transparency (i.e. the "conversation"), when collecting the relevant information and continue it on an ongoing basis with those from whom the personal information is collected.

A lesson from the large retailers is that transparency and entering a "bargain" with customers for use of their information for Big Data analytics are valuable tools in reducing the pushback/the creepiness. That is being upfront and clear with customers about, and offering a discount or reward to encourage people to be involved in and agree to, the use of their personal information for your Big Data analytics.

5. SECURITY/PRIVACY GOVERNANCE AND CYBER RISK MANAGEMENT – A LIKELY SIGNIFICANT INCIDENT OR INVESTIGATION IN 2015-2016

The Privacy Commissioner's top priority for 2015 (mentioned at the November conference) is ensuring companies have appropriate privacy governance (e.g. in line with the obligations under APP 1), including appropriate security measures to protect the personal information they hold. In addition, the growing focus on cyber risk management ties in with the privacy governance and security focus of the Privacy Commissioner in 2015 such that, in these combined and overlapping areas, we expect to see at least one significant issue arise in 2015-2016. We expect, possibly in the insurance industry, that there will be a significant and very public cyber incident or privacy breach and/or investigation in Australia in the next 12 to 24 months.

Of course, for listed companies, failure to implement an appropriate cyber risk management framework and privacy governance/security framework may result in actions (or a class action) against the directors of the company for failure to meet their duty of care should the share price be impacted by any such incident, for example.

In addition, we expect that the Murray Report, the increased discussion of privacy resulting from the passing of the Regulation and the growing awareness and interest in the security and cyber risk areas in 2015 will have a particular focus on the financial services sector.

Therefore, apart from being good governance and part of the Board's duty of care, we urge all insurers, if they have not already done so, to implement appropriate privacy governance, security and cyber risk management frameworks as a top priority in 2015.

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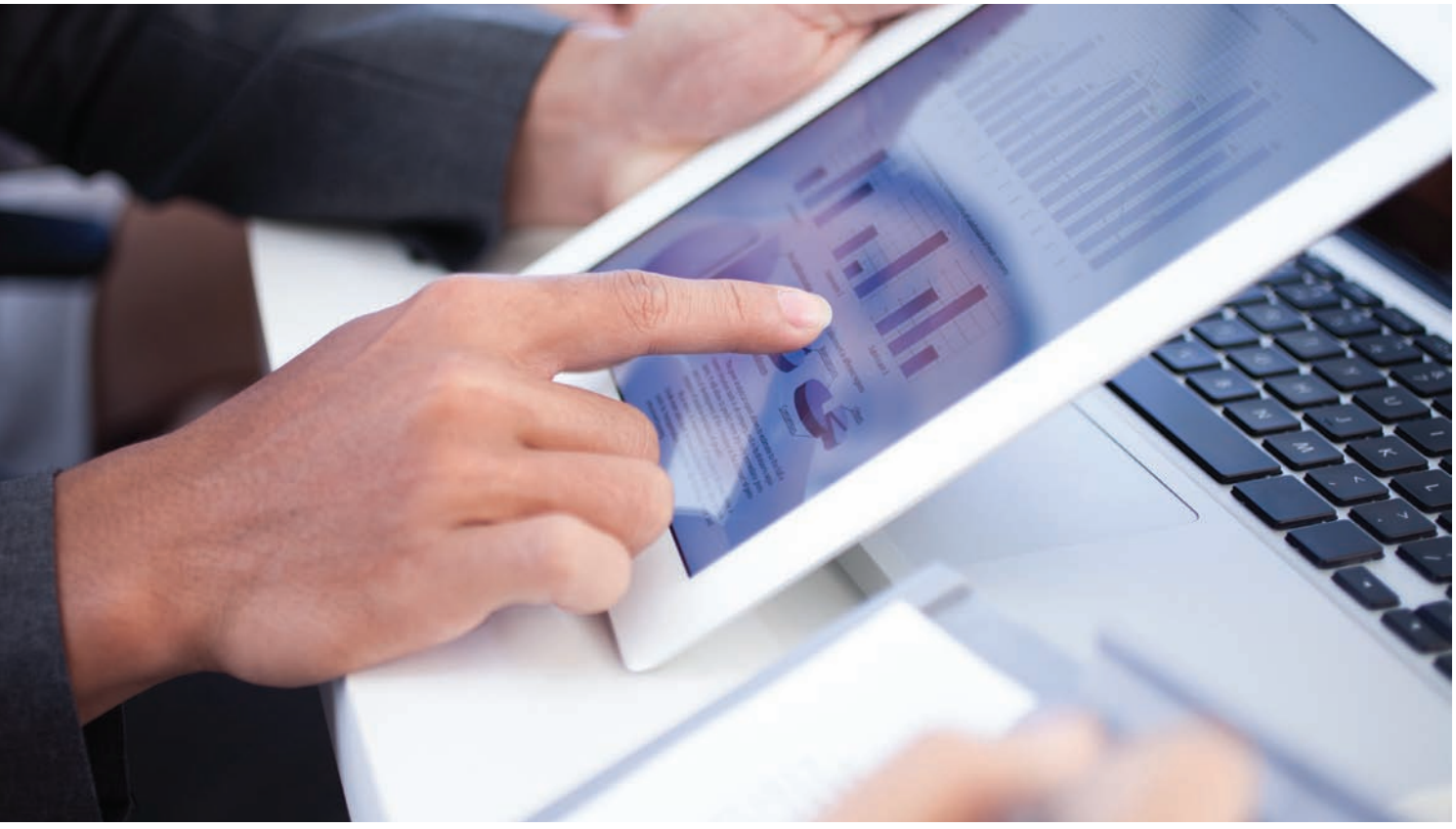

DIRECTORS AND OFFICERS RECENT DEVELOPMENTS

2014 was a busy year in the Directors & Officers (D&O) liability sphere and the trends we have observed show the beginnings of potential regulatory shifts that may have widespread impact on directors and officers. The issues where we continue to see on-going change are class actions, cyber (and physical) security risks, and increasing regulatory scrutiny by ASIC focusing on corporate responsibility.

THE PERCEIVED GROWTH AND SHIFTING LANDSCAPE OF CLASS ACTIONS

A new report published by the Monash Business School has moderated concerns surrounding the perception of growing class action activity in Australia. The report suggests that rather than seeing any dramatic increase over recent years, the number of class action cases has actually seen little to no movement since they began featuring prominently in the early 1990's.

Experts on group proceedings have commented on the reality of class actions as against the myth that there is a "snowball" effect in place as public knowledge of class actions increases, particularly with the number of high profile cases seemingly on the rise. Surprisingly, the study found that public perception of growing class action activity does not appear to be substantiated by any existing data. According to the report, class actions have only increased by as little as 0.2 percent each year over the past five years. Part of this is because of the rather small concentration of class action specialist litigators, along with their calculated and targeted approach to class actions. There is speculation that this dynamic might change in the near future.

We are however seeing a shift in the subject matter of class actions as the claims which arose from the global financial crisis have now largely worked their way through the courts. Class action subject matter is now moving from more securities-based litigation to a broader scope of claims. These broader claims are likely to cause additional problems for those funding or bringing the proceedings, including how to properly identify the relevant class(es) of persons on whose behalf the proceedings are brought. However we are also seeing growing sophistication and litigation funding in this sphere, including a growth in class actions pertaining to natural disasters such as bushfires and floods. This area has shown us that class actions are available to insurers through subrogation recovery efforts.

There are calls from within the industry to implement a comprehensive reform of class action litigation in Australia due to concerns regarding litigation funding. In May 2014 the Attorney-General announced that an advisory panel would be formed to examine the litigation funding industry. Part of the need for the panel stemmed from the current potential for opportunistic litigation to occur. However, whilst the push for class action reform remains topical in

the litigation sphere, the movement has not yet produced any formative changes. For example, both the Australian courts and the Federal Government have stopped short of imposing any meaningful boundaries in respect of third party litigation funders, despite the prominence of a small number of large funders who are involved in a substantial proportion of class actions in the Australian market. On the other hand, in 2014 we saw increasing calls for the lifting of the prohibition on contingency fee arrangements by solicitors which would, if successful, likely result in increased plaintiff class action activity, and which would have obvious repercussions in the D&O space. While 2014 saw little permanent change in the status quo in this area, we expect company directors and those in the D&O insurance industry alike will have a clearer view as to the likelihood of class action reform in 2015.

CYBER SECURITY

There have been a number of high profile data breaches and cyber attacks over the last year. While most of these have occurred outside of Australia, Australian Boards of Directors are developing a growing awareness and acceptance that data and cyber security are essential parts of a company's overall risk management strategy. It is important that companies have comprehensive policies in place to manage cyber security, including dealing with the physical security of the computers and networks themselves. An organisation's computers and networks that are used to handle confidential information must also be protected from both physical and digital unauthorised access. A cyber attack does not necessarily need to be related to a hacker obtaining unauthorised remote access to an organisation's internal network, but may also include unauthorised physical access to an employee's computing terminal.

In the same way that a lack of accounting knowledge on the part of a director was no defence in *ASIC v Healey* (2011) 196 FCR 291, directors can not blindly delegate responsibility for cyber security to others and they must take a proactive role in managing this risk at Board level. If directors are found to not have taken adequate consideration into protecting their physical systems on site, they open themselves up to potential liability and litigation.

However, we have observed that it is not all bad news, as directors are becoming increasingly aware of these risks and are beginning to discuss these issues at board level while seeking counsel from appropriately skilled consultants. In the US, the level of proactive action required by directors has already been tested in the courts, for example in the recent case of *Palkon v Holmes et al* 2:14-cv-01234-SRC-CLW. In this case, the District Court of New Jersey dismissed a claim against the Board of Wyndham Worldwide Corporation, in connection to a series of cyber breaches the company had experienced. The Court outlined in its dismissal that it had taken into consideration the fact that the Board had discussed in depth cyber-related issues, including the company's security policies at numerous board meetings at the time the breaches occurred. They held that in the current circumstances, this had satisfied the directors cyber security obligations.

We expect that directors will continue to improve the depth and breadth of their knowledge around cyber risks. Those Boards who ignore or underplay the issue of cyber security will do so at their peril. For further detail on cyber risk, see Alec Christie's article on page 11.

THE INCREASING ROLE OF ASIC?

In June this year, the Senate Economic Reference Committee released a highly critical review of ASIC's performance, labelling ASIC a "timid, hesitant regulator."

The review noted that the current civil penalties are insufficient and proportionately low given the seriousness and impact of civil penalties available in other international jurisdictions and to other Australian regulators.

As part of its new strategy, ASIC has highlighted three areas in which it intends to strengthen its enforcement role: by increasing penalties, adopting a more robust enforcement approach (with more strongly worded enforceable undertakings) and to be increasingly aggressive in pursuing larger cases.

Interestingly, even with the advent of a more vigilant ASIC, the Australian Government is continuing to push towards its goals of de-regulation and budget cuts. As part of this effort, ASIC's budget for 2014-15 has been cut by 12 percent, and the ATO is expected to lose more than 2,300 staff. However, whilst such changes will place increased pressure on resources involved in regulatory investigations and enforcement, we do not expect a drastic reduction in overall regulatory activity. Our rationale stems from the current push for increased cooperation and information sharing between regulatory bodies, both nationally and internationally, in attempts to make regulatory bodies more efficient.

It is important to note that there is a global trend in effect that is seeing increasing cooperation between cross-border competition regulators. Regulators are interacting through organisations such as the International Competition Network, in order to increase efficiency, and attempting to snare directors and companies in jurisdictions that will enforce the highest penalties. By way of example, the ACCC has recently signed a memorandum of understanding with the Ministry of Commerce of the People's Republic of China, paving the way for increased cooperation, and more efficient reviews of cross border transactions and investigations. This is but one example of the growing web of bilateral and multilateral agreements between international regulators. We believe this trend will increase over the coming years in the face of the continuing globalisation of commerce and global governments driving for more spending efficiency.

HARSHER PENALTIES ON THE RISE

It is not just the risk of investigation that is rising, the pecuniary penalties being imposed on directors and businesses by the courts are also increasing steadily. Public sentiment appears to be reflected in recent court decisions holding directors to higher standards of responsibility, we have witnessed a year with the highest penalties ever imposed for breaches of continuous disclosure requirements.

Some of the key cases decided in 2014 saw significant penalties in excess of AU$1 million being imposed upon companies by the Federal Court.

In recent regulatory matters, the courts have not hesitated to increase pecuniary penalties that were agreed between ASIC and the infringing party. A notable example can be found in *ASIC v GE Capital Finance Australia* [2014] FCA 701, where the parties agreed to a penalty of AU$1 million, but the Federal Court considered that was inadequate and imposed a higher penalty of AU$1.5 million. However, in *ASIC v Newcrest Mining Limited* [2014] FCA 698, penalties totalling AU$1.2 million were agreed by the parties as appropriate and ratified by the Court due to Newcrest not knowingly or intentionally breaching its corporate obligations.

CONCLUSION

While the environment for directors over the last year have been relatively steady, there are a number of matters on the horizon which may lead to this status quo changing. This includes the increasing public focus on cyber and privacy security and the number of high profile incidents, the restructuring of key regulators and increased cooperation between regulators both domestically and internationally and also the Courts' apparent willingness to impose higher and higher penalties for breaches of director duties.

Directors and their insurers will be watching the global and Australian economies with interest. Any major shocks to those economies may have significant impacts on the risk landscape as well as the outcome of any regulatory reviews.

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JAMES BERG IN CONVERSATION WITH MICHAEL GILL

After 38 years as a partner of DLA Piper (previously DLA Phillips Fox and Phillips Fox), Michael Gill has been a consultant with us since 2008. His focus is now firmly set on pro bono and corporate responsibility initiatives. In 2014, Michael was awarded the Lifetime Achievement Award at the ANZIIF Insurance Awards. On the same night, DLA Piper received the Award for Insurance Law Firm of the Year.

Michael has made his mark in the legal profession, the community and perhaps mostly in the insurance industry. His career was as an insurance lawyer, but as the achievements set out below attest, his efforts are far reaching. Always a thought leader, Michael has constantly looked for ways to make both the legal profession and the insurance industry do things better, and be better.

Although his focus at the office is no longer on the provision of legal services to the insurance industry, Michael:

- Served 20 years as the Chair of the Code Compliance Committee for the General Insurance Industry Code of Practice, concluding his role in 2014. He was the inaugural Chair of this committee.
- Has also recently worked with the Reviewer of the General Insurance Industry Code of Practice re development of the new Code of Practice.
- Was appointed the inaugural Chair of the Code Compliance Committee for the National Insurance Brokers Code of Practice in 2014.
- Is Immediate Past-President of the International Insurance Law Association (AIDA) – Association Internationale de Droit des Assurances, having been President from 2010 – 2014.
- Has had the opportunity to use his insurance law expertise in pro bono projects dealing with microinsurance and in assisting NGOs such as the International Office of Migration and PILCH.

In 1980 he was elected President of the NSW Law Society. In 1985 he was elected president of the Law Council of Australia.

Michael was instrumental in setting up

- AILA: he was the inaugural President and a board member for 31 years
- LawCover
- Solicitors Mutual Indemnity Fund (he was the inaugural Chairman)
- New South Wales Motor Accidents Authority (he was the inaugural Chairman)

DLA Piper Partner James Berg recently caught up with Michael to talk to him about the future of the insurance industry.

James: First off Michael, I'd like to congratulate you on your ANZIIF Lifetime Achievement Award.

Michael: James, I appreciate that, thank you. As I tried to say on the night, the most important achievements in one's life invariably come about in the context of a group or a team or a family or a community. One may receive the accolades but such achievements are the result of generosity, expertise and hard work on the part of many people. In my case, I thank those for permitting my name to be used as the symbol of all of their names and their unique contributions.

James: A young professio nal looking at your ANZIIF award might wonder how they could possibly make a similar contribution and make difference in the insurance industry and the legal profession. Is it harder now? What is left to be done?

Michael: All I can say is that I was younger, it was said that there were only two certainties in life: death and taxes – I have come to the view that the only certainty in life (and perhaps in death) is change. No one and nothing remains the same. So opportunities never come to an end, they just change. The opportunities that were there for me 30 or 40 years ago were interesting and challenging. They represented significant change, but I am not sure that they were more challenging than what's before us at the moment.

Back then the insurance industry, like the legal profession, was under attack for not delivering fair and professional services to clients or policy holders. Some policy wordings were unfair as was some of the existing law. The legal profession was seen to be remote and not delivering service of the type which consumers needed or, increasingly, were expecting to receive. Much of it was very uncomfortable for those who had become used to practising in a particular way. Substantial reform was seen to be needed for both and in the period between 1975 and 1985 substantial reform was delivered for both. Much of it was very uncomfortable for people who had become used to practising in a particular way. For the legal profession, significant areas of legal practice were disappearing and the self-regulation monopoly of law societies was going.

For the insurance industry, the much needed reforms contained in the Insurance Contracts Act and the Insurance (Agents and Brokers) Act caused enormous change and challenge. As a side comment, I subsequently came to learn that in many ways Australia was leading the common law world (and perhaps beyond) with these reforms.

Over this period many legal and insurance practitioners felt that they were in the middle of a crisis. I recently learnt that the Chinese word for 'crisis' is made up of two characters. The first represents danger, and the second represents opportunity.

Danger can paralyse; opportunity can energise. So the challenge remains the same, whatever the era; see the opportunity and find the energy to do what needs to be done.

So, you ask, what is left to be done?

I think the opportunities are huge and exciting. We are truly globalising in every sense. We face the challenge of Australia's role in that context. And within that role, what are the opportunities for the insurance industry and the legal profession? How do we take our special gifts and talents to a world market? I know from my experience internationally that we are very good at what we do in law and in insurance. We have much to give. [*Editor's note: see Sophie Devitt's article on UK regulation on page 9*]

James: So what do you see as the single major issue facing the local insurance industry?

Michael: I think that the single biggest issue facing the local insurance industry is to align its product offerings with the expectations of its policy holders, the community, the regulators and politicians and remain financially sound and appropriately profitable. "Appropriately" is an interesting discussion, perhaps for another day.

Much of the business transacted by the insurance industry in Australia provides aid to ordinary Australians in their times of greatest need. One can suggest that insurance in Australia today is thus a significant part of the social contract or social support network. It is not just about the interpretation of individual wordings in response to floods or fires, or many other risks.

So the industry needs to close the gap between the technical language of its products and the reasonable expectations of its customers. A related challenge is how do we better align the objectives and needs of shareholders and policyholders.

James: What about global challenges?

Michael: From my years with AIDA, I have a good appreciation of how much the Australian industry can offer from its own experience in regulation, distribution, product design and dispute resolution. In particular, we can offer a

culture and experience where fairness (or if you like, utmost good faith), plays a real role. It must be more than a mere advertising offering designed to make people feel good.

A second major global issue may be the impact of risk of the evaporation of national boundaries, in the sense that they confine or restrict the spread of risk. Major risk issues such as contagion disease, financial collapse, climate and environmental issues and fanaticism do not recognise the existence of national boundaries. Domestic regulation and laws in the absence of a global context will be of limited use.

But how do we cooperate? How do we get over the fear factor, that is so often associated with other countries and their approach to the solution of such issues. The challenge is to solve them together. It's pretty clear that we can't solve them individually. The insurance industry can either play a role as part of the solution or simply see itself as somebody coming in at the end of the game, either as a victor or victim.

More broadly, the Australian industry can also organise itself to work more closely with the growing number of significant international agencies who are trying to find the means to bring appropriate insurance offerings to the most disadvantaged people across the globe.

James: You refer there to microinsurance I assume?

Michael: I certainly do. But also to legal education in developing countries.

Microinsurance may be the most important insurance development in 300 years. At present, it is struggling to find sustainable solutions for its key challenges.

For me at least, doing this work has produced a purpose for life and rewards personally more valuable and meaningful than the rewards of law firm partnership.

Microinsurance challenges us to find solutions for regulation, distribution, clear communication and dispute resolution which are much more cost effective, speedy and certain. The learnings from microinsurance could in the medium to long-term change the entire insurance industry.

It is not only microinsurance which has given me much satisfaction. I have become involved in legal education in developing countries such as Vietnam and Myanmar. It has shown me how well we can apply our experiences of life, our expertise, our talents and abilities in helping with projects and challenges and education which may not be immediately associated with what we practised professionally for most of our lives, but nevertheless, is valuable to our new fields of challenge.

Basic skills as basic as listening, interviewing, drafting, writing reports, presenting, advocating, counselling can all be applied across a broad range of activities. It may push us out of our comfort zone and you may doubt your ability to deal with the relevant subject matter, but if your mind is open, you can be taught how to teach and write lesson plans. I've experienced this myself, and seen it in others.

James: When Insurance Review last caught up with you in 2012, you were half way through your 4 year presidency of AIDA. Now that you are immediate past-president, what do you see as the major challenges in international insurance law that AIDA are likely to tackle in the future?

Michael: AIDA is working extremely well in sharing information about insurance issues that are cropping up in various countries, how they're being solved, or what stands in the way of solutions. This sharing of information and experience is absolutely critical to creating an environment which has better prospects of leading to the harmonisation of laws. *Please see Veronica Cress's article on the difference in New Zealand and New South Wales on an important insurance point please see page 35*

I know the Industry and the regulators are also doing this.

Key laws including insurance law and dispute resolution must be better harmonised in a world which is increasingly globalised and where so many of the major issues affect every nation and its people. Taking one example, AIDA's Climate Change Working Party is doing great and essential work on that important topic.

In the challenge of climate change, insurance does have an important role to play but it can only be successful within the context of broader political and national solutions.

AIDA can play its role in seeing that insurance law practitioners in each country are educated and well-equipped for the time when they can work together to find good insurance solutions.

I have referred to Microinsurance in the answers above and I won't repeat what I've said. I have come to appreciate at this stage in my life just how well we can apply our experiences of life, our expertise, our talents and abilities in helping with projects and challenges and education which may not be seen immediately as closely aligned with what we practised.

James: Over your career you have seen a vast increase in the regulation of corporate Australia. Has it all been good?

Michael: I think much of the world believes that we have done very well with our insurance legislation and regulation. Many envy us, and rightly so. I am referring here, of course, to the dispute resolution scheme for the insurance industry, presently operated by FOS, and established 25 years ago.

The comments that I am about to make are not restricted to the insurance industry, although that industry and its products have a particular relationship with the doctrine of the utmost good faith. It is also an industry which long ago identified that the resolution of most disputes arising under insurance contracts should not simply be according to strict black letter law.

Based on the experience I had of the insurance industry when I first came into practice, I wonder if the volume and detail of law, regulation, and compliance has not snuffed out the notion of "doing the right thing". Not just the insurance industry, but more broadly, directors, senior management and others seek assurance from lawyers that an action or decision is "legal". Having procured that advice, the relevant step is then taken.

I know there are times when senior management and boards pause to consider whether the legally permissible thing is the same as the right thing. But does it happen as often as it should? As a nation, have we become a little afraid of posing that question? Is that important balance between law and ethics where it should be in Australia? The challenge is that the volume of law in its various guises may be so difficult, time consuming and suffocating that many people have neither the heart nor the will-power for going beyond the legal assurance to seek the right decision.

It is important to remember that the biggest insurance collapse in Australia's history, HIH, was not due to a lack of regulatory oversight, but individuals doing the wrong thing.

When I was a "baby lawyer", insurance claims were often paid, although the legal advice was that the claim need not be paid, either because it was not covered, or a smaller amount should be paid. Decisions were based on perceived fairness, longstanding relationship, and customer needs. In my experience it was often the case that an insurer would step back from the circumstances and pose a fresh question "but what did we intend to cover by this policy? – what did the client think he was buying?"

So while our regulatory environment may be the envy of the world, in my view, a new type of challenge for the future. For the insurance industry, to some extent, this can be linked back to the question of whether insurance forms part of the social contract of a fair nation, or is it just a disconnected set of commercial contracts.

James: Thanks for your time Michael, I'm sure our readers will appreciate your stories and insights. All the best for your trip to Myanmar next year.

Shortly before printing this publication, I heard from Michael who was in Myanmar after having observed on behalf of BABSEACLE the first community legal education program ever conducted in Myanmar. Ten students from the law department at the University of Mandalay visited a nearby workers village in which inhabitants typically worked on building sites within the Universities or as cleaners. The presentation lasted 90 minutes and focussed on the rights of workers who make claims for injury or illness under the workers compensation legislation of Myanmar.

The four role plays featured being drunk on the job, digging a trench despite a warning notice and being electrified, failing to wear protective headgear, and finally an industrial disease brought on by the use of chemicals.

Not only another amazing chapter in Michael's career, but a simple example of the insurance and legal market operating in a location of real poverty to protect the interests of those who need it most. The insurance industry has the potential to play a significant role in the development of under-developed nations as it aligns its products to growth areas, forging the way for opportunities to be realised and at the same time ensuring fairness amongst the communities.

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CLAIMS AGAINST LAWYERS

This year witnessed a number of decisions in the defence of professional negligence proceedings involving solicitors, particularly with respect to the application of the doctrine of advocates' immunity and the application of the proportionate liability legislation.

ADVOCATES' IMMUNITY

On 13 June 2014, Davies J of the New South Wales Supreme Court summarily dismissed a claim applying advocates' immunity in *Stillman v Rushbourne* [2014] NSWSC 730.

Stillman, the plaintiff, was a director of and the beneficial owner of shares in Goldfields Crushing and Screening Pty Ltd (GCS). In 2006, Stillman was named as a defendant in Supreme Court proceedings brought by Coast to Country Crushing and Screening Pty Ltd (CCCS). Stillman retained the defendant firm of solicitors, Rushbourne, to act in respect of those proceedings. The matter settled at mediation in 2007 based on advice provided by Rushbourne.

The plaintiff subsequently instituted proceedings against the defendants on the basis of negligent advice given at the mediation which he alleged caused him to settle the proceedings to his detriment. The defendants applied for the proceedings to be dismissed on the basis of advocates' immunity. In allowing the application and dismissing the claim, His Honour confirmed it is clear that advice in advance of a hearing falls within the immunity as it "affects the conduct of the case in court" as the settlement resulted in final judgement.

The plaintiff contended circumstances of coercion fell outside the immunity. In his determination, Davies J held that the authorities cited by the plaintiff did not support the conclusion that the conduct fell outside the scope of the immunity. In fact, the weight of authority was against the plaintiff. The plaintiff argued it was inappropriate to determine the issue of advocacy on a strike-out application. His Honour found the evidence and the state of the pleadings were such that it was appropriate to make the order sought. The claim was struck out.

Similar issues were before the New South Wales Court of Appeal in *Jackson Lalic Lawyers Pty Limited v Attwells* [2014] NSWCA 335 handed down on 1 October 2014. The primary judge had declined to answer the question of whether advocates' immunity precluded the success of the respondents' negligence claim against the applicant. The respondents were guarantors for a loan. The debtor defaulted and proceedings were brought to enforce the guarantee. The guarantee proceedings were settled by consent order, in which Jackson Lalic Lawyers, the applicant, represented the first respondent. The consent order held the guarantors liable for the full amount of the debt. The respondent commenced proceedings against the applicant for negligently advising them to agree to the consent order. The applicant admitted to providing advice in respect of the consent order but denied negligence. The applicant pleaded advocates' immunity.

The primary judge expressed concern in deciding the separate question regarding the application of advocates' immunity on a summary basis without a proper inquiry and finding on the issue of negligence. The Court of Appeal considered the primary judge failed to consider that the operation of advocates' immunity does not depend on the degree of negligence involved. The public interest in the finality of litigation has been held to outweigh the consequences to the aggrieved litigant of letting a wrong go without a remedy. The Court of Appeal held that the applicant was immune from suit and this was a complete answer to the claim brought against the applicant which was summarily dismissed.

PROPORTIONATE LIABILITY

The New South Wales bench was also responsible for some noteworthy proportionate liability decisions in 2014. The first of these was *Polon v Dorian* [2014]

NSWSC 571 handed down on 13 May 2014. The plaintiff, Hazel Polon, brought an action in the Supreme Court of New South Wales in relation to her investment in a bridging finance scheme between September 2005 and March 2006. The plaintiff's action was brought against the first defendant, Mr Dorian, who introduced the plaintiff to the scheme and its operators. The other defendants were the lawyer who represented the scheme and the firm she worked for. Mr Dorian was declared bankrupt and took no part in the proceedings. Similarly, the companies operating the scheme and their principals were not part of the proceedings. Both principals were declared bankrupt and the companies were in liquidation.

The second defendant was the lawyer who had represented the scheme at certain meetings and had made representations to investors including the plaintiff. The Court considered the second defendant's statements and actions could not be construed as her acting simply as a conduit passing on information. She herself accepted that she was giving legal advice.

The Court found the claim to be apportionable pursuant to Part 4 of the *Civil Liability Act 2002* (NSW) (CLA) and apportioned the damages between the concurrent wrongdoers – 60 percent to the Scheme's proponents and entities, 30 percent to the second defendant and 10 percent to Mr Dorian. The second defendant's contribution was based on her substantial role in promoting the scheme, which is a far broader role than merely drafting transaction documents. The presence of the second defendant as a lawyer at the scheme meetings gave the scheme credibility that would not have been achieved without the second defendant.

The issue of proportionate liability in this context was addressed again by the Court in *Bakovski v Lenehan* [2014] NSWSC 671. Mr and Mrs Bakovski, the plaintiffs, were approached by an acquaintance, Mr Mitrevski, who indicated a desire to purchase two of their properties. In order to acquire the funds to purchase the properties, Mr Mitrevski needed to complete the construction and sale of a prior property development project. Mr Mitrevski requested financial help to complete the development project. The plaintiffs agreed. Mr Mitrevski took them to Lenehan & Co, the first defendant, to execute various documentation. The plaintiffs met with Mr Arkoudis, the second defendant, with whom they had had no prior dealings. The plaintiffs believed they were acting as guarantors to Mr Mitrevski's loan plan. Unbeknownst to them, Mr and Mrs Bakovski entered into a two-month loan with Accom Finance Pty Ltd. The terms dictated compound interest of 60 percent per annum and penalty interest of 96 percent.

The plaintiffs alleged that Mr Arkoudis failed to advise them as to the risk and consequences of the transactional documents for the Accom loan. Both parties presented different versions of events. The plaintiffs claimed that Mr Arkoudis provided no advice in relation to the documents and were merely told to sign. Mr Arkoudis contended that he provided strong advice, urging the couple not to enter into the transaction.

The Court concluded that the plaintiffs did not understand that there was a proposal for them to borrow loan funds from Accom at the time of attending on Mr Arkoudis. Mr Arkoudis did not advise the plaintiffs of the risks associated with the Accom transaction, nor did he advise them against entering into it, or that they should seek independent financial advice and seek to renegotiate the conditions of the loan.

The defendants failed to establish contributory negligence. The plaintiffs were unsophisticated and required clear and strong advice. The plaintiffs' claim was found to be an apportionable claim under Part 4 of the CLA. There was sufficient evidence that Mr Mitrevski was a concurrent wrongdoer having made material misrepresentations to the plaintiffs which induced them to agree to assist him obtain short-term finance from Accom. Mr Arkoudis' breach of duty represented a gross departure from the duty of care required by a solicitor retained to give independent advice. The breach was a primary cause of the plaintiffs' loss and represented a serious departure from the standard of reasonable care, skill and diligence required. The proportionate liability of the concurrent wrongdoer, Mr Mitrevski was attributed 60 percent. The first and second defendants were attributed 40 percent.

In summary, the continued acceptance of the doctrine of advocates' immunity and a growing number of decisions involving proportionate liability in 2014 are useful tools for those who practice in the area of professional indemnity in defence of claims brought against solicitors.

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BROKER CLAIMS

In 2014 we have observed a reduction in the number of claims being made against insurance brokers reflecting major loss events (such as the Brisbane floods) and a return to a more steady flow of negligence actions concerning failure to arrange specified insurances and failure to advice on insurance needs or terms of cover.

Set out below are three cases in which judgment was delivered during 2014 that provide guidance on the steps a court considers insurance brokers must undertake to discharge their duty of care.

ADVICE AND EXPLANATION IN A BUSINESS INTERRUPTION CONTEXT

In *Eurokey Recycling Ltd v Giles Insurance Brokers* [2014] EWHC 2989 the UK Queen's Bench division confirmed an insurance broker is not responsible for setting sums insured under business interruption insurance. Whilst it is not legally binding, it is broadly consistent with Australian authorities. The case involved allegations of negligence and breach of contract by a grossly underinsured client. In finding for the insurance broker, the Court observed:

- a broker's obligation is to provide sufficient explanation about the policy terms to enable its client to provide instructions about appropriate sums insured;
- this obligation necessarily requires an insurance broker to explain the method of calculating the sum insured under the policy; and
- to provide a proper explanation, the insurance broker must explain key terms used in the policy (e.g. estimated gross profits) and understand the nature of the client's business and its insurance needs.

Importantly, the Court confirmed a broker's obligation does not extend to verifying information provided by a client unless there is reason to believe it is not accurate. Whilst not ultimately relevant to the outcome, the Court assessed contributory negligence at 50 percent.

NO NEWS DOES NOT ALWAYS MEAN GOOD NEWS – BROKER'S ROLE IN CONTINUING DUTY OF DISCLOSURE

In *Swansson v Harrison & Ors* [2014] VSC 118 an insurance broker was found to have breached his duty by failing to specifically enquire of any change in the Insured's circumstances after a proposal for a new policy was completed and before:

- the proposed policy incepted; and/or
- an existing policy was cancelled/lapsed.

It is important to note this decision turned on the particular circumstances in play as set out below. The decision does not represent a blanket rule that all brokers should call

Insureds to confirm there are no change in circumstances after a proposal is completed and before cover is bound but does make plain it is essential in certain circumstances.

Background

The insured held a policy with AXA from 2004 to March 2012 providing cover for death or terminal illness but sought advice from the broker when he received a renewal notice indicating a substantial premium increase.

At a meeting on 7 March 2012 the broker presented a statement of advice containing a recommendation to 'switch' cover from AXA to AIA. The Insured reported an attendance upon a GP two days prior to the meeting for a sore stomach. The Court accepted during this meeting the broker provided an explanation to the insured about the duty of disclosure and specifically advised it was an ongoing duty until the proposal put to AIA had been accepted, however there was competing evidence on this point. The Court did not accept that the broker failed to advise of the significant risk in changing cover was that AIA was able to avoid the policy within the first three years for non-disclosure.

After the 7 March meeting and before AIA accepted the proposal an issued a new policy on 23 March:

- The Insured attended upon his GP once more concerning stomach pain, was referred for ultrasound and further diagnostic scans, attended upon a gastroenterologist and was diagnosed with pancreatitis
- The Insured spoke with representatives of the broker's office on two occasions and did not mention any of the abovementioned developments

On 2 May, after the AIA policy had incepted and the AXA policy had been cancelled a diagnosis of pancreatic cancer was made and surgery and chemotherapy followed. In 2013 a claim upon the AIA policy was made but declined due to non-disclosure including the failure to advise of the ongoing symptoms, consultations and investigations before the AIA policy commenced. A claim upon the AXA policy also was made but declined on the basis it had been cancelled on 28 March 2012.

Reasons

A number of grounds of negligence were pursued, three of which fell on the Court's determination of facts and which ultimately did not succeed. The Court was left with the question of whether the broker had been negligent in failing to take reasonable steps to ascertain whether any material events had occurred before commencement of the new policy or sending a cancellation notice to AXA.

The broker's position was that it was not reasonable to require the broker, a skilled insurance adviser, to enquire of the Insured three weeks after the 7 March meeting and having heard nothing from him since.

However, the Court held a reasonably prudent broker would have enquired of the Insured to properly discharge his duty in circumstances where:

- the broker knew the special value of the AXA policy, in that it could not be avoided for innocent non-disclosure
- the broker was aware the client had been to a doctor only two days before the meeting
- the broker conveyed his own wife's experience of the condition taking some time to clear
- the broker was aware three weeks had elapsed since the meeting and as such the last information about the Insured's stomach complaint was out of date
- it was a relatively easy thing to make any enquiry of the Insured about his medical status

Additionally, the Court was satisfied the client had contributed to his loss by carelessly failing to inform the broker's office of developments in his medical condition in particular noting he had at least two occasions to do so. A prudent Insured would inform his or her broker even if only to check it did not matter.

Whilst the broker was liable, the damages awarded were reduced by 50 percent to reflect the Insured's contributory negligence.

NO DUTY OWED BY BROKER TO THIRD PARTY, EVEN IF CLOSELY CONNECTED TO CLIENT

In *Hamcor Pty Ltd & Anor v State of Qld & Ors* [2014] QSC 224 the Court found an insurance broker's duty did not extend to undertaking broad enquiries and advising on the adequacy of existing cover placed by another insurance broker for a third party with close connections to the broker's client.

The plaintiffs in the matter were Hamcor Pty Ltd and Mr Armstrong, the owners of land and a factory from which a chemical manufacturing business was operated by an entity called Binary Industries. Mr Armstrong was the managing director of Binary Industries. A fire occurred at the factory and the Fire and Rescue Service doused it with water. The water was contaminated by chemicals and escaped into surrounding properties and creeks. The plaintiffs, as landowners, incurred legal costs in connection with an Environmental Protection Agency (EPA) prosecution and contamination remediation costs exceeding AU$10 million.

The broker was specifically engaged by Binary Industries to arrange AU$10 million in public liability insurance cover because the plaintiff's usual broker was unable to do so. The usual broker continued to arrange other policies addressing the plaintiff's general insurance needs. The Court was satisfied, having regard to the specific instruction mentioned above, a duty was owed by the broker to Binary Industries and in that context the retainer was properly discharged as the cover required was arranged by the broker.

However, the plaintiffs contended a much broader duty of care was owed.

First, it was contended the broker ought to have named the plaintiffs as Insureds on Binary Industries' public liability policy, because the broker knew or ought to have known the plaintiffs were the owners of the land and were exposed to EPA prosecution and remediation costs.

Second, it was contended the broker ought to have obtained an Industrial Special Risks (ISR) policy for the plaintiffs. It was said information passed to the broker placed it on notice of the need for further investigation, that in turn would have revealed the insurance placed by the usual broker was inadequate.

These contentions failed for several reasons. First, the broker had no reason to think cover placed by the usual broker for the plaintiffs was inadequate. Second, the Court was not satisfied the plaintiffs would have followed the broker's advice, even if the broker did all the plaintiffs allege he ought to have done. Third, no insurer would have provided the ISR policy it was contended ought to have been recommended by the broker whilst existing property cover remained in force. Fourth, even if an insurer offered the ISR policy contended, it would not have covered what the plaintiffs ultimately claimed.

This decision serves to reinforce existing authority concerning duties owed to third parties to a contract (in this case, for the provision of broking services).

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SOLICITORS' DUTIES TO THIRD PARTIES – RECENT DEVELOPMENTS

In most circumstances, a solicitor's duty is owed solely to his or her client subject to the rules and standards of the profession.

That is because the solicitor's duty is to advance the interests of the client in the transaction in which the solicitor is retained. The duty should not be tempered by the existence of a duty to any third person whose interests are not coincident with the interests of the client.

However, there are circumstances where a Court will be prepared to find that a solicitor owes a duty of care to a third party or non-client.

The decisions of *Fischer v Howe* [2014] NSWCA and *Polan v Dorian* [2014] NSWSC 571 were both delivered in 2014 and provide a good analysis of some circumstances where a duty to a third party or non-client can be found. Each of those cases are discussed briefly below.

FISCHER V HOWE [2014] NSWCA – DUTY TO A BENEFICIARY OF A WILL

It is now well established that solicitors can be liable to intended beneficiaries of their client, where the client is a testator and the intended beneficiaries are not clients. The high court has emphasised the coincidence of the interest between the client and the beneficiary in finding the existence of the duty.

In *Fischer v Howe* [2014] NSWCA the New South Wales Court of Appeal considered the scope of the duty which the solicitor acting for the testator of a will owed to the beneficiaries of that will. The facts of the case were very briefly as follows:

- The solicitor, attended Ms Fischer, a 94 year old lady to prepare a new will which increased dispositions to Ms Fischer's son and daughter at the expense of one of her other children.
- It was agreed between the solicitor and Ms Fischer that that the solicitor would return in a few weeks with a draft will for Ms Fischer to review, however Ms Fischer died unexpectedly in the meantime.
- Two of Ms Fischer's children made a claim against the solicitor for breach of duty of care owed to them as disappointed beneficiaries under the proposed new will.

A major consideration in the case was whether there was a significant risk that Ms Fischer could lose capacity before the will was to be signed.

The Court at first instance, found that the solicitor's retainer was to give effect to Ms Fischer's testamentary intentions and not merely to prepare a formal will and arrange for its subsequent execution. The result was that due the performance of the retainer entailed procuring immediate execution of an informal will.

However, the Court of Appeal found that the solicitor's retainer was simply to fulfil Ms Fischer's objective of making a formal will according to the agreed time frame and also to avoid any reasonably foreseeable frustration of that objective. Ms Fischer's death was not reasonably foreseeable and there was no duty to execute an informal will.

Overall, the decision confirmed the position that a solicitor's duty to a disappointed beneficiary under a will is defined by the terms of the retainer and the instructions of his or her client to whom the primary duty is owed.

Any breach of the retainer by failing to take reasonable care to perform and fulfil the retainer would also be a breach of duty to the beneficiary.

POLAN V DORIAN [2014] NSWSC 571

In *Polan v Dorian* [2014] NSWSC 571 Hall J of the Supreme Court of New South Wales was prepared to find among other matters that a duty of care to a third party arose. Negligent misstatement by the solicitor had (among other matters) been alleged.

The facts of the case were very briefly as follows:

- Ms Polan claimed damages against the solicitor for losses she suffered after investing money in a scheme styled as a bridging finance scheme (operated by Skyder Investments Pty Limited). The scheme involved the provision of money by investors to Skyder, who would then use the funds to operate a short term bridging finance business.
- The solicitor had been engaged by Skyder to facilitate loan agreements and to assist in the administration of the scheme.
- During a number of public meetings with potential investors (attended by Ms Polan), the solicitor made various representations about the security and management of the scheme and its benefits and safeguards. In doing so, the solicitor relied on information she had received from Skyder and did not make her own investigations of the scheme.
- Ms Polon invested funds in the scheme on three occasions.
- The solicitor prepared loan agreements on behalf of Ms Polon and corresponded with Ms Polon for the purposes of providing information to complete the loan contract.
- Prior to Ms Polan's last investment, the solicitor became aware of irregularities in the management of the scheme (most relevantly the defects in the security) and failed to alert Ms Polan. Ms Polan alleged that the solicitor breached her duty of care by advising her to invest in the scheme (and failing to advise her when she identified irregularities in the scheme).

As to the existence of a duty of care, Hall J said:

> "The question of the whether Ms Fowler (the solicitor) owed a duty of care is to be answered by considering whether a solicitor addressing a meeting of potential investors upon the soundness of investing in a particular financial product would realise that he or she is being or is likely to be trusted by those who are the recipients of that particular information and advice given by the solicitor, believing that the solicitor is in a position to give same. If so, the statements by the solicitor may give rise to a relationship between the solicitor and the recipient(s) requiring the solicitor to give reasonable care in giving the information or advice."

In finding the existence of a duty and breach, Hall J took into consideration that the solicitor had made known to the investors at the public meeting that she was a solicitor familiar with the scheme; that the solicitor did not disclose that she had not verified the existence and operations of the scheme's safeguards (her statements were not qualified) and that she did not inform or warn those present at the meeting that they should rely on their own enquiries with the assistance of a solicitor.

It was also relevant that Ms Polan (as an attendee at the public meetings) was in an unequal position being unaware that the solicitor's statements were solely based on the assertions of her client (Skyder).

Importantly, Hall J said:

> "I am of the opinion that it remained Ms Fowler's (the solicitor's) continuing duty to take reasonable steps to provide to those to whom she made the representations appropriate cautions and warnings that made clear that the statements she had made on or about 19 September 2005 and thereafter as to the security of the Scheme had not been verified by her and were based on the say so of Messrs Tombleson and Hraiki (the principals of Skyder) and the representees should undertake their own enquiries."

The relationship of solicitor and client which existed with Skyder did not prevent the solicitor from issuing a subsequent warning to investors.

Overall, this case, while unique in its facts, clearly demonstrates that there will be circumstances where a solicitor may be found to owe a duty to third parties or non-clients. It is not sufficient to simply assert that the solicitor was acting in the interests of his or her own client in a transaction.

For further discussion on this case from the perspective of proportionate liability, see Emma Cameron's article on page 22.

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MEDICAL INDEMNITY – CLAIM TRENDS

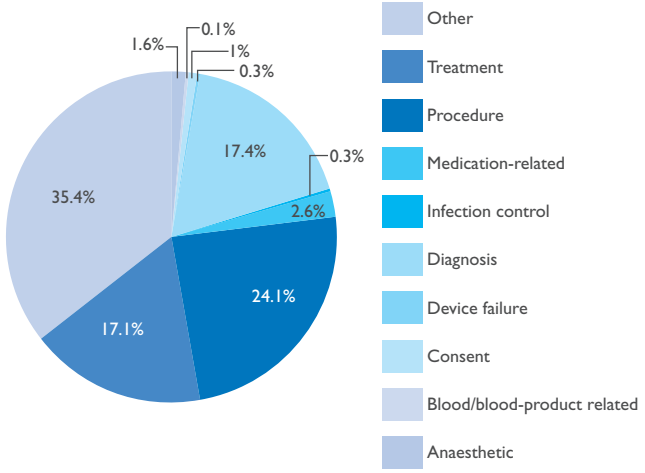
In July 2014, the Australian Institute of Health and Welfare released the latest in its series of reports on medical indemnity claims in the public and private sectors. The report examined claims made, current or finalised in the 2012-13 period.

Compared to the previous reporting period, there was only a minimal reduction in the number of new claims (from 4525 to 4225), despite continuing focus on risk management, continuing education and technological improvements.

Errors in procedures represented the highest proportion of claims (24 percent), followed by errors in diagnosis (17 percent) and errors in treatment (17 percent). In general practice, medication-related errors surprisingly represented the highest proportion of claims (47 percent), followed by errors in diagnosis (38 percent). Presumably at least in part due to ongoing education and training by medical defence organisations, consent to treatment claims have continued to decrease and made up only one percent of all claims during the reporting period. Infection control represented only 0.3 percent of claims, although it will be interesting to see whether this statistic alters in subsequent reporting periods following the media emphasis on hospital-borne illnesses during 2014.

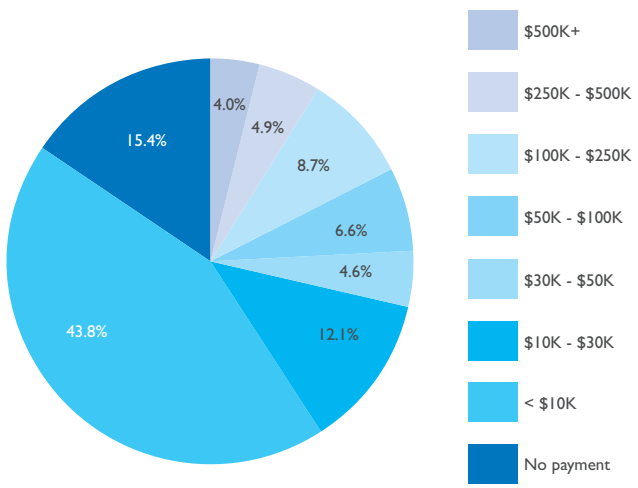
General medical practice generated nearly three times more claims during the reporting period than any other area of practice (23 percent), followed by general surgery (eight percent) and orthopedic surgery (seven percent). While emergency medicine practitioners were involved in a higher percentage of claims that during the previous reporting period, it was the fifth highest (nearly five percent) after obstetrics and gynecology (nearly six percent).

Claims by category (percent)



The data also revealed a reduction in the number of large claims, with only four percent of claims settling for over AU$500,000 compared to 5.3 percent in the previous reporting period. Nearly 44 percent of claims settled for less than AU$10,000 while 15.4 percent of claims settled for no payment, meaning that close to 60 percent of all claims settled for under AU$10,000.

Claims by settlement size (percent)



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MEDICAL NEGLIGENCE RECENT CASES

It was a busy year for the country's superior courts. Two decisions of the High Court of Australia stood as book ends against a number of decisions from various state courts of appeal, all of which saw the dismissal of claims for damages against health care providers.

PAUL V COOKE [2014] HCATRANS 25

The year opened with the High Court dismissing an application for special leave to appeal against the NSW Court of Appeal's decision in *Paul v Cooke* [2013] NSWCA 311. The Court of Appeal had held that the scope of a negligent defendant's liability does **not** extend beyond the occurrence of a particular risk that cannot be avoided with the exercise of reasonable care and skill. Readers of our *Insurance Flashlight* will recall that, in 2003, Ms Paul had had a scan to determine whether she had an intracranial aneurysm. Dr Cooke, a radiologist, failed to diagnose the aneurysm and thereby breached his duty of care to her. The aneurysm was eventually diagnosed in 2006. Ms Paul underwent surgery to remove it. Unfortunately, the aneurysm ruptured during the surgery (without any lack of skill or care on the part of the surgeons). Ms Paul suffered significant injuries, which she claimed were caused by Dr Cooke's negligent failure to diagnose the aneurysm in 2003.

In rejecting the application for special leave, the High Court upheld the Court of Appeal's decision that, even though it was highly likely that Ms Paul would have suffered no harm had the surgery been performed in 2003 (because there was a one percent chance of the aneurysm rupturing during surgery), Dr Cooke's negligence did not cause the injuries Ms Paul suffered in 2006. This was because the delayed diagnosis did not increase the risks associated with surgery (the aneurysm did not change in size, shape or propensity to rupture during those the years).

ODISHO V BONAZZI [2014] VSCA 11

In *Odisho v Bonazzi*, the Victorian Court of Appeal considered the extent of the duty of medical practitioners to warn patients of rare risks when providing treatment. Dr Bonazzi prescribed a course of tranexamic acid to Ms Odisho to treat menorrhagia. Ms Odisho developed a pulmonary embolus. She subsequently sued Dr Bonazzi, claiming Dr Bonazzi had negligently failing to warn her of (albeit remote) risk that the tranexamic acid could cause her to suffer a thromboembolic event.

Thromboembolism is a rare side effect of tranexamic acid and Ms Odisho was not able to prove that the tranexamic acid treatment had caused her pulmonary emobli. The Court of Appeal held that it was no more than possible that the tranexamic acid had played some part in the subsequent pulmonary emboli and that, at best, the question which invited speculation. While it was consequently not strictly necessary for the Court to consider whether a warning would have made any difference to Ms Odisho's decision, the Court considered this issue. The Court noted that the prescription of tranexamic acid was the least invasive treatment available to Ms Odisho and that she probably would have undergone the tranexamic acid treatment even if she had been warned of the risk of pulmonary embolism.

The case is a useful example of the combined objective and subjective aspects involved in assessing the merits of a failure to warn case. It also illustrates the difficulty plaintiffs face when arguing that, had they been warned of a remote risk,

they would not have proceeded with treatment. Despite this obstacle in failure to warn cases, medical practitioners must continue to have regard to a patient's particular circumstances. If a medical practitioner forms the view that a patient will attach significance to a risk, even if that risk is remote, the practitioner must provide the patient with the relevant information prior to commencing treatment.

LANE V NORTHERN NSW LOCAL HEALTH DISTRICT (NO 3) [2014] NSWCA 233

In July, the New South Wales Court of Appeal's decision in *Lane v Northern NSW Local Health District (No 3)* [2014] NSWCA 233 highlighted the legal risks associated with managing the competing wishes of family members where a patient is no longer capable of making his or her own decisions.

Mrs Lane had a seizure at her home and suffered a brain injury due to a lack of oxygen. Her husband was her legal guardian. After receiving advice from Mrs Lane's doctors, Mr Lane accepted that Mrs Lane's death was unfortunately inevitable and decided that steps should not be taken to prolong her life beyond its natural course. After Mrs Lane died, her daughters (who had disagreed with Mr Lane's decision) sued the body corporate responsible for the hospital's operation for damages for psychiatric injuries. They argued that Mr Lane's consent to Mrs Lane receiving only palliative care was not fully informed because the hospital had not told him about other treatment options. They said that the hospital's treatment of Mrs Lane had been negligent and that they had a valid claim for damages for psychiatric injuries caused by witnessing her treatment and her ultimate death.

While the daughters' claim was not successful on the evidence that was lead at trial, the case highlights the legal risks associated with informed consent in a palliative care context. The Australian Institute of Health and Welfare's latest report on medical indemnity claims indicates that claims relating to consent to treatment are decreasing. However, the potential for multiple psychiatric injury claims arising from a decision to provide only palliative care to a patient remains. This emphasises the importance of ongoing training and guidance for health practitioners when communicating with decision-makers in these difficult, emotional and distressing circumstances.

HUNTER AND NEW ENGLAND LOCAL HEALTH DISTRICT V MCKENNA [2014] HCA 44

The year concluded with the High Court's decision in *Hunter and New England Local Health District v McKenna*, where the court held that hospital and medical staff who discharge mentally ill patients do not owe a duty of care to protect other people from harm caused by the patient after discharge.

The case concerned the discharge of a mental health patient into the custody of his friend, Stephen Rose, to enable them to travel by car to Victoria where the patient's mother lived. Prior to this, Mr Rose had arranged for the patient to be taken by ambulance to a hospital where, following a medical assessment, the patient was compulsorily detained at the hospital under the *Mental Health Act 2007 (NSW)* (Act). After a subsequent assessment by a psychiatrist, the patient was discharged the following day into Mr Rose's custody. During the journey to Victoria, the patient killed Mr Rose. The patient later committed suicide.

Mr Rose's mother and sisters claimed damages for psychiatry injury resulting from nervous shock caused by the alleged negligence of the hospital. They claimed the hospital owed them and Mr Rose a common law duty of care, which it breached by discharging the patient from the hospital into Mr Rose's custody.

In deciding whether the hospital owed a duty of care owed to the relatives, the High Court was required to decide whether such a duty would be consistent with the provisions of the Act. The Act required that any restriction on the liberty of mentally ill patients were to be kept to the minimum necessary in the circumstances. The Court held that a specific provision in the Act had the effect of prohibiting detention of a person unless the medical superintendent was of the view that no other less restrictive care was appropriate and reasonably available.

Against the background of the hospital having a statutory obligation **not** to detain unless no less restrictive care was appropriate and reasonably available, the High Court held that the hospital did not owe a duty of care to those who might be harmed by the patient if released. This was because such a duty was inconsistent with the hospital's statutory obligations to the patient.

Mental health care is an area of considerable pressure for many health care providers, who do their best to provide services in an increasingly high demand area despite the finite resources available to them. The High Court's decision provided much needed certainty to mental health professionals who discharge patients into the community in accordance with the Mental Health Acts in the various states and territories.

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POLICY INTERPRETATION

From construction contracts to oil spills in the Antarctic, it was a varied and interesting year (or so) for policy interpretation, and we have included some of the highlights below. We have previously reported on these and numerous other judgments on our www.insuranceflashlight.com blog, and we encourage you to spend some time exploring our blog – if you haven't already!

WHAT DOES "PROFESSIONAL SERVICES" MEAN?

Mr Robinson was an officer of Reed Constructions Australia Pty Limited (Reed) which was engaged by 470 St Kilda Road Pty Limited (470 St Kilda). The contract in question provided that Reed was required to claim progress payments for work performed, and may also be required to provide evidence in support of any such claims.

Mr Robinson made a statutory declaration in support of a progress claim. 470 St Kilda commenced proceedings against Mr Robinson, alleging he did not have a reasonable basis for making the statutory declaration. Mr Robinson sought indemnity from his D&O insurer, yet indemnity was denied on the basis the preparation of the statutory declaration was part of the function of project management, which was a professional service that attracted the professional services exclusion in the policy. Mr Robinson cross-claimed against the insurer seeking indemnity.

The Court found against the insurer and observed that whether something involved professional services will depend upon the commercial context in which the policy is made, and its purpose. In this case, the Court found there was no requirement that the statutory declaration be undertaken by a professional person. It was essentially a routine administrative task undertaken by an officer necessary for the conduct of the business. To have applied the exclusion clause in the manner contended by the insurer would have resulted in an interpretation of the policy that would severely circumscribe cover.

See *470 St Kilda Road v Robinson* [2013] FCA 1420.

WHAT IS DAMAGE TO "PROPERTY"?

The Commonwealth of Australia (Commonwealth), through its self-managed fund Comcover, was noted as the insured on an Ultimate Net Loss Insurance Policy (UNL Policy) issued by the insurer. Comcover insured the Australian Antarctic Division (AAD).

An oil spill occurred at Casey Base Station in Antarctica contaminating approximately 2000 tonnes of soil, and Comcover indemnified AAD for the remediation works. Comcover's claim under the UNL Policy however was denied as the insurer submitted that Casey was not the AAD's real or personal property within the relevant definition of the term "property" in the UNL Policy.

By a 2:1 majority, the Court concluded the insurer was not liable to indemnify Comcover and limited the scope of cover to real property in the form of buildings or structures capable of replacement and personal property – not land. Reliance was placed on the extent of cover, which was limited to paying "the actual replacement value of the property lost, destroyed or damaged", which suggested that real property in the form of land was not intended to be covered.

See *Commonwealth of Australia v Vero Insurance Limited* [2013] FCAFC 152.

WHAT IS A "CLAIM"?

LM Investment Management Ltd (LM) was the insured under certain policies of professional indemnity insurance. It lent money to Bellpac Pty Ltd (Bellpac). The loan was guaranteed by Mr Wong. Bellpac later went into liquidation. LM commenced proceedings seeking to enforce the guarantee against Mr Wong. Before the insurance policies incepted, Mr Wong filed his Commercial List Response, which pleaded that LM had breached its duties to Bellpac.

The Federal Court was called upon to consider whether the allegations in the Commercial List Response constituted a "Claim" under the professional indemnity insurance policies. If that was the case, as the insurers contended, then the "Claim" was not first made during the period of insurance and the policies would not respond.

The definition of "Claim" within the policies included, relevantly, "any suit, civil or third party proceedings, counter-claim or arbitration proceeding brought against You alleging a Wrongful Act." The focus was therefore on whether the Commercial List Response met that definition.

In the end, the Court found that the Commercial List Response was not a "Claim", including because it did not make a claim for "Loss" as defined in the policies (including damages or compensation). An allegation of a set off was insufficient.

See *Amlin Corporate Member Ltd v Austcorp Project No 20 Pty Limited* [2014] FCAFC 78.

WHAT IS "IN CONNECTION WITH THE BUSINESS"?

Port Phillip City Council (Council) retained Kane Constructions Pty Ltd (Kane) to carry out works in its Town Hall. The insurer issued a construction works policy in favour of Kane, which, in the usual way, also provided cover for principals.

Council later varied the construction contract by deleting an area known as the gallery from the scope of the works. Subsequently, an employee of another contractor working in the gallery was injured after he tripped over a "step-over" in a doorway that had been cut out of a temporary hoarding. Kane had erected the hoarding and cut out the temporary door.

The injured worker succeeded in proceedings for personal injury, and Council and Kane were ordered to pay damages. The insurer refused to indemnify Council on the basis the area in which the incident occurred had been returned to Council prior to the date of the incident. Despite this "handover", Council argued that the incident clearly had a "connection" with the construction works, thus triggering the policy. The issue to be considered was therefore whether the injury arose "*in connection with*" the construction contract.

The Court of Appeal took a commercial approach and paid close attention to the rules which govern the construction of insurance contracts, before determining that Council's liability arose in connection with Kane's business and activities and the construction contract, and for that reason Council was entitled to indemnity under the policy. The fact that Kane had followed a later direction from a representative of the Council to cease work in the gallery did not alter the situation.

The Court did note however that the result may have been different if work in the gallery had never been a part of the scope of works under the construction contract.

See *Lumley General Insurance Ltd v Port Phillip City Council* [2013] VSCA 367.

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SECTION 54

WHAT DOES SECTION 54 AND *MAXWELL V HIGHWAY HAULIERS* MEAN FOR THE INDUSTRY?

Readers of this publication are no doubt well aware of the judgment of *Maxwell v Highway Hauliers Pty Ltd* [2014] HCA 33, which considered whether an insured was entitled to the remedial benefit of section 54 of the *Insurance Contracts Act 1984* (Cth) to obtain indemnity under its heavy vehicle insurance policy.

In this article, we focus not just on the decision of the High Court (which has already been considered on the www.insuranceflashlight.com blog), but on the impact the decision is likely to have on the way insurance policies are written, and the way claims are handled.

BRIEF RECAP ON THE FACTS AND FINDINGS OF THE HIGH COURT

The insured sought indemnity for damage sustained to its trucks in two separate accidents. The insurer refused indemnity on the basis that the drivers of the trucks at the time of the accidents had not achieved a minimum score on a driver test known as the People and Quality Solutions (PaQS) test (such circumstances being excluded under the policy by virtue of an endorsement).

However, the Court found that the relevant "act", for the purposes of section 54, was the insured allowing the operation of the trucks with drivers who had not attained the minimum PaQS score, which could be remedied by the operation of section 54(1). In circumstances where the insurer conceded that the drivers' failure to attain the minimum PaQS score could not reasonably be regarded as being capable of causing or contributing to the losses, the Court was not required to consider the potential operation of sections 54(2), (3) and/or (4).

The Court found the insurer was obliged to extend indemnity under the policy.

WHAT ARE THE CONSEQUENCES OF THIS DECISION FOR INSURERS IN TERMS OF UNDERWRITING PROCESSES?

It has been suggested this decision, and section 54 in general, means it is exceedingly difficult for insurers to effectively limit the scope of the risk they are willing to cover. Whilst we understand the sentiment behind such a suggestion, we do not see it as being that dire.

There are a number of examples where section 54(1) has been found to apply – yet insurers have still been able to effectively limit the scope of cover through precise policy

provisions, comprehensive underwriting regimes and/or the inclusion of specific ongoing obligations upon the insured in the policy wording. *Ferrcom Pty Ltd v Commercial Union Assurance Company of Australia Ltd* (1993) 176 CLR 332 is a good example of this. Yet there are obviously significant commercial factors associated with doing so, particularly with respect to increased process and costs, that need to be weighed and considered.

Section 54 will also not apply to relieve the insured of a restriction or limitation that is inherent in a claim, or which must necessarily be acknowledged in the making of a claim, having regard to the type of policy under which that claim is made.

In that way, it is important to remember that section 54 does not override the policy wording; rather, it operates to relieve an insured from the effect of certain policy provisions in certain circumstances. Having said that, it does not matter whether the term in question is expressed as an obligation, or a continuing warranty, or a temporal exclusion from cover, or a limitation on the defined risk. It is a matter of substance over form.

WHAT ARE THE CONSEQUENCES OF THIS DECISION FOR INSURERS IN TERMS OF CLAIMS HANDLING PROCESSES?

The nature and extent of any consequences will depend on an insurer's existing claims handling processes. If an insurer is already applying section 54 in a remedial way consistent with the objects of the *Insurance Contracts Act 1984* (Cth), this decision will probably be of little impact – apart from affirming that process.

On the other hand, if an insurer is applying section 54 in a narrow and restrictive way, this decision may cause the insurer to re-evaluate its approach.

This decision is also a timely reminder of the need for insurers to give careful consideration to the impact that section 54 may have on all aspects of their policy wordings. As outlined above, this decision affirms that a court will take a substance over form approach, by focusing more on the "act" or "omission" in question, rather than the legal character of the reason why the insurer refuses to pay the claim.

In that light, it is extremely important for insurers (as well as insureds) to properly characterise the facts giving rise to the relevant "act" or "omission" when seeking relief via section 54. After all, what constitutes the relevant "act" or "omission" for the purpose of section 54 will depend on the particular circumstances of the case, and different results may arise from different characterisations.

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TRANS-TASMAN DIVERGENCE ON THE TERRITORIAL APPLICATION OF STATUTORY CHARGES OVER INSURANCE POLICIES

In November 2014 the New Zealand Court of Appeal released its judgment in *Bridgecorp Limited (In Receivership and in Liquidation) v Certain Lloyd's Underwriters Under Policy No B0701LS05809* [2014] NZCA 571 (Lloyd's case). This is the latest contribution from the New Zealand courts to the continuing 'Bridgecorp saga' that was discussed by Toby Barrie and Belinda Randall in the 2014 Insurance Review at page 69.

The issue in the Lloyds' case was whether section 9 of the *Law Reform Act 1936 (NZ)* created a statutory charge over money payable under an insurance policy that was issued by London underwriters in New Zealand. The New Zealand Court of Appeal held that section 9 did not apply because the insurers, and therefore the 'debt' under the insurance policy, were situated outside of New Zealand.

The decision highlights the continuing differences in approach by the New Zealand and New South Wales courts to almost identical statutory charging provisions.

SECTION 9

Section 9 of the *Law Reform Act 1936 (NZ)* gives a person who has suffered injury or damage the right to make a direct claim against the insurer of the wrongdoer. The section creates a statutory charge over all insurance money that is or may become payable in respect of the insured defendant's liability to pay damages or compensation. The charge is created when the event giving rise to the claim against the insured for damages or compensation happens and applies even if the insured wrongdoer has died insolvent or is being wound up at that time. The charge takes priority over all other charges affecting the insurance proceeds.

The legislative intent behind the section (as discussed by the New Zealand Supreme Court in *Ludgater Holdings Limited v Gerling Australia Insurance Pty* Limited (2010) 16 ANZ Insurance Cases para 61-844) was to enable a successful plaintiff to recover directly from an insurer the insurance policy proceeds that would otherwise be payable to an insured defendant. This was considered necessary to address what the court referred to as 'the obvious unfairness' in the denial by the common law of priority for an injured plaintiff's claim to insurance proceeds payable to an insolvent insured defendant.

THE *LLOYD'S* CASE – CONFIRMATION OF "THE RESIDENCE RULE" IN NEW ZEALAND

Bridgecorp was a New Zealand finance company that failed in 2008. Bridgecorp had, through its New Zealand insurance broker, arranged insurance against losses suffered on realisation of securities given by borrowers over various properties. Bridgecorp's insurers declined to indemnify the company under those policies for a number of reasons. Bridgecorp issued proceedings against its insurer to challenge the declinature and joined the insurance broker to those proceedings on the basis that, if Bridgecorp's insurance policy did not respond, the insurance broker would be liable for breach of professional duties to arrange suitable insurance for Bridgecorp.

The insurance broker was in liquidation and held professional indemnity insurance with a syndicate of Lloyd's underwriters in London. Bridgecorp applied for leave under section 9 to charge the proceeds of the Lloyd's policy against the contingency that Bridgecorp's claim against the broker would succeed. In response, the Lloyd's underwriters filed a protest to the New Zealand Court's jurisdiction on the basis that section 9 does not have extra territorial effect.

The New Zealand Court of Appeal upheld a High Court decision in favour of the underwriters. It did so by confirming that section 9 will only apply to a debt that is situated in New Zealand and that a debt is situated where the debtor resides (the residence rule). In the Lloyd's case, the Lloyd's

underwriters were the "debtor" under the professional indemnity policy. They conducted their business from London and nowhere else. It followed, in accordance with "the residence rule", that the underwriters resided in England, the debt was situated there also, and as a result section 9 did not apply.

The Court of Appeal explained that the rationale for "the residence rule" is that a debt is located in the country where it is properly recoverable or enforceable or where the means of satisfying a judgment in respect of the debt may be discovered. In the Lloyd's case, the broker's professional indemnity policy stated that the underwriters could only be sued under the policy in the New Zealand courts and in accordance with New Zealand law. However, the court noted that any judgment that might be obtained against the underwriters would need to be enforced against the underwriters' assets in England.

The Court of Appeal also discussed the more difficult situation when a debtor carries on business in multiple jurisdictions and can therefore be regarded as "resident" in more than one location (as many multi-national insurance companies do). The court reviewed the cases and observed that in multiple residence cases, the location of the debt depends on where the contract creating the debt is required to be performed (the multiple residence rule).

In these multiple residence cases, the location of the debt will depend on the insurance contract in question and where the policy proceeds are required to be paid pursuant to either an express or implied provision of the contract, or alternatively, where the policy proceeds would be paid in the ordinary course of business.

THE *CHUBB* CASE – A DIFFERENT APPROACH IN NEW SOUTH WALES

The New Zealand Court of Appeal's application of 'the residence rule' in the Lloyd's case is slightly different to the approach the New South Wales courts have taken to determining the territorial application of the equivalent New South Wales provision – Section 6 of the Law Reform (Miscellaneous Provisions) Act 1946 (NSW).

Section 6 was considered by the New South Wales Court of Appeal in *Chubb Insurance Company of Australia Limited v Moore* (2003) 17 ANZ Insurance Cases para 61-976 (discussed in the 2014 review) (Chubb). In *Chubb* the court held that the territorial connection with New South Wales that was required for the statutory charge in section 6 to operate was that the underlying liability claim against the insured defendant had to be prosecuted in the courts of New South Wales.

In that case, none of the underlying Great Southern Proceedings against former executives and one of the companies of the Great Southern Group had been brought in a New South Wales Court. The claimants had filed the underlying Great Southern Proceedings in the Supreme Courts of Western Australia and Victoria. It followed, in the New South Wales Court's view, that section 6 had no application to any of those claims against the insured that were being prosecuted outside the New South Wales courts.

THE DIVERGENCE OF APPROACH IN AUSTRALIA AND NEW ZEALAND

The New Zealand Court of Appeal's decision in the *Lloyd's* case highlights what appear to be overtly different approaches by the courts in New Zealand and New South Wales to the territorial application of the statutory charging provisions.

There are also conflicting decisions in New Zealand and Australia on the related question of whether the statutory charges takes priority over defence costs payable to the insured under the policy. In particular:

- In *Chubb* the New South Wales Court of Appeal held that the statutory charge does not extend to money payable under a policy for defence costs, legal representation expenses, or costs and expenses if paid in accordance with the policy before the amount of the insured's liability is determined by judgment being entered or settlement agreed.
- In contrast, in *BFSL 2007 Ltd v Steigrad* [2014] 1 NZLR 304, the New Zealand Supreme Court reached the opposite conclusion and ruled that the statutory charge takes priority over defence costs. As a result, New Zealand insurers pay defence costs at their own peril if the total claims against an insured defendant exceed a combined policy limit for liability and defence costs.

The drafting of both statutory charge provisions has been criticised by courts and commentators alike. In *Chubb* the court expressed the view that the New South Wales provision "…should be repealed altogether or completely redrafted in an intelligible form, so as to achieve the objects for which it was enacted." Similar views have been expressed about the New Zealand provision and it remains to be seen whether calls for legislative reform in this area are taken up.

In the meantime, New Zealand and Australian Courts grappling with almost identical statutory charge provisions continue to diverge in their approach to both territorial and defence costs issues.

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FRAUD IN MARINE INSURANCE CLAIMS

Participants in Australia's general insurance industry are very familiar with the ameliorative impact that the *Insurance Contracts Act 1984(Cth)* has upon the relationship between insureds and insurers, particularly when it comes to claims and allegations of fraudulent conduct.

The English marine insurance case of the *DC Merwestone* is a timely reminder that alternative insurance regimes, such as the *Marine Insurance Act 1909 (Cth)*, operate in a markedly different way. In doing so, they yield results that may seem harsh by Australian general insurance standards. In reality however, the unique nature of the risks covered by marine insurance policies and the fact that knowledge lies principally (if not exclusively) in the hands of an insured means that heavy sanctions are necessary, particularly when dealing with questions of fraud.

THE DC MERWESTONE AND THE MARINE INSURANCE ACT

In *Versloot Dredging BV v HDI-Gerling Industrie Versicherungs AG (The DC Merwestone)* [2014] EWCA Civ 1349, the English Court of Appeal, supported HDI-Gerling's (HDI-Gerling) decision to decline Versloot Dredging BV's (Versloot) claim for machinery damage under a hull and machinery policy.

Facts

Versloot owned a gearless general cargo ship named 'DC Merwestone' (the Vessel). HDI-Gerling was the hull and machinery underwriters of the Vessel.

Before embarking on a voyage the Vessel's crew used the emergency fire hose to pump seawater at high pressure to remove ice from the deck. After using the hose the crew failed to properly empty the hose, and pump, and close the sea locks. The remaining sea water froze and expanded in the pump, cracking the casing and distorting the filter lid, destroying the watertight seal. Once the Vessel sailed, the ice melted and water bypassed the bowthruster space and duct keel (both of which should have been watertight) and flooded the engine room. The main engine and gearbox failed and needed to be completely replaced.

The Vessel was managed at the time by a Dutch company. The general manager, in answering HDI-Gerling's questions about the circumstances of the casualty said that the bilge alarm had been activated at around noon on 28 January 2010, and that it had been ignored because its sounding was attributed to the rolling of the Vessel in heavy weather. The general manager advised that he had been informed of both of these things from the Master of the Vessel.

It later emerged from investigations with the Master, that the bilge alarm had not gone off as advised by the general manager. The Court at first instance found that the general manager, when preparing his responses to the insurer's questions, believed that it would assist the claim if he minimised any opportunity for attributing fault to the Owners, rather than the crew, in relation to the cause of the casualty. Despite having no evidence from the crew that an alarm had gone off at around noon, or that it had been ignored, the manager genuinely believed that if the alarm had gone off, it would probably have been ignored as a result of the weather conditions he believed the Vessel was encountering. His account was given to fit his theory of ingress although he made no attempt to check whether it was supported by anything the crew had said about the alarm going off.

Accordingly, HDI-Gerling rejected the claim because it was supported by a 'fraudulent statement or device' in addition to other reasons such as unseaworthiness.

The Fraudulent Claims Principle

The Court, applying comments made in *The Aegeon* [2003] QB 556, found that a fraudulent device is where the insured seeks to embellish the facts by some lie to significantly improve the strength of its claim. It found that, if not for the fraud, the claim would have been valid.

In reaching its decision, the Court drew particular attention to the special character of the relationship between an insurer and insured under a marine policy. It observed that the relationship is given a 'special character' because the insurer commits no wrong, but yet they are indemnifying the insured against loss. Because of this, the Court concluded that the use of a fraudulent device 'crosses a moral red line, and as Lord Hobhouse put it, has "a fundamental impact on upon the parties' relationship".

The court acknowledged numerous figures and statistics about the cost of fraudulent insurance claims. The Court emphasised the need to protect insurers due to the 'imbalance between the information available to the insured and that available to them'. In doing so, the Court addressed the issue of 'proportionality'.

The Court noted the three elements identified in the *The Aegeon* that were relevant to the question of whether a claim could be declined because a fraudulent device had been employed:

- firstly, that the device must be directly related to the claim;
- secondly, the device must have been intended by the assured to promote his prospects of success; and
- thirdly, it must not be irrelevant, but would yield a not insignificant improvement in their claim (modified by the Court in *DC Merwestone* to be a "significant improvement").

The Court observed that this was not a matter of 'asking whether the consequence in any given case is proportionate to the relevant fault. Rather '[o]nce it is accepted that deterrence is itself a legitimate aim, the fact that forfeiture is a harsh, in some circumstances very harsh, sanction does not mean that it is disproportionate to that aim'.

His Honour justified his view because the principle and subsequent forfeiture did not apply to the "careless or forgetful insured", rather only to those who have *actively* chosen to commit fraud. His Honour found that that the conduct of the crew member gave a false narrative of the facts "recklessly in support of the claim, to which it was directly related, in the hope of a prompt settlement."

The Court did not distinguish between the varying degrees of fraud or dishonesty. Therefore, if an insured, under a policy to which the *Marine Insurance Act* applies, commits any kind of fraud no matter how small, or is reckless and allows it to happen, Australian courts may be more willing to find that insureds will forfeit any right to their underlying claim. The justification for this is that the insurer and insured share obligations of utmost good faith, and the insurer relies heavily on the information offered up by the insured when determining the validity of a claim.

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HIGH COURT CLARIFIES DUTIES TO SUBSEQUENT PURCHASERS – BROOKFIELD MULTIPLEX V OWNERS CORPORATION

The duty of care owed by a builder to subsequent purchasers of a building has long been a source of contention. In a decision handed down on 8 October 2014, the High Court in *Brookfield Multiplex Limited v Owners Corporation Strata Plan 61288& Anor* [2014] HCA 36 found that a builder of a commercial building does not owe a duty of care beyond the duty defined in the contract.

This is good news for builders and their insurers but perhaps not great news for purchasers of apartments. It shows the determination of the current High Court to confine the scope of duty of care. In its unanimous decision, the High Court overturned the NSW Court of Appeal's unanimous decision. The High Court has clarified any perceived inconsistency between in its previous decisions on this issue.

DECISION IN BRIEF

The facts concern a conventional commercial apartment development. Brookfield built the apartments pursuant to a design and construction contract with the developer, Chelsea Apartments Pty Ltd. The contract price was just over AU$57 million. The contract between Brookfield and Chelsea contained the usual detailed provisions relating to the quality of services and remedies for default. Most significantly, Brookfield's liability ceased on completion of the defects liability period.

Chelsea sold the apartments to individual purchasers. As usual, there was an owners corporation that was responsible for managing the common property. Latent defects arose. The purchasers had rights against the developer in relation to the repair of those defects. The cost of those repairs **were not** the subject matter of this proceeding. Rather, the common property had defects. The owners corporation responsible for the common property, repaired those defects then sued Brookfield for the cost of those repairs. The owners corporation argued that Brookfield should be liable in negligence for a breach of duty to take reasonable care in construction of the apartments to avoid a reasonably foreseeable economic loss to the owners corporation in having to rectify these defects.

PREVIOUS RELEVANT HIGH COURT DECISIONS

In what is clearly now a "high watermark" decision, the High Court in *Bryan v Maloney* [1995] HCA 17 found that the builder of a domestic dwelling, assumed responsibility for the construction and the subsequent purchaser relied on that. As such, the subsequent purchaser was owed a duty of care by the builder and had an effective remedy against the builder. Builders could be sued many, many years after construction.

However, in *Woolcock Street Investments Pty Ltd v CDG Pty Ltd* [2004] HCA 16, the High Court found that in relation to a commercial building, a subsequent purchaser was not owed a duty by the builder as it had the capacity to protect itself against economic loss.

In simple terms, the Court's distinction is that commercial entities are big and ugly enough to look after themselves, whereas, individual property owners generally are not.

RECONCILING *BRYAN* AND *WOOLCOCK*

This case concerned an apartment complex which is an amalgam of the two positions. Whilst the developer is a commercial entity, the end purchasers of the apartments are often individuals acquiring a property for residential purposes. Nevertheless, the High Court has found that Brookfield and Chelsea defined its obligations in the commercial contract and, in effect, this contract "covered the field". There was no entitlement of any subsequent purchaser to infer a duty beyond the contract between Chelsea and Brookfield. As such, the claim for the cost of repairs of the common property failed, because Brookfield did not owe a duty of care to the current owner of the common property.

There are four separate decisions of the seven justices of the High Court. The four decisions reach the same conclusion via different routes. Three judges considered that the vulnerability of the subsequent purchaser was decisive. However those judges considered that the subsequent purchasers in this instance were not vulnerable as they were able to protect themselves.

The other four judges focused on the contract between Chelsea and Brookfield. They were less concerned with the vulnerability of the subsequent purchaser, nor did they make any clear distinction between domestic dwellings and commercial buildings. Perhaps the take home quotation is from the decision of Crennan, Bell and Keane JJ which states:

> *“To impose upon a defendant builder greater liability to a disappointed purchaser than to the party for whom the building was made and by whom the defendant was paid for its work would reduce the common law to incoherence.”*

In short, the terms of a contract between a builder and developer will be paramount where the respective rights and obligations of the contracting parties are comprehensive. The risk of latent defects can be transferred to the developer and, in this case, was successfully done. In practical terms, it means that developers and subsequent purchasers need to either take the risk of latent defects, or purchase insurance to cover those potential problems. It is possible that this reasoning could be applied to a matter involving a domestic dwelling in certain circumstances.

This is good news for the construction industry. Builders can now close off jobs at the end of the defects liability period, with some confidence that long tail liabilities will not come back to bite them in the future. Just make sure that the contract is clear, because the contract is king.

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PROJECT SPECIFIC PROFESSIONAL INDEMNITY POLICIES

In last year's Federal budget the Government announced it is investing AU$50 billion in infrastructure projects across Australia over the next seven years. When combined with state, territory and private funding, total infrastructure investment is likely to be in the range of AU$125 billion.

The New South Wales Government has also recently announced plans to spend up to AU$60 billion on new infrastructure projects if re-elected next year, in addition to projects that are presently underway (such as the North West rail link).

While the construction phase of the mining boom is winding down, there are a number of projects which will still go ahead over the next couple of years primarily in Western Australia and Queensland.

The size and complexity of many of these public and private projects will see engineering and other design professional consultancies with varying specialties or expertise join together (as a joint venture or otherwise) with contractors to bid for the project and execute it (often as one package).

This has been the approach taken for many major infrastructure and mining projects in recent times.

This structure gives rise to a number of considerations, one of which is the allocation and transfer of the risk arising from acts, errors and omissions in the performance of the professional services.

The allocation of risk must be considered as part of the bidding process. It is invariably a matter of central importance for the principal who is most at risk in respect of a design failure, the consequences of which can include increased cost of construction, rectification costs, delayed completion, lost profits and loss of use.

While each design consultancy and the contractor will have their own company professional indemnity insurance policies which they can draw upon,

- What contractual warranties are given and are they covered?
- Is there is contractual liability for liquidated damages and if so, is that covered?
- Are contractual indemnities provided and if so, are they covered?
- Is there to be cross liability between the parties and how is that to be managed?
- What rights of subrogation (if any) will be available to the Insurer?

How each of these issues are addressed in the project's contractual framework will impact considerably on the Insured's ability to claim on the policy and the Insurer's overall exposure to the project. For example, it is invariably the case that a fitness for purpose warranty will be provided in a consultancy agreement and the parties will need to decide whether cover under the Project Specific Professional Indemnity Policy is provided for that and, if so, on what terms. Such warranties are usually excluded by boiler plate policy exclusions.

Another very important consideration is that of double insurance. The Insured will inevitably have their own professional indemnity policy which in the normal course will respond to any claim which is made.

Depending on the agreement between the parties, it may be that the Project Specific Professional Indemnity Policy is intended to act as a primary or excess policy to the company policies.

Most company policies will include an «other insurance» clause and it is important from both the Insured's and the Insurers' perspective that consideration is given to the potential interplay between that clause and the Project Specific Policy, particularly in light of Section 45 of the Insurance Contracts Act.

Section 45 renders "other insurance" clauses ineffective except in permitted circumstances of compulsory insurance or where the cover is appropriately specified and a great deal of uncertainty can arise where the question of other insurance is not managed properly. The New South Wales Court of Appeal decision of *HIH Casualty and General Insurance Ltd v Pluim Constructions* [2000] NSWCA 281 is the most recent occasion this has been considered an appellate level.

Finally, and possibly most importantly, all intended Insureds must be properly identified as insured's under the Project Specific Policy. Failure to do this could affect the Insurers rights of subrogation and cross liability exposure. It can also have implications where other insurance is raised in light of the decision in *Zurich Australian Insurance Ltd v Metals & Minerals Insurance Pte Limited & Ors* [2009] HCA 50. The High Court in that decision confirmed Section 45(1) only applies to provisions affecting double insurance where the Insured is a party to the contract of insurance.

While the Project Specific Policy provides an attractive solution for the management of professional liability in larger and more complex infrastructure projects, its terms and conditions must be considered by the Insurer and Insured in the context of the contractual arrangements to be entered into by the parties and other insurance arrangements which they have. Failing to do so (particularly in a high risk, high value project) could result in significant and unexpected financial consequences for the Insured and/or Insurer.

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2014 – RECENT DEVELOPMENTS IN DEFAMATION

Again no judgments were handed down by the High Court in defamation matters in 2014. One case that will shortly be seeking special leave though is the Victorian case of *Setka v Abbott* [2014] VSCA 287 where courts in NSW and Victoria (and SA and WA) are at odds over the interpretation of uniform defamation legislation and the extent to which it overrides or is inconsistent with the common law.

The Court of Appeal in Victoria has upheld a pleading practice in Victoria whereby the defendant can plead different imputations which are only "nuances" to the plaintiff's imputations and can win if they are proved true, even if the defendant cannot prove true the plaintiff's imputations. This is called the "Hore-Lacy" defence after a case bearing that name in 2000 in Victoria.

In NSW, in *Bateman v Fairfax Media Publications Pty Ltd (No 2)* [2014] NSWSC 1380 McCallum J observed that the pleading rules in NSW oblige a plaintiff to specify a defamatory meaning or imputation and a defence in common law must therefore meet that specific meaning and not another one (this is contrasted to the statutory defence of contextual truth). Her Honour said: "It follows, in my view, that the decision in Hore-Lacy has no work to do in New South Wales having regard to the law and practice in this State. It will therefore be very interesting to see if the High Court agrees to resolve this unfortunate interstate impasse."

Two recent developments have changed matters in the defamation list in NSW. Firstly, the Court of Appeal in *Corby v Allen & Unwin Pty Ltd* [2014] NSWCA 227 stated that interlocutory challenges, on the basis that a publication does not have the capacity to convey certain imputations, should be treated "with generosity not parsimony." In other words it's going to get a lot harder for defendants to succeed in striking out meanings at an early stage.

This was borne out in *Brown v Random House* [2014] NSWSC 1505, where McCallum J found that even imputations which relied upon inferences on inferences, were now capable of being conveyed and that *Corby* means that great caution is now required before striking out an imputation.

The second development is the new Practice Note SC CL 4 which seeks to streamline and expedite matters by requiring parties to be ready for imputation arguments by the first return date and that by the second return date, a defence should be on and any objections provided. Whether this results in a more efficient system for the resolution of matters remains to be seen.

Finally, a couple of recent damages awards have sent shock waves through the offices of those advising defendants. Firstly *Pedavoli v Fairfax Media* [2014] NSWSC 1674, where *The Sydney Morning Herald* newspaper mistakenly identified a female schoolteacher who was alleged to have had sex with at least two boys in year 12 of a Catholic boys school in Sydney. The woman was described as a drama and English teacher at the school in her late 20s, which fitted the description of the plaintiff (the actual person had left the school previously). A defence of offer of amends for AU$50,000 failed and aggravated damages were awarded for the defendant's cross-examination of the plaintiff during the trial. Total damages amounted to AU$350,000.

The second case is *Polias v Ryall* [2014] NSWSC 1692 where the plaintiff, a poker player sued four defendants (also poker players) over eight publications, five of which were on Facebook. The essence of the defamations was allegations that the plaintiff was a thief. It was found that one of the defendants had deliberately lied whilst giving evidence and the defences of truth failed. Damages were awarded against each defendant of AU$125,000, AU$130,000, AU$50,000 and AU$35,000.

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PLAY SMART, NOT HARD: GETTING THE MOST FROM YOUR SETTLEMENT OFFERS

No matter how skilled your legal representation or how efficiently a case is managed, litigation is inevitably expensive. Legal and expert witness costs are a legitimate and often overriding focus for parties involved in a dispute.

Recognition of an impending and sizeable legal spend generally encourages parties to the negotiating table as early as is feasible. Unfortunately, despite alternative dispute resolution, sound legal advice and the best efforts and goodwill of the parties and their lawyers, some cases simply do not settle and require a judicial determination to end the dispute.

Properly advised, all parties ought take steps to protect their position on costs if a dispute is likely to conclude with a trial or an appeal. Calderbank offers have had a long-standing role in this area. However, the threat of seeking indemnity costs is rarely followed through. It is even less common that a Calderbank offer yields the intended result. This is because courts will only award indemnity costs to the party making the offer where that party demonstrates that it was unreasonable for the other party not to accept the offer. Given the punitive nature of indemnity costs orders, parties and their lawyers cannot lay the foundations to an indemnity costs application in a blasé manner. Precision, diligence and timing are critical.

The 2014 calendar year saw a number of courts consider indemnity costs applications following the non-acceptance or rejection of one or more Calderbank offers. The decisions provide valuable reminders of the optimal practice when making formal settlement offers:

1. While the value of the offer has little ultimate bearing on the entitlement to indemnity costs, the offer must be some form of compromise in the proceedings. Equally critical are how and when the offer is presented and what information is available to the recipient to properly evaluate whether the offer should be accepted.
2. Parties must remain alert for settlement opportunities throughout the course of multi-stage litigation. Calderbank offers should be considered at all stages of court proceedings, not just at one point.
3. Re-instating previous offers, or making a lower offer than previously, should not be treated as an act of recalcitrance or belligerence. Offers should be made as the litigation develops and a party's position demonstrably strengthens or weakens: the non-acceptance of a Calderbank offer early in proceedings might be reasonable on the limited information available at the time, yet the non-acceptance of an offer made on the same terms later in the proceedings may not be reasonable in the light of additional information disclosed between the parties during the intervening period.

SETTLEMENT GROUP PTY LTD V PURCELL PARTNERS (A FIRM) [2014] VSCA 68

Prior to trial, the defendant made two settlement offers to the plaintiff. The first offer was made by email. The second offer (for the same amount) was made by letter two weeks later. Neither offer was accepted. The plaintiff went on to trial and obtained judgment against the defendant for AU$211,486 **plus** costs. Costs were estimated at around AU$110,000.

The defendant appealed the decision and, after filing the appeal notice (but before the hearing of the appeal), made an offer to compromise the appeal for 486 **inclusive** of both interest and costs. The plaintiff did not accept this offer either.

After succeeding in its appeal, the defendant sought an indemnity costs order against the plaintiff on the basis that the plaintiff's non-acceptance of any of the offers had been unreasonable.

In assessing the application, the Court of Appeal considered the factors set out in *Hazeldene's Chicken Farm Pty Ltd v Victorian WorkCover Authority (No 2)* (2005) 13 VR 435. It confirmed that, when deciding whether the rejection or non-acceptance of an offer was unreasonable, a court should take into account:

- the stage of the proceeding at which the offer was received;
- the time allowed to the offeree to consider the offer;
- the extent of the compromise offered;
- the offeree's prospects of success, assessed as at the date of the offer;
- the clarity with which the terms of the offer were expressed; and
- whether the offer foreshadowed an application for indemnity costs in the event of an offeree's rejecting it.

The Court of Appeal noted that the defendant's first offer was a brief email which invited further negotiations and did not foreshadow an application for indemnity costs if the plaintiff did not accept it. The first offer was therefore not sufficient to entitle the defendant to indemnity costs.

The second offer was expressed much differently. It was set out in a detailed letter, which contained a clear and cogent analysis of the legal position that was ultimately fully vindicated by the majority judgment of the Court of Appeal. However, the offer was only open for acceptance for two working days. The Court considered this time period to be inadequate. Further, the offer was "modest" and, like the first offer, did not foreshadow an application for indemnity costs if the plaintiff did not accept it. For these reasons, the Court of Appeal did not consider the plaintiff's non-acceptance of the second offer to be unreasonable either.

Fortunately for the defendant, its final offer hit the mark. The Court of Appeal considered the final offer was clear in its terms and complied with the procedural requirements of the relevant Court rules. The offer was open for acceptance for 14 days, which the court considered was sufficient time for the plaintiff to consider it. The Court of Appeal also considered the offer was a very substantial one which, in practical terms, equated to about two thirds of what the plaintiff had achieved at trial. It was also made against the background of the defendant's solicitors having clearly and cogently laid out in the second offer the correct legal analysis of the parties' respective positions. As a result, the Court of Appeal ordered the plaintiff to pay the defendant's costs on an indemnity basis from the date of the third offer.

The decision is noteworthy because it demonstrates that the courts are willing to view multiple offers collectively to assess the reasonableness of rejecting a later one, rather than considering each offer in isolation.

STEWART V ATCO CONTROLS PTY LTD (IN LIQUIDATION) (NO 2) [2014] HCA 31

Where the outcome at trial is dependent on the proof of facts by witness testimony or the resolution of differences of expert opinion, a party seeking indemnity costs will generally be challenged to demonstrate that the recipient's decision not to accept the offer was unreasonable. The High Court of Australia's decision in *Stewart v Atco Controls Pty Ltd (in Liquidation) (No 2)* highlighted that demonstrating unreasonableness is significantly easier where the issues between the parties are focused on disputes involving the application of existing law than the proof of particular facts.

The appellant was the liquidator of Newtronics Pty Ltd, a company related to the respondent. The dispute between the parties involved the reasonably narrow issue of whether the liquidator of Newtronics was entitled to an equitable lien over a fund in the liquidation for the costs and charges he had incurred in obtaining that fund through proceedings he had brought against someone else.

Prior to an appeal hearing in the Victorian Court of Appeal, the liquidator made a Calderbank offer to Atco. The offer proposed that Atco abandon its claim for the fund and abandon the appeal, in exchange for which the liquidator would not pursue his costs of the original Supreme Court action or his costs of the appeal. Atco did not accept this offer and went on to be successful in its appeal. The liquidator then appealed to the High Court. He was successful. He sought his costs in both the Court of Appeal and the High Court against Atco on an indemnity basis. The application was founded on Atco's rejection of the liquidator's Calderbank offer prior to the Court of Appeal hearing.

When considering the liquidator's application, the High Court noted that the legal principles of the case were not novel. Atco needed to distinguish those principles in order to succeed in its claim, but failed in its attempt. The High Court therefore found that Atco's non-acceptance of the liquidator's Calderbank offer was not reasonable and ordered Atco to pay the liquidator's cost of the appeal to the Court of Appeal on an indemnity basis.

The liquidator's application for indemnity costs in the High Court was approached differently. This was because the Calderbank offer was not open for acceptance during the course of the High Court appeal. Atco had therefore not failed to do anything during the High Court proceedings that warranted an order for indemnity costs being made in those proceedings.

DUNMALL V O'SULLIVAN [2014] WADC 121

This decision of the District Court of Western Australia highlighted the importance of strategic, well-timed offers. The court considered a defendant's application indemnity costs against an unsuccessful plaintiff. The application was based on the plaintiff's non-acceptance of a series of offers the defendant had made to him prior to trial.

An initial offer of AU$80,000 plus costs was conveyed to the plaintiff in a letter written by the defendant's original solicitors. However, the offer was not accompanied by any submissions regarding why it would be unreasonable for the plaintiff to accept the offer. The defendant subsequently changed solicitors. Later in the action, she made a further offer to the plaintiff to settle the action. The offer was for AU$40,000 inclusive of costs, which was significantly lower than the original offer. This lower offer was contained in a letter written by the defendant's new solicitors which contained detailed submissions and observations about the weaknesses in the plaintiff's case.

The court observed that the final Calderbank offer:

> *… succinctly and courteously summarise[d] the deficiencies in the plaintiff's claim the strengths of the [defendant's] case that ultimately led to the dismissal of the plaintiff's claim. … [M]any of the points raised presciently anticipate the reasons for judgment.*

The court went on to say:

> *… [A] very substantial offer was made in 2006, close to the time of the commencement of proceedings. By July 2012, after some six years of litigation, the [defendant's] position had hardened. Given the evidence that then existed that undermined the position taken by the plaintiff towards the [defendant], that is understandable. Indeed it is difficult to see what there was that could have led the plaintiff, properly advised, to think that it was then reasonable to continue proceedings against the [defendant].*

The court awarded indemnity costs to the defendant from the period after the lower offer expired. These included indemnity costs of a lengthy trial.

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PRIVILEGE ISSUES FOR INSURERS AND INSUREDS

The past year has seen the delivery of many judgments addressing privilege issues, but two decisions are of significance to the insurance sector.

DOMINANT PURPOSE TEST IN A LOSS INVESTIGATION CONTEXT

In *AusNet Electricity Services Pty Ltd v Liesfield [2014] VSC 474*, the Court determined whether documents prepared by or for AusNet Electricity Services (AES) in connection with the Victorian Black Saturday bushfires in 2009 were privileged and thus exempt from disclosure.

Following the bushfires AES established a "Bushfire Response Team", which was responsible for collating information and instructed solicitors to act for AES on all aspects of the bushfires. When it was disbanded one year later, AES' Legal Manager assumed responsibility for instructing AES' solicitors.

Some two and a half years after the bushfires, AES was informed the Police were considering potential causes, including AES' electrical assets, as an alternative to the initial belief that arson was the cause. Thereafter, a sub-committee of the board of AES (ie, not the Legal Manager or Bushfire Response Team) commissioned the technical analysis documents. The Legal Manager gave evidence that the sub-committee's role was to guide and assist her in instructing AES' solicitors, but AES failed to tender any contemporaneous document attesting to the purpose of the sub-committee.

The evidence of the facts surrounding the commissioning of the technical analysis documents did not disclose the necessary element of confidentiality nor the dominant purpose of seeking and obtaining legal advice to sustain a valid claim of privilege. It was inferred there were a number of other purposes for the creation of the technical analysis documents, including business and operation reasons.

In an insurance context, insurers intending to claim privilege over investigation reports should be mindful that a **dominant** purpose in connection with legal advice must be established. It is doubtful a dominant purpose will be established if the investigation report is obtained before solicitors are instructed and/or goes to policy indemnity considerations and reserving. Having regard to the potentially significant ramifications of disclosure of investigation reports to claimants, prudent insurers should seek early legal advice about how to proceed with investigations whilst preserving so far as possible a claim for privilege over ensuing reports.

NO COMMON INTEREST PRIVILEGE – NOW WHAT?

The decision of *Asahi Holdings (Australia) Pty Ltd v Pacific Equity Partners Limited (No 2)* [2014] FCA 481 involved an analysis of whether the provision of a document by an insured to its insurer constituted an implied waiver of legal professional privilege (LPP) in circumstances where there was no common interest privilege (CIP) attaching to the document. It will be of significant interests to insureds.

In many instances the insurer and insured share commonality of interest such that the provision of a document by the insured to the insurer is not inconsistent with the intention to preserve confidentiality and privilege. In these circumstances, CIP applies. However, in our experience CIP is often assumed rather than claimed and rarely the subject of proper consideration by insureds. The provision of documents to an insurer when CIP does not apply can have potentially disastrous consequences.

In Asahi an insured provided to its insurer a document prepared by its solicitor in respect of which a valid claim for LPP existed at the time the document was created. The issue was whether the provision of the document to the insurer was inconsistent with the maintaining of confidentiality over the document and as such whether the LPP attaching to the document had been waived. The Court ultimately concluded LPP had been waived as the provision of the document was "entirely antithetical to the confidential purpose and thus was 'inconsistent with the maintenance of the confidentiality which the privilege is intended to protect.'"

There are four important lessons for insureds to learn:

First, consider whether CIP applies to a document before providing it to the insurer. In *Asahi* the interests of the insurer had a real prospect of aligning with the interests of the party adverse to its insureds.

Second, where CIP does not apply, carefully consider if the document has to be provided. In *Asahi* the Court observed the document provided to the insurer was not legally required to be provided to the insurer and as such was provided voluntarily. This is not consistent with the intended maintenance of confidentiality.

Third, marking a document "privileged" and "confidential" is not enough to demonstrate an intention to maintain confidentiality over the document and does not secure a valid LPP claim. In Asahi the Court formed the view the inclusion of these words was a carry over from another document. Actions are thus more instructive than mere words.

Fourth, take proper steps to ensure the document to be provided to the insurer will be treated confidentially and in a manner consistent with the maintaining of legal professional privilege *before* it is provided to the insurer. It is not safe to simply assume the insurer will maintain confidence, even having regard to the insurer's good faith obligation. The agreement negotiated in advance with an insurer should address both the intention to maintain confidentiality and provide the conditions upon which the document is provided and appropriately framed limitations on its use by the insurer.

In instances where insureds perceive their interests do not align with an insurer's interests or are otherwise on notice of a divergence in interests, insurers can expect a greater level of consultation about the intended use of documents sought from an insured and reassurance concerning.

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CLASS ACTIONS – 2014 ACTION

2014 saw significant local activity in the class action space, with plaintiff law firms aggressively generating interest in pursuing mass tort litigation.

The highpoint of 2014 was undoubtedly the settlement of the Black Saturday Kilmore East-Kinglake bushfires class action. Approved by the Supreme Court of Victoria on 23 December 2014 (judgment was still pending following a lengthy trial when the litigation settled), the plaintiffs will receive $494 million for losses sustained in this bushfire, less costs, making it the largest class action settlement in Australian legal history.

The fact that the plaintiffs' legal costs will assess at around $60 million will no doubt encourage plaintiff law firms to pursue similar opportunities going forward. An interesting aspect of this case (and indeed other class actions) is that insurers with subrogation claims took an active role in the proceeding, including providing funding for the claim. This provides an interesting dimension to the debate whether the class action process is something of a curse for the insurance litigation landscape, or can be a good thing.

Indeed, class actions arising from bushfires and fire events appears to be a growth industry. There have been 10 class actions issued in relation to bushfires since 2009. Where once the media focus when reporting on these tragic events was solely on personal loss and stories of courage, too often those reports are now sharing column space with pieces about the prospect of issuing a class action. Recent examples include the Hazelwood coal mine fire, the Mickleham bushfire in February 2014 and the Docklands tower fire in late 2014.

Similarly, financial institutions and securities related litigation continue to be a focus for class actions. The second largest settlement for 2014 came in the Great Southern litigation involving a failed investor scheme, again a compromise whilst a Supreme Court of Victoria judgment was pending following a lengthy trial (and the largest class action settlement until the Black Saturday settlement). The settlement is now subject to a proposed scheme of arrangement.

The February 2014 Federal Court Ruling (currently on appeal) that ANZ Bank charged exorbitant late payment fees will not only embolden the plaintiff law firm involved to continue with its class actions against numerous other banks, but to be on the lookout for similar opportunities. Plaintiff law firms appear to be closely monitoring company reporting and shareholder announcements, and one cannot help but sympathise with companies who are targeted in this fashion, with mass tort litigation proving a costly distraction both on an operational and financial basis. The scope of discovery alone in such disputes can be an incentive to explore settlement and "move on".

In other securities class actions, the courts have adopted a far more conservative approach. In the case of Treasury Wine Estates (Treasury), for instance, which has been targeted in two separate class actions arising from a 2013 write-down announcement, Treasury was successful in having the Victorian Supreme Court rule that a minor shareholder's company, known as "MCI" (of which a practicing lawyer is the sole director and sole shareholder) could not continue as both the lead plaintiff and the solicitor on the record in the separate class action that his company had issued. Treasury was unsuccessful, however, in having the Victorian Supreme Court conclude that the class action was an abuse of process. On appeal, however, the Victorian Court of Appeal overturned the decision. The Court of Appeal, by majority,

held that the class action was an abuse of process on the basis that the predominant purpose of the proceeding was enabling MCI's sole director and sole shareholder to earn legal fees and said (at [13] to [14]):

"The nature of the cause of action – as a claim based on an alleged breach of disclosure requirements – is immaterial to MCI's purpose. Its sole purpose has only ever been to create for itself – in this case, by acquiring a small parcel of shares – a cause of action to sufficient merit to induce the defendant company to pay Mr Elliott's [the practicing lawyer, sole director and sole shareholder of MCI] fees.

It seems to us that this is a clear example of an abuse of process. The process of the Court do not exist – and are not to be used – merely to enable income to be generated for solicitors. On the contrary, they exist to enable legal rights and immunities to be asserted and defended. In the common form of class action, that is the sole purpose of proceedings. The members of the class wish to vindicate their rights. The fact that success will result in the solicitors' fees being paid does not affect the proprietary of the proceeding".

(Citation/Footnote: *Treasury Wine Estates Ltd v MCI* [2014] VSC 351)

The Court went on to say (at [21]):

"… there would have been very few cases in the history of Anglo-Australian litigation where a plaintiff has instituted a proceeding with the predominant purpose of enriching its solicitor, and indeed it would probably not have been a realistic possibility until the advent of the modern form of class action litigation during the last 20 years."

(Citation/Footnote: *Treasury Wine Estates Ltd v MCI* [2014] VSC 351)

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A related issue where the lines appear to blur is that of class certification. Unlike in the US where groups of litigants have difficulty establishing commonality when suing for personal injuries and the like, certification appears much easier in Australia. For instance, two Federal Court class actions were allowed to proceed against several pharmaceutical companies (both settled in 2014 subject to Court approval), however comparable proceedings in the US were not able to proceed as class actions and instead were dealt with in tranches involving numerous US plaintiff law firms. Companies should look seriously at challenging at the outset whether a class can be certified when such mass tort litigation is threatened or issued.

With the ongoing influence of litigation funders and the Productivity Commission still pondering the benefits of recommending the introduction of contingency fees, 2015 is expected to see continuing interest in mass tort litigation. If contingency fees were to be introduced in any form, that may diminish the influence of litigation funders as plaintiff lawyers seek to increase their share of the costs, thereby mirroring the situation in the US where litigation funders have little influence on account of the fact that the US Plaintiff Bar self-funds and in the process recovers significant costs, often in frivolous consumer class action claims and the like (such claims may have some attraction to Australian plaintiff lawyers given the ever-increasing focus by regulators on product misrepresentation, and the fact that such claims would not be subject to tort reform).

The prospect of additional financial incentives to litigate on a mass tort scale being rolled out is something that corporate Australia should be very wary about given the appetite for class action litigation that already prevails.

CLIMATE CHANGE INDUCED EXTREME WEATHER EVENTS – Considerations for the Insurance Industry

Australia has been experiencing a record-breaking streak of extreme weather events, including sweltering through the warmest spring in recorded history in 2014 (see Australian Government, *Special Climate Statement 50 – Australia's warmest spring on record* (Bureau of Meteorology, 2 December 2014)). The impact of the changing climate has the potential to significantly damage property, infrastructure and the environment, at a huge cost to the general population, business and all levels of Government.

Development situated along the coast is particularly at risk to climate change associated weather impacts, including shoreline erosion, climate change related sea level rise, more severe storm surge and coastal inundation.

It is estimated that around a quarter of a million properties are at risk of inundation from a 1-in-100 year flood event, should sea levels rise by 1.1 metres. The costs associated with the damage that could be caused by such an event are staggering, falling into the billions of dollars (see Australian Government, *Climate Change Risks to Australia's Coasts* (Department of Climate Change and Energy Efficiency, 2009)).

Therefore the impacts of climate change is a serious consideration for the insurance industry. So, what more can be done to mitigate liability associated with climate change induced extreme weather events?

POTENTIAL FOR NEGLIGENCE CLAIMS AGAINST LOCAL GOVERNMENT

Local Government is particularly at risk to climate change litigation if steps are not taken to ensure that planning and environmental decisions are made with due consideration to the potential future impact of climate change.

When determining a development application in NSW, for example, a consent authority must consider, amongst other matters, any coastal zone management plan that applies to the relevant land (s 79C(1)(a)(v) of the *Environmental Planning and Assessment Act 1979* (NSW)). Further, the Standard Instrument Local Environmental Plan requires a Council to 'recognise and accommodate coastal processes and climate change', amongst other requirements, when assessing development in a coastal zone (cl 5.5(1)(b)(iv) of the *Standard Instrument – Principle Local Environmental Plan*).

In New South Wales, Local Government is afforded some protection against claims in relation to land susceptible to certain extreme weather events, including flood liable land, land in coastal zones and land subject to the risk of bushfire, provided that a Council acts in **good faith** in relation to such land.

The protections afforded to Local Government are extensive (found at s 733 in the *Local Government Act 1993* (NSW)), and include exemption from liability in relation to:

- Any failure to upgrade flood mitigation works or coastal management works in response to projected or actual impacts of climate change;
- The provision of information relating to climate change or sea level rise; and

- Anything done or omitted to be done regarding the negligent placement or maintenance by a landowner of temporary coastal protection works.

A Council will be found to have acted in good faith when providing advice, or acting in a particular manner, so long as the Council acted substantially in accordance with any manual in relation to the management of the coastline, of which publication was notified in the Government Gazette.

However, the risk still remains that climate change litigation will be commenced against Local Government by landowners relying on the common law tort of negligence.

Actions that could be brought against Local Government could seek compensation for loss to business as a result of the breakdown of public infrastructure or services, and the devaluation of property prices (see McDonald, J, *A risky climate for decision making: The liability of development authorities for climate change impacts* (2007) 24 EPLJ 405).

THE APPROACH OF THE COURTS

The Courts have generally been slow to uphold climate change adaption or mitigation measures, taking a more conservative approach to protect private property rights.

However, we are slowly starting to see some recognition from the Courts of the importance of climate change in relation to present and future development.

In *Gippsland Coastal Board v South Gippsland Shire Council* [2008] VCAT 1545, the Victorian Civil and Administrative Tribunal ultimately found that climate change will result in extreme weather conditions that exceed historical records, and that increases in the severity of storms and rising sea levels would result in an unacceptable inundation of the subject site.

Gerroa Environment Protection Society Inc v Minister for Planning and Cleary Bros (Bombo) Pty Ltd (No 2) [2008] NSWLEC 254, concerned the extension of an existing sand quarry. The proceedings were brought by an objector (the Gerroa Environmental Protection Society Inc), who objected to the extension as it would have unacceptable impacts on endangered ecological communities located on and adjacent to the area of the quarry extension, and on biodiversity generally in the area. The Land and Environment Court of New South Wales ultimately approved the extension, subject to a number of conditions, including a requirement for a voluntary planning agreement that specifically provided for insurance of the conservation area against the impact of fire or vandalism.

In *Newton and Anor v Great Lakes Council* [2013] NSWLEC 1248, however, the Land and Environment Court of New South Wales found that the imposition of a "time limited development consent", intended to protect against climate change induced sea level rise, imposed to far on private property rights. The condition in question restricted the life of the development consent to a 20 year period, and sixty days prior to the expiry of the consent that "the owner's consultant shall undertake a review of coastal controls, including but not limited to long-term recession and storm erosion, both current and projected at the time."

THE ROLE OF INSURERS

Due to the high cost that climate change induced extreme weather events will inevitably have on the insurance industry, it is likely that the insurance industry will play a key role when it comes to climate change adaption and mitigation action in Australia.

For example, the insurance industry may chose not to insure properties in highly susceptible coastal zones, unless adequate mitigation and adaption measures are put in place, such as requiring new homes to be constructed off the ground, rather than on traditional concrete slabs directly at ground level.

Local Government should be proactive in implementing adequate climate change mitigation and adaption measures, particularly in relation to development in coastal zones, to reduce climate change related property damage, and a subsequent increase in climate change related litigation. However, a fine balance must be drawn so as not to restrict private property rights too significantly.

For further discussion on extreme weather events, see Kieran O'Brien's article on mass tort litigation on page 49.

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