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The forces of globalisation and regulation are making insurance ever more complex.

Our experienced, international team of leading insurance lawyers actively participates in the insurance industry, and from this vantage point we can provide up-to-the-minute commentary and thought leadership on important industry developments.

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

www.insuranceflashlight.com
Floods, earthquakes, tsunamis, nuclear breakdowns, bushfires... in many ways, 2011 was a cruel year. And as always, the insurance industry was in the eye of the storm. For that reason, in this edition of *Insurance Year in Review* we have devoted several articles to the insurance implications of natural disasters - focusing on the official enquiries resulting from the Queensland floods and also on the issues facing insurers when considering policy response in the face of calamities such as the New Zealand earthquakes and the floods in Thailand.

We were proud to work with the Insurance Council of Australia and some major insurers in the Queensland Flood Commission (Commission). Our clients were valiant in the face of onerous demands by the Commission. We will continue to work with our clients as the recommendations from the Commission and the Federal Government’s Natural Disaster Insurance Review are implemented.

It is interesting to watch regulators all over the world beef up their prudential standards for insurers. Europe is looking at Solvency II, New Zealand’s Reserve Bank is about to become the insurance industry’s watchdog and Hong Kong is looking at implementing an independent insurance authority. The Australian insurance industry is used to regulatory oversight and has invested a lot to ensure its organisations comply with the numerous standards and codes in place. Nevertheless, right now our insurer clients are facing more and more regulatory changes in the face of Future of Financial Advice (FOFA) reforms and new prudential standards.

For us it was an exciting year, because on 1 May 2011 DLA Phillips Fox integrated with DLA Piper International LLP to become DLA Piper Australia. As a result of the integration, DLA Piper now has a footprint across 31 countries and 77 offices, accommodating more than 4,200 lawyers. Our Asia Pacific business is comprised of more than 700 lawyers in Australia, mainland China, Hong Kong, Japan, Singapore and Thailand.

A key factor in our decision to integrate with DLA Piper was its commitment to the insurance industry. As one of the six global sectors we have chosen to focus on, the insurance sector provides work and opportunities for well over 400 DLA Piper lawyers across the globe. I am delighted that Australian Partner, Michael Down has been chosen to jointly lead the sector across our Asia Pacific business. In our opening article Michael provides a more extensive overview of the events of 2011.

As many insurance companies look beyond their own backyard for future growth prospects, we would like to take this opportunity to introduce you to our international colleagues. Further information on how they can assist you if the need arises can be found towards the back of this publication.

These are both exciting and challenging times and as always we thank you, our clients, for your loyal support in 2011 and look forward to working with you in 2012 and beyond.

Russell Adams
Joint Head of Litigation & Regulatory, Asia Pacific
T +61 2 9286 8259
russell.adams@dlapiper.com
In terms of natural disasters, 2011 was another terrible year. In Australia, the year started with a continuation of the Queensland floods and in February, Cyclone Yasi hit northern Queensland. February also saw the devastating Christchurch earthquakes and then in March, the catastrophic earthquake and tsunami in Japan, with nearly 20,000 deaths, almost eclipsed everything that had preceded it that year. Then later in the year we witnessed the worst flooding in Thailand for 50 years. Destruction and human suffering was once more on a vast scale.
The Asia Pacific region had the dubious honour of accounting for 80% of the year’s economic losses from natural disasters. According to research by Munich Re, overall worldwide losses from natural disasters for January to September 2011 amounted to US$310 billion, of which US$80 billion were insured. These figures obviously exclude the massive losses from the Thailand flooding in November, with insured losses estimated to be as much as US$13 billion.

The insurance industry inevitably comes under the spotlight in such times. Certainly insurers in Australia came under a lot of scrutiny after the Queensland floods highlighted inconsistencies surrounding the availability of flood cover. Flood cover and definitions of flood have long been thorny issues for insurers, and this in part led to the Natural Disaster Insurance Review and the Queensland Floods Commission of Inquiry. As a result of the recommendations of the Review, flood cover in home building and contents insurance and domestic strata insurance will be mandatory once legislation amending the Insurance Contracts Act 1984 (Cth) (Insurance Contracts Act) passes through both houses of parliament. Extending unfair contract laws to insurance policies is also on the agenda.

Members of the insurance industry continue to be thought leaders when it comes to climate change. Some sceptics continue to assert that the evidence is insufficient, yet it is rare to find such scepticism in the insurance industry. The research and statistics leave little doubt that we are seeing a steady increase in weather catastrophes. This clearly will continue to present the industry with enormous challenges.

I hope you enjoy reading our editor’s interview with Michael Gill. Michael continues to play an important role in the firm, in the local insurance industry and globally in his role as President of the Association Internationale de Droit des Assurances. He makes the surely incontrovertible point that risk management and compensation for natural disasters must be borne by governments, industry and individuals working together and that to point the finger at just one industry, the insurance industry, is unhelpful.

**REGULATORY CHANGE**

The other long awaited amendments to the Insurance Contracts Act, including the electronic transaction reforms, seem to be as far away as ever. First contemplated in 2003, the Bill lapsed in August 2010 and has languished ever since.

Another area of reform contemplated is the harmonisation and improvement of the currently fragmented proportionate liability legislation throughout Australia. The Standing Committee of Attorneys-General is currently reviewing the large number of submissions it received on its draft model proportionate liability provisions. It will be interesting to see what emerges from that process. Some insurers are keenly watching the proposed consumer claim exclusion, which, if implemented, would mean many claims would no longer enjoy the benefits of the proportionate liability regime.

Meanwhile, the regulators, the Australian Securities and Investments Commission and the Australian Prudential Regulation Authority, continued to be very busy keeping insurance companies on their toes in terms of compliance. See Samantha O’Brien’s article on page 22 for a summary of some of the major developments last year and what awaits our clients this year. Change is afoot everywhere in our region - New Zealand is undergoing major changes and further changes can be seen in Hong Kong and Thailand. The European Union is preparing for more regulation of its insurance industry. Known as Solvency II, the new regulations aim to harmonise prudential standards across Europe. This is a massive undertaking so the proposed implementation deadline is 1 January 2014.

**DISABILITY SCHEME**

In August 2011, the Productivity Commission delivered its report to the Federal Government into a long-term disability care and support scheme. The Federal Government is committed in principle to implementing the recommendations and has won rare bipartisan, albeit muted, support for the initiative. We provide a summary of the key recommendations of the report and its implications for the insurance industry on page 48. At a glance, the scheme looks good. If implemented, it will mean catastrophically injured people in dire need of care and support do not have to desperately search for a deep pocket (ie insurer) to get that assistance. The current system places way too much reliance on insurers and leaves many people in need.

**INTERESTING VIEWS FROM THE COURTS**

Directors and Officers (D&O) insurance continues to be fertile ground for ongoing corporate collapses and claims. In the decision ASIC v Healy, “intelligent, experienced, conscientious and honest” directors were found to be liable
because they were found to have over-delegated their responsibilities. Although they faced only mild penalties, the case would give anyone cause to pause when considering accepting a position on the board of a publicly listed company.

Another chilling case for directors was the New Zealand case of Steigrad and others v BCFL Limited and others CIV, colloquially known as the Bridgecorp decision. In that case, a claimant successfully exercised a charge over the entire limit of indemnity, leaving the directors without access to cover for defence costs. That tactic, had it been employed in respect of the D&O cover for HIH and FAI directors, would have meant havoc for all those individuals who were the subject of numerous commissions, inquiries and hearings.

Insurers are enjoying some good “black letter” decisions coming from the courts. We sometimes witness cases not settling at mediation because claimants and their legal representatives fail to allow for reductions for proportionate liability, contributory negligence, causation and foreseeability.

But it can be one step forward, one step back. When the NSW Court of Appeal overturned the decision in Mitchell Morgan Nominees Pty Limited v Vella [2011] NSWCA 390, a solicitor who was initially found liable for 12.5% was suddenly liable for 100% because the fraudsters were not concurrent wrongdoers. Equally disappointing was the decision in Perpetual Trustee Company Ltd v Milanex Pty Ltd (in liquidation) [2011] NSWCA 367, where a mortgage broker did not enjoy the benefits of a contributory negligence finding because the case was pleaded under the Fair Trading Act 1987 (NSW).

Meanwhile, Samantha Kelly’s article on page 29 outlines some good decisions in injury cases. At the risk of sounding self-serving, sometimes insurers need to dig in for the long haul to get the right result. One of my clients did precisely that and instructed me to take one case to the High Court, not once but twice, both times successfully.

**ONE LIME PLACE**

From time to time, business takes me to the Lloyds building at One Lime Place (pictured on page 6). I’m delighted to see the building, which is only 25 years old, has now been awarded Grade I status by the English Heritage because of its exceptional interest and rarity. Only 2.5% of the 375,000 buildings with heritage listing are classified Grade I.

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**THE YEAR AHEAD**

Insurers and brokers will be busy with compliance this year, implementing on-going regulatory reform and amending their policies to reflect the flood changes.

Insurers have already been busy recasting their D&O cover to prevent being caught by a canny claimant exercising a charge over insurance monies, as in Bridgecorp. As always, the insurance industry has responded appropriately in the interests of their insureds.

We look forward to the finalisation of the examination of the impact of unfair terms legislation on insurance contracts, as well as the progress of the amendments to the Insurance Contracts Act and the draft model proportionate liability. There should also be a fair bit of interest in the next stages of the disability scheme.

We remain committed to being a recognised leader in insurance services and have strong insurance practices throughout the Asia Pacific region. We have over 150 lawyers in our Insurance Team in Australia. Many of our team have embraced the world of social media, with the launch in September of Insurance Flashlight, a blog committed to “shining the light on insurance” in the Asia Pacific region. If you haven’t already done so, log on to www.insuranceflashlight.com, where you will find a whole new world of legal commentary on issues affecting the insurance industry with links to articles, cases, legislation and government discussion papers.
The Queensland floods of December 2010 and January 2011 were devastating. At least 35 people died. Approximately 29,000 homes and businesses were inundated. Over 78% of Queensland was declared a disaster zone and over 2.5 million people were affected. The directly referrable financial cost has been estimated at between $5 and $6 billion. The wider economic impact has been estimated at over $30 billion.

Further still, the full impact remains to be seen, including the impact on the Australian insurance industry. Nevertheless, two significant inquiries that considered this issue, in detail, were the Queensland Floods Commission of Inquiry (Commission) (at state level) and the Natural Disaster Insurance Review (Review) (at federal level). DLA Piper had the privilege of acting for the Insurance Council of Australia and a number of insurers in the Commission.

QUEENSLAND FLOODS COMMISSION OF INQUIRY
The Commission was called upon to examine (amongst other things) the performance of private insurers in meeting their claims responsibilities. It is required to issue its final report, which will include reference to these insurance-related matters, by 24 February 2012.

Unlike the Review, the Commission was not called on to examine issues such as the availability of flood cover, disclosure of exclusions, the definition of flood and/or the adequacy of specific policy wordings. In contrast, it focused on the processes by which insurers assessed and decided the outcome of claims, as well as the manner in which insurers handled complaints about their performance. Although selected insurers were taxed heavily in this process, it is a testament to the insurance industry that:

■ While there were in excess of 130,000 claims lodged during the flood and cyclone season, only 11 insureds gave evidence at the Commission of complaints against insurers.
■ While there were hundreds of submissions made to the Commission, there were actually very few complaints regarding insurance.
■ Where it could be proven by call recordings and other records, the evidence often emphasised that insurers acted with compassion and diligence, despite the very significant strains on resourcing investigations and communications during the relevant months.

Nevertheless, although the Commission’s final report and recommendations have not yet been released, a detailed
review of the evidence adduced before the Commission indicates that it is likely to identify areas for improvement by insurers generally. These areas include:

- The documentation to be provided to insureds on declinature
- The explanations to be provided to insureds during internal dispute processes
- The information to be provided to insureds in relation to claims processes
- That time frames be set regarding the determination of claims as a result of a natural disaster (noting that the Insurance Council of Australia has already recommended the Insurance Industry Code of Practice be changed for determinations to be made within four months, except in exceptional circumstances)
- That time frames be set regarding communications with insureds as to the progress of their claims during natural disasters, again necessitating amendments to the General Insurance Code of Practice.

Further pending recommendations in relation to flood mapping regulation and the preparation and collation of hydrology information should also assist insurers to better understand, measure and cost risks.

These recommendations and anticipated legislative and Code changes will impact on the systems and processes used by Australian general insurers in their handling of claims. Obtaining early advice and giving attention to implementing those changes will be prudent.

**NATURAL DISASTER INSURANCE REVIEW**

The Review examined systemic questions as to how disaster insurance should operate. Whilst the Review arose due to various extreme weather events in late 2010 and early 2011 (including storms, cyclones and flooding), its primary stimulus was the absence of flood insurance for many policyholders affected by the Queensland floods.

As anticipated, the availability and affordability of flood cover was very much at the heart of the Review’s final report, which made four “pivotal recommendations” and 47 “specific” recommendations. The pivotal recommendations were:

- **Architecture:** That an agency sponsored by the Federal Government be created to manage the national coordination of flood risk management and to operate a system of premium discounts and a flood risk reinsurance facility, supported by a funding guarantee from the Commonwealth
- **Availability:** That all home insurance, home contents and home unit insurance policies include flood cover
- **Affordability:** That a system of premium discounts be introduced so that most purchasers of home insurance, home contents and home unit insurance policies in areas subject to flood risk are eligible for discounts against the full cost of flood insurance

- **Funding:** That the Federal Government guarantees the payment of claims by ensuring that, whenever a funding shortfall occurs in the reinsurance facility through claims exceeding the funds held in the facility, the Commonwealth would meet the shortfall and seek reimbursement of a portion of the shortfall from the state or territory government in whose jurisdiction the flood occurred.

The 47 specific recommendations included the following:

- Mandatory flood cover in home building and contents insurance and domestic strata insurance, but not that the purchase of insurance be mandatory
- The introduction of a flood insurance premium design and discount regime that will match flood premium with flood risk and provide phased out discounts on flood premium for eligible homes
- Flood insurance for small businesses on an opt-out basis
- By the end of 2014, all home building insurance policies must have a sum insured that is set at full replacement cover in the event of a total loss
- The establishment of a “government-guaranteed” flood risk reinsurance facility, or reinsurance pool, which would have two primary functions:
  - To deliver discounts to home, contents and home unit insurance policies for eligible properties
  - To provide flood reinsurance capacity to the insurance market
- The establishment of a national agency sponsored by the Commonwealth to undertake national coordination of flood risk management and to operate the system of premium discounts and the flood risk reinsurance facility
- That access to insurance be enhanced through the development of alternative payment options, in particular by payments through Centrelink and state, territory and/or local governments and community housing organisations
- The introduction of a standard definition of flood and amendments to the Insurance Contracts Act 1984 (Cth) to require derogation from standard cover by means other than by simply providing a copy of the insurance policy or Product Disclosure Statement
- That the unfair contract terms laws be applied to general insurance
- Changes to the General Insurance Code of Practice, including in relation to the time required to decide claims arising from natural disasters, internal dispute resolutions systems and processes and the appointment to the General Insurance Code Compliance Committee.

In responding to the Review’s final report, the Federal Government accepted (amongst other things) the Review's:
THE YEAR AHEAD

The availability of better flood mapping and other hydrological information will continue to allow more insurers to offer flood cover, although premiums for risks with higher exposure to natural disasters, such as floods, will increase.

Although the examination and assessment of the insurance industry’s response to the Queensland flood events is by no means complete, insurance industry participants will need to give careful and urgent attention to additional obligations and responsibilities that will arise as a result of these inquiries and consequential changes.

Recommendation for a standard definition of flood: namely, the covering of normally dry land by water that has escaped or been released from the normal confines of (a) any lake, or any river, creek or other natural watercourse, whether or not altered or modified; or (b) any reservoir, canal, or dam.

Endorsement of the Federal Government’s proposal for the implementation of a requirement for insurers to provide their customers with a key facts sheet for all home and home contents policies, which clearly sets out, on a single page (as a complement to the existing Product Disclosure Statement), all key information about the features of the policy.

This saw the introduction of the Insurance Contracts Amendment Bill 2011 (Cth), which is yet to be the subject of parliamentary debate.

If they are implemented, the provisions of the Bill and the Review’s recommendations will have a significant impact on the terms and cost of flood cover in the Australian retail insurance market. The Federal Government is therefore continuing to consult with relevant stakeholders, including with respect to those recommendations concerning premium calculation and reinsurance.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE

In addition to the above inquiries, the House of Representatives Standing Committee on Social Policy and Legal Affairs (Committee) is also examining the insurance industry’s response to the Queensland flood events, including the claims processing arrangements and the conduct of external dispute resolution processes.

However, unlike the Review or the Commission, the Committee is focused on the insurance industry’s response to the numerous recent extreme weather events that have occurred around Australia (even as far back as five years ago), whether that be flooding, bushfires, storms, cyclones or otherwise. The Committee’s report is expected to be available once it has been tabled in Federal Parliament, which should occur in early 2012.

Alison Haly
Partner
T +61 7 3246 4091
alison.haly@dlapiper.com

James Morse
Senior Associate
T +61 2 9286 8530
james.morse@dlapiper.com
The second major earthquake in Canterbury in February 2011 was more devastating than the first in September 2010. Although it was of a slightly lesser magnitude, it was shallower and centred nearer the Christchurch CBD. This resulted in loss of life and greater damage than occurred during the September earthquake.

The incidence of two major related loss events in a short period has raised complex insurance coverage issues beyond those arising from each loss alone. This is particularly so for those policyholders who suffered both losses in the same policy year.

**APPLICATION OF DEDUCTIBLES AND AGGREGATE LIMITS**

The application of deductibles and policy limits can be dictated in the policy by whether the events are in a series and arise from the same source or original cause. We have had to obtain expert geotechnical advice from earthquake specialists in order to advise underwriters on this issue.

A further issue has been policy wordings that refer to a single total sum insured across all the insured buildings in the policy wording. Usually, when the cover is written, sums insured have been allocated for each building and the premium has been calculated on this basis. Can these sums insured be relied upon by underwriters when the damage for a particular building exceeds that figure, but is still within the total sum insured stated in the policy?

**REINSTATEMENT OF SUM INSURED**

Many policyholders have discovered they are under-insured. Sometimes this has been deliberate, but often not. One of the interesting aspects of such widespread damage is that sums insured based on replacement cost valuations have proven to be woefully low. The valuations may have been accurate for standalone damage, but prove far from adequate when costs become inflated by the sheer scale of the surrounding damage.

Many policyholders are trying to apply the reinstatement of sum insured condition found in most commercial property policies to obtain a top-up in cover between the September 2010 and February 2011 earthquakes. The standard wording of this condition is difficult to interpret. Just when is the amount by which the sum insured is depleted by the loss “automatically” reinstated? This becomes difficult in instances where no repairs had been started on the damage caused by the September 2010 earthquake before the February 2011 earthquake hit, causing more damage and in many cases, total loss.

**LIQUEFACTION**

One of the unusual aspects of the Christchurch earthquakes was the large amount of liquefaction that occurred, particularly in residential areas.

Many houses suffered minor and reparable damage but the land has sunk and is no longer suitable to support houses. As insurance policies do not insure land, what is the underwriter obliged to pay when the house is reparable but will probably have to be abandoned because the land won’t support it anymore?

**BUSINESS INTERRUPTION**

A multitude of issues have arisen under business interruption policies. The most difficult is whether the policy only covers interruption caused by the damage to the insured building or whether interruption caused by the wider area damage and consequent loss of attraction can be taken into account.

A further issue is whether the cover available under sub-limited extensions can be “stacked”. The widespread nature of the damage often meant more than one extension continued to apply over a period of time. Once one 10% sub-limit was exhausted, can you move on to the next one?

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**Grant McDonald**
Partner
DLA Phillips Fox
T +64 9 300 3896
grant.mcdonald@dlapf.com

DLA Piper has an exclusive alliance with DLA Phillips Fox in New Zealand.
THE YEAR AHEAD

With the seemingly increased incidence of widespread natural disasters in the world, these issues will become more common across a number of jurisdictions. New Zealand may become one of the first jurisdictions where these issues become the subject of judicial determination.
The floods in Thailand in 2011 were the worst for more than 50 years, with the Thai Finance Ministry estimating that the total economic cost of flood damage could exceed US$6 billion. Some in the industry regard this as a severe underestimate.

To date, it is estimated that the flooding in Thailand has cost around US$3.3 billion in insurance claims. Both residential and industrial areas in and around Bangkok have been affected by the flooding, as several large industrial estates have been left without facilities and resources. It is likely that large global businesses will suffer as a result of this disruption.

This article highlights issues that are likely to arise when insurance claims are brought in the wake of the flooding and practices to be considered when deciding whether an insurance policy responds to a claim.

**LIKELY ISSUES ARISING FROM THE FLOODING**

As industrial all risk insurance policies in Thailand generally provide coverage for flood damage (unless specifically excluded), policy interpretation issues are likely to arise.

**Who is the insured?**

Around 15,000 industrial and manufacturing plants have been damaged following the flooding in Thailand. Many factories operated by global businesses have been forced to close and many have found their supply chains disrupted. Insurers will need to clarify who is in fact bringing the claim. Can a manufacturer outside of Thailand bring a claim for reduced production due to disruption to its suppliers in Thailand?

**Reinstatement value clause**

Most insurance policies contain a clause that enables the insured to claim for the replacement of destroyed property with new property. The policy usually provides that damaged property will be repaired to a condition as it was when new. One issue that may cause difficulties for insurers is where the insured intends to relocate its operations overseas. In this case, the insurer will need to consider whether the insured can claim the full reinstatement cost and whether in any event the reinstatement clause allows the insured to relocate to a new location and specifically whether this must be in Thailand.

**Business interruption issues**

Business interruption coverage is designed to compensate the insured for the financial effect of the interruption or interference to that business due to physical damage. The intention is to restore the business to the same financial position as if the loss had not occurred (subject to the terms and conditions of the policy). Business interruption claims are normally linked to material damage and can often lead to the largest, most complex and contentious claims following natural disasters. In part, this is due to the many factors that affect the calculation of loss.

**Deductibles and occurrences**

Deductibles are an effective way of reducing insured losses and the large amount of work involved in settling minor claims. The policy itself is likely to define whether the flooding constitutes one occurrence, which means that one deductible is payable by the insured. The occurrence is likely to be referenced to a time limit (such as a 72-hour clause). The number of occurrences therefore affects the number of deductibles and the amount paid by the insured, insurer or reinsurer. Calculating the number of occurrences and their respective impact can therefore have enormous financial consequences.

**Wider area impact**

Issues may also arise in respect of business interruption claims where damage is sustained both to the insured’s property and the surrounding area. The essential characteristic of a natural disaster is that it causes damage to a wide area. Is an insurer entitled to disregard and exclude the impact of wide-area damage when considering losses arising from the same insured peril? Again, insurers need to look at the specific wording within each policy and consider them on their individual merits.

**LEARNING FROM RECENT NATURAL DISASTERS**

When dealing with flooding insurance claims in Thailand, insurers may want to look to the recent severe natural disasters that have happened across the Asia Pacific region:
earthquakes in New Zealand, flooding in Australia and the earthquake and tsunami in Japan. Such events may provide insurers with useful guidance when considering policy interpretation.

New Zealand
The Canterbury earthquake of February 2011 was the largest single insurance event in the history of New Zealand, with the Insurance Council of New Zealand estimating that the cost of the earthquake was to reach US$10 billion. As New Zealand suffered from three separate earthquakes, the insurance market was faced with the difficult task of quantifying the damage and loss sustained following these three events. As described above, one difficulty faced was the issue of deductibles.

Japan
Following the Tohoku earthquake in Japan and the subsequent tsunami in March, the General Insurance Association of Japan ensured that all insurers used adjusted standard guidelines to enable quick and prompt assessments.

Australia
One issue that insurers faced in Australia following the flooding in Queensland was the policy definition of defined events. Policies may have excluded “flood” while retaining cover for storm damage or other similar concepts. Naturally this resulted in considerable debate in respect of the interpretation and ambiguity in policy wording. Following an independent review of natural disaster insurance, the Australian Federal Government has announced it will introduce regulations standardising flood cover for homes.

THE YEAR AHEAD
Global insurers faced with flooding claims in Thailand may be able to look to the issues and solutions that have arisen in respect of other natural disaster insurance claims during the past few years. Different perspectives and strategies have been used, which can be referred to when deciding on a specific course of action in Thailand. There is no doubt that there are some important insurance lessons that can be learnt from the flooding in Thailand, which has certainly highlighted the need for clarity in insurance policies. Policies may be very different and legal and factual disputes may consequently arise. In any event, as the flooding continues to cause unprecedented damage, it remains to be seen what the full scale and extent of the damage will amount to.

Peter Shelford
Partner and Head of Insurance Asia
T +662 686 8533
peterselford@dlapiper.com

Louise Joyce
Trainee Solicitor
T +44 121 281 3722
louise.joyce@dlapiper.com
Michael Gill is a DLA Piper consultant, having been a partner for almost 40 years. He is one of Australia’s leading insurance lawyers. Michael has previously held the roles of chairman of the firm and managing partner of the Sydney office. In 1980 he was elected the youngest ever president of the New South Wales Law Society, at age 33, and in 1985 was elected president of the Law Council of Australia. Michael has been instrumental in significant initiatives such as LawCover, the Solicitors Mutual Indemnity Fund and the New South Wales Motor Accidents Authority. He is currently the president of the International Insurance Law Association, and the independent chair of the Code Compliance Committee established under the General Insurance Code of Practice. He shared his thoughts on the industry with Kerry Hogan-Ross.
After 38 years as a partner in the Insurance Team at DLA Piper and its predecessors you are now a part-time consultant. You must have some spare time on your hands - are you enjoying playing with your grandchildren, fishing and going to the movies perhaps?

I continue to enjoy almost every aspect of what I do, including playing with the grandchildren. Fishing is no part of it but more movies would be appreciated. Travel remains important, especially overseas. It took me 12 years to work out why I did law and the reason that I came up with was that I had this passion for travel and visiting other places, but more importantly learning as much as I can about other people and cultures.

That may be so, but you are still very busy. What’s on your work agenda these days?

The split is between the law (including DLA Piper), insurance and the not-for-profit sector.

For the firm it’s three days a week on average, which is mainly spent in the area of risk and professional indemnity, helping Tony Holland (DLA Piper Managing Partner; Australia) in his role as a director of the Large Law Firm Group, as well as working with Michelle Milnes (DLA Piper Community Investment Manager) in the Community Investment area and Nicolas Patrick (DLA Piper Head of Corporate Responsibility, International) in the Pro Bono area.

Part of my excitement for 2012 is that I now have an opportunity to spend a couple of weeks with Action Aid in Cambodia on a particular legal project for them. I’m also involved with the Shinta Mani Foundation, which is based in Siem Reap. In my local community, I am deputy chairman of the Board of the James Milson Village, which is a beautiful nursing home and retirement village in Kirribilli, close to where I live.

And you are still on the Code Compliance Committee?

Yes, I’ve been the Independent Chair of the Code Compliance Committee for the General Insurance Industry for 17 years. 2012 may be very interesting - we think we will see a large number of complaints about the handling of claims arising out of the Queensland floods. We’ve not experienced that previously.

You were elected President of the International Insurance Law Association (AIDA) in May last year. Have you combined your knowledge of insurance and your love of travel?

Yes, my presidency of AIDA takes a fair bit of time, but it means I have a great opportunity to work with lawyers and insurers from all around the world. We have two Presidential Council meetings a year and in 2012 they will be in Istanbul in May and London in September. I should mention that the acronym, AIDA is based on its French name, the Association Internationale de Droit des Assurances.

Tell us a bit more about AIDA and its purpose.

AIDA is the peak body worldwide not just for insurance lawyers, but for all with an interest in insurance law. It was set up about 50 years ago. The very wise people who set it up saw the harmonisation of insurance law as being absolutely critical for the future. That view was formed in the context of the emerging European community at the time. The globalisation of major sectors of world activity, not the least of them being insurance, demonstrates the importance of harmonisation of law regionally, and ultimately globally. The Australian Insurance Law Association (AILA) is our national chapter of AIDA. It is one of the best in the world.

What insights have you gained into the global nature of insurance and what challenges the industry faces?

I believe that we are appreciating, increasingly, just how interdependent all things are on this earth. There is no greater example than climate change and the impact it is having on the lives of all of us, as well as the way in which our lives are having an impact on the environment and climate.

The insurance industry, no matter what part of the world it operates in, is now recognising that the risks that it is trying to understand, measure, manage and rate are very often risks that are not just particular to individual countries but, more frequently, are risks that have an international flavour to them.

Quite apart from something as enormous as the environment, we are also living with the worldwide uncertainties of the Eurozone and the impact that failure in that zone may have on the worldwide economy. Of course any failures of that sort have enormous significance for the insurance industry, which underwrites banks and all sorts of other organisations that can suffer enormous loss in the event of a serious economic downturn, wherever in the world it happens.

Is AIDA active in the Asia Pacific region?

There are many active AIDA national chapters in our area, apart from AILA. One of my principal objectives as president of AIDA is the formation of additional national chapters in the Asia Pacific region. We don’t have as many chapters as they have in Europe or South America, for example. Since I became president we’ve worked to resuscitate our chapters in Hong Kong and Taiwan. With great assistance from Singapore, we are planning new chapters in Malaysia and India. We are having discussions Thailand and Vietnam. With the aid of Hong Kong we’ve had our first insurance law conference in the Peoples Republic of China, and are planning a National Chapter there.
There is a huge amount of change going on in those countries. This must present opportunities and challenges to the insurance industry.

As those countries’ economies grow, expand and trend in the direction of first-world status, they are becoming the technological, electronics and manufacturing powerhouses for much of the world. Not only will there be a growth in the number of businesses requiring good insurers to assist them with the management of their risk, we’ll also see the emergence of an ever-growing middle class with all of the wealth and risk that brings with it and the need for insurance in those sectors as well. Indeed, the biggest of those countries are likely to take views about insurance, its regulation and arrangement that may well lead to the biggest changes the industry has ever seen.

In the last 12 to 18 months, the world of insurance has focused on our region in a way we’ve never seen before. Our natural disasters were just enormous: a tsunami and nuclear disaster in Japan, a devastating earthquake with consequential liquefaction problems in New Zealand, unbelievable flooding in Queensland and the worst recorded flooding in Thailand.

Munich Re’s research found that 80% of all economic losses from natural disasters this year came from this region.

Absolutely. You end up with a financial risk to the world’s insurance industry, which really puts Asia Pacific right up there with the worst of the events that have occurred in North America or Europe. For a long time our part of the world was seen to be a comparatively benign area for catastrophes, by world insurance standards. That is no longer the case.

And you believe AIDA is well placed to assist the insurance industry in those countries?

Yes. Whatever role AIDA can play in assisting the regulators, the industry and the insurers in those countries with the creation of and the operation of a really good system of insurance law in its various manifestations, then that will be to the benefit of those countries and the world as a whole. It’s not just about harmonisation, it’s also about good law and good law is something that all areas of human endeavour should have available to them.

Many would think such a comment to be boring to the point of self-serving. Be that as it may, it happens to be correct. Unfortunately, with the many great and urgent challenges faced by the various segments of the economy, good law rarely gets to the top of the agenda of any senior executive.

What challenges does this bring for the industry and for lawyers?

Let me give you three examples. The first one is the ongoing provision of reinsurance for our region.

Secondly, the recent experience of business interruption claims demands a total re-think of that risk type, how it’s insured and how it’s rated.

Thirdly, part of the response to the devastating floods in Queensland has been the total relocation of some householders. Hopefully this is just the beginning of a realisation that too much development has been permitted in inappropriate areas and, for the medium to long term, relocation is the best option for all concerned. Christchurch is another example of this.

This all reinforces the old but sometimes forgotten message that at its worst, risk is not something that can be totally managed by the private sector. When we think about catastrophic worldwide risk, we must acknowledge the need for partnership between government (governments when appropriate) and the private sector. Each must play its appropriate role. At its worst, global risk is something humanity cannot manage. We can’t stop the worst of natural catastrophes. All we can do is be smart about keeping ourselves and our assets out of harm’s way and to be fair and equitable about assisting people to restore their lives. All of that requires very good public policy and sensible cooperation between all stakeholders.

Of course, an example arises from the debate that has occurred in this country so many times about flood definitions and compulsory insurance. They are the micro issues that really underscore this need for a sensible relationship between the public and the private sector. There is no sense at all in representatives of either sector throwing silly aggressive comments at one another. They both have important roles.
What observations would you make about Australian insurance law generally? What do we have to learn from other places and what they might learn from us?

During my years in practice, Australia has been incredibly good at reforming laws that are relevant to the insurance industry. Let me give a few examples.

The Law Reform Commission work in the 1970s and 1980s, which gave rise to the Insurance Contracts Act and the Insurance (Agents and Brokers) Act, was absolutely first class and even today in many areas it represents very useful examples of solutions that other jurisdictions can make use of. We don’t say that what works for Australia should be axiomatically taken up in every other nation in the world, but there is learning experience from Australia that is very valuable. That’s to be seen in the work of the Law Commission in England, Wales and Scotland on one of its current references on insurance contracts law, where Professor Rob Merkin has looked very closely at what we do here.

One example of how much others have to learn is that the former CEO of Aon, Dennis Mahoney made a speech in London in November 2011. He covered a broad range of issues and concluded by saying that the one area he wishes that the industry could solve was in determining whether an insurance broker is the agent of the insured or the insurer! When I read those comments from Dennis, I thought to myself how wise were we all those years ago introducing the Insurance (Agents and Brokers) Act.

In the regulatory area, I think the Australian regulators, the industry and the politicians learnt a lot from the collapse of HIH. I think that the consultancy regime we now have in place can be fairly criticised for being too heavy handed in some areas. For example, I think the role of Product Disclosure Statements has been a costly mistake. But having said that, I think the overall regime that emerged following the collapse of HIH presented for the Australian industry and for its policy holders a far more transparent industry, one in which the community could have more confidence. This is very different to the situation in many other parts of the world. Our legal and regulatory regime enables shareholders, regulators, policy holders and intermediaries to know a lot about insurers without being overly intrusive into areas of commercial confidentiality. I think it’s essentially a good balance, one that other jurisdictions could look at.

The third area that I’ll touch on that I think we undersell in many ways is how brilliantly Australia has done over the last 30 years with the resolution of disputes. This isn’t all good news for the lawyers, and so be it, but if we went back 30 years, most insurance coverage disputes had to find their way through the courts if they didn’t settle.

About 20 years ago the general insurance industry, under very wise leadership, set up what is now the Dispute Resolution System within the Financial Ombudsman Service. Just about every dispute under an insurance policy is resolved within this system. It’s a marvellous system for the consumers and small businesses. Not surprisingly, you hear some complaints about it. But then again we do hear the occasional complaint about courts and lawyers! However, the Dispute Resolution System has delivered an outcome for policy holders that I think is as good as any I have seen anywhere else in the world. Financial and insurance ombudsmen from many countries visit or make enquiries about how our system operates.

In the early 1980s we saw the advent of mediation, which ultimately, at least in New South Wales, became a compulsory part of our court life and probably the most prominent type of alternative dispute resolution in our jurisdiction. We didn’t embrace arbitration in the same way that so many other countries have as the only alternative to a costly and time-consuming court system.

The litigation process is still a core part of what insurers do, defending their insureds or recovering a paid out loss via subrogation. How do you rate Australia’s legal systems?

I think we’ve done well in civil liability reform. It’s not perfect but it’s better than what existed 10 to 20 years ago. The big challenge today is harmonisation between jurisdictions and injury types, especially for bodily injury. We may not be able to achieve complete harmonisation, but there is scope for progress. The rest of the world continues to talk about reforms but seems incapable (particularly in Europe and North America) of moving towards sensible and significant reform.

One big impact on the insurance industry and those that insure is the emergence of litigation funding companies. I am seeing more and more evidence overseas of the emergence of their role. Australia has started to think about their regulation. Other countries are still simply musing about the fact that the old rules of champerty and maintenance should still be in place and that these sorts of things shouldn’t be allowed to happen.

I think in a country like Australia, we do recognise the importance of access to justice. We just don’t pay lip service to it. It’s much more than simply reciting three paragraphs of Magna Carta. We need to think about how the average person can seriously find justice within a legal system and a set of rules that are coming to be ever more complex and even challenge the understanding of lawyers and others who live with them every day of the week.

Michael Gill
Consultant
T +61 2 9286 8419
michael.gill@dlapiper.com

Kerry Hogan-Ross
Consultant
T +61 2 9286 8326
kerry.hogan-ross@dlapiper.com
2011 saw developments in the areas of security of payment claims and contracting out of proportionate liability.

**SECURITY OF PAYMENT CLAIMS – FURTHER GROUNDS TO REVIEW AN ADJUDICATOR’S DETERMINATION**

Jurisdictional error usually occurs when a decision-maker makes a decision outside the limits of his or her functions or powers conferred on them. In the context of the Building and Construction Industry Security of Payment Act 1999 (NSW) (SoP Act), the relevant decision-maker is an adjudicator hearing security of payment applications.

In 2010, the New South Wales Court of Appeal widened the possible grounds of review of an adjudicator’s decision to include jurisdictional error. Previously, jurisdictional error had been ruled out as a ground for reviewing an adjudicator’s decision.

It all started with the High Court’s feisty decision of *Kirk v Industrial Relations Commission of New South Wales* [2010] HCA. That case had nothing to do with building payment claims, but it set the stage for a series of cases contesting adjudicators’ decisions. The High Court ruled that a state’s Supreme Court must retain its power to provide relief in the event of “jurisdictional error” and that any legislation to the contrary is unconstitutional.

Soon after in relation to an adjudication under the SoP Act, the New South Wales Court of Appeal was asked to decide whether an adjudicator’s decision was valid in *Chase Oyster Bar Pty Ltd v Hamo Industries Pty Ltd* [2010] NSWCA 190 (Chase decision). The case concerned time limits under the SoP Act. Hamo Industries had not observed a time limit and Chase argued that the adjudicator therefore had no jurisdiction to hear the security of payment application.

The Court of Appeal agreed with Chase and said that the time limit issue put the matter beyond the jurisdiction of the adjudicator. Therefore, to proceed to hear the matter was a jurisdictional error by the adjudicator and was a ground for review of the decision by the Supreme Court. The case marked a turning point because previously, in *Brodyn Pty Ltd v Davenport* (2004) 61 NSWLR 421, jurisdictional error had been ruled out as a ground for reviewing an adjudicator’s decision.

While the Chase decision indicates that jurisdictional error can be a ground to review an adjudicator’s decision, it is probably not surprising that 2011 has seen a spate of cases that highlight the difficulty in distinguishing between jurisdictional error and non-jurisdictional error and the underlying tension surrounding state Supreme Court interventions into statutory decision-making powers, which are designed to be final.

The way in which the Chase decision has subsequently been applied or distinguished in several cases around Australia demonstrates this difficulty.

In *Thiess Pty Ltd v MCC Mining* [2011] WASC 80, the Supreme Court of Western Australia considered jurisdictional issues arising from the *Construction Contracts Act 2004* (WA) (CC Act). As in the Chase decision, it was argued that as the claim had been made out of time, the adjudicator had no jurisdiction to hear the dispute. However, the adjudicator refused to dismiss the adjudication application. In finding that the failure to bring an application within time was not a jurisdictional fact, the court found that Thiess was entitled to enforce the judgment, effectively upholding the adjudicator’s decision. In particular, the court considered that the conclusion in the Chase decision that it was for the court to determine whether the adjudication application had been made in time does not apply to judicial review of a decision under s 31(2) (a) of the CC Act.

In *Olympia Group v Hansen Yuncken* [2011] NSWSC 165, the adjudicator concluded that he did not have jurisdiction to determine a dispute because the work was performed outside New South Wales. The Supreme Court of New South Wales agreed the adjudicator had no jurisdiction because the contract did not deal with construction work in New South Wales, as required by the SoP Act.
In *H M Australia Holdings v Edelbrand* [2011] NSWSC 604, it was argued that the defendant’s contract was for the coordination of services, not for construction work, and that as such the adjudicator had no jurisdiction. The Supreme Court of New South Wales agreed and held that “the adjudicator made a basic and essential error in proceeding to a determination in the absence of a construction contract”.

In *Perrinepod Pty Ltd v Georgiou Building Pty Ltd* [2011] WASCA 217, the Court of Appeal of Western Australia considered a case where an adjudicator decided not to dismiss an application under the CC Act but to make a determination on its merits. It was argued that the matter was too complex for the adjudicator, but the adjudicator disagreed. The Court of Appeal found that there was no right of review of a decision by an adjudicator not to dismiss an adjudication application and dismissed the appeal. The adjudicator’s decision stood.

In *VK Property Group Pty Ltd and Ors v Conias Properties Pty Ltd and Anor* [2011] QSC 54, the Supreme Court of Queensland had to determine whether an adjudication made under the *Building and Construction Industry Payments Act 2004* (QLD) should be set aside by reason of numerous alleged jurisdictional errors. No jurisdictional errors were found and the application to dismiss the adjudication was dismissed. Again, the adjudicator’s decision stood.

**CONTRACTING OUT OF PROPORTIONATE LIABILITY**

Proportionate liability continues to create difficulties in the construction industry, particularly in jurisdictions such as Tasmania, New South Wales and Western Australia where it is permitted to contract out of proportionate liability legislation. Contracting out of proportionate liability legislation can lead to serious gaps in insurance cover. Proportionate liability law continues to develop and it is timely to revisit a little-heralded case in Tasmania.

In *Aquagenics Pty Ltd v Break O’Day Council* [2010] TASFC 3, the Full Court of the Supreme Court of Tasmania considered whether a principal (Break O’Day) and contractor (Aquagenics) had contracted out of the proportionate liability legislation, even in circumstances where they did not specifically intend to at the time of entering the contract. The contract between the parties provided for arbitration in the event of a dispute. Aquagenics issued court proceedings (since its position was that the contract had been repudiated) and Break O’Day successfully applied for a stay of the court proceedings so that the parties could arbitrate. Aquagenics appealed the stay to the Full Court. Aquagenics argued that the court proceeding should proceed because the claim involved complex questions in relation to proportionate liability of sub-contactors.

The Full Court dismissed the appeal, and held that:

- The parties had contracted out of the proportionate liability legislation, despite there not being any specific exclusion to that effect in the contract.
- There does not need to be an express provision between the parties to abandon a right under the Act, or that it even needs to include a reference to that Act.
- The contract “made provision for each parties’ rights, obligations and liabilities in relation to any matter to which the Civil Liability Act applied”, which is all the Act requires in order to “contract out”.

Having removed the proportionate liability obstacle, the parties were entitled to proceed to arbitration. While there was no need for the court to find whether proportionate liability would apply to arbitration proceedings, it gave a clear message that it was most unlikely. This was primarily based on the presumption that other parties could not be joined to the arbitration.

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**Rohan Bennett**
Partner
Tel +61 3 9274 5143
rohan.bennett@dlapiper.com

**Kristy Cappellotto**
Senior Associate
Tel +61 3 9274 5215
kristy.cappellotto@dlapiper.com

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**THE YEAR AHEAD**

For further commentary on proportionate liability in 2012, see page 26, or visit our blog at www.insuranceflashlight.com.
Australian insurers continue to attract their share, or perhaps more, of regulatory review and change. In this section DLA Piper Partner, Samantha O’Brien explains some of the significant regulatory developments in 2011 affecting the insurance industry.

As you will see below, the regulators in Hong Kong, New Zealand and Thailand are also busy. Read our interview with Michael Gill on page 18, who has mostly positive things to say about the Australian regulatory regime. He also comments on the inevitable rise in regulation in the Asia Pacific region. To keep up to date with regulatory change, log on to our blog www.insuranceflashlight.com where you will find that Samantha O’Brien and lawyers in our Asian offices are regular bloggers on these issues.

**CHANGES TO REGULATION OF INSURANCE CONTRACTS**

Luckily, no-one held their breath when, on 10 September 2003, the Federal Government announced a comprehensive review of the *Insurance Contracts Act 1984* (Cth) (Insurance Contracts Act). Nine years later, the review still hasn’t produced any legislative change.

There was change on the horizon when the *Insurance Contracts Amendment Bill 2010* (Bill) was introduced to the House of Representatives on 17 March 2010. The Bill gave effect to a number of the review panel’s recommendations. In several areas the review panel’s recommended approach was modified to take into account subsequent consultations with stakeholders of the details of the proposed amendments. In particular, the proposed amendments to section 54 were removed. However, the Bill included the much needed electronic transaction reforms.

The Bill passed the House of Representatives, but as a result of the Federal Election in August 2010 it lapsed before it could pass through the Senate.

So what has been the hold up since then?

In addition to the election in 2010, it is likely that matters the subject of ongoing consultation have impacted the timing of the Insurance Contracts Act amendments. These include the unfair terms laws, standard flood definition and key fact sheet reforms.

Flood insurance reforms were inevitably the subject of a number of state and Commonwealth reviews and inquiries in 2011, notably the National Disaster Insurance Review (Review) and the Queensland Floods Commission Inquiry. The flood reforms are discussed in some detail on page 9.

An interesting development to come from the Review was the recommendation to extend the unfair contract terms in Australian Consumer Law and the *Australian Securities and Investments Commission Act 2001* (Cth) (ASIC Act) to insurance contracts. Insurance contracts are not presently “caught” by the unfair contract terms because contracts covered by the Insurance Contracts Act are specifically excluded.

In light of the Review’s recommendations in respect of unfair contract terms, Treasury released a Consultation Draft Regulation Impact Statement, *Unfair terms in insurance contracts* (Impact Statement) on 12 December 2011. The “problem” to be addressed through consultation is expressed in the Impact Statement as “the current imbalance between protections offered under existing regulation of insurance products and that which currently applies to other financial products and services”.

In the Impact Statement, Treasury outlines the options available to ensure that consumers of insurance products and services receive comparable protection to consumers of other financial products and services where the unfair contract terms presently apply. These options include applying the unfair contract terms laws to insurance contracts, either by modifying the ASIC Act or the Insurance Contracts Act, enhancing the current remedies under the Insurance Contracts Act or encouraging self regulation. Status quo remains an option for consideration.

It is anticipated by Treasury that a resolution on these issues will pave the way for the introduction of the other long-awaited Insurance Contracts Act amendments. Based on the time lines mentioned in Impact Statement for the introduction of unfair contract terms, this time line may stretch out to 2013.

**APRA ISSUES NEW PRUDENTIAL STANDARDS**

On 12 September 2011, the Australian Prudential Regulation Authority (APRA) issued four consolidated prudential standards on governance, fitness and propriety, outsourcing and business continuity management to replace 12 existing standards for Authorised Deposit-Taking Institutions, general insurance and life insurance industries. The new standards will take effect from 1 July 2012.
At that time, APRA also issued minor consequential amendments to Prudential Standard GPS 221 Risk Management: Level 2 insurance groups to remove material contained in the consolidated standards.

On 5 October 2011, APRA issued its new refinements to the prudential supervision of general insurance groups, which are mainly consistent with the proposals APRA released in its May 2011 discussion paper.

The new prudential standards effective on 1 December 2011 are Prudential Standard GPS 001 Definitions; Prudential Standard GPS 111 Capital Adequacy: Level 2 Insurance Groups; and Prudential Standard GPS 311 Audit and Actuarial Reporting and Valuation: Level 2 Insurance Groups.

The capital standards no longer require reinsurance assets not meeting governing law requirements in foreign jurisdictions to be deducted. However, APRA expects that Level 2 insurance groups understand and comply with relevant regulatory requirements in jurisdictions in which they operate.

For the purposes of determining the Level 2 insurance groups’ capital base, reserves from equity-settled share-based payments (shares or share options) granted to employees as part of their remuneration package may only be included in reserves if certain conditions in GPS 111 are met.

In assessing the overall capital strength of a Level 2 insurance group, APRA may request that the parent entity provide details of the group’s intra-group exposures, including capital transactions and intra-group guarantees such as details of all intra-group exposures provided by the parent entity to the Level 2 insurance group. APRA may also request details of material exposures between entities controlled by the parent entity.

CHANGE IN THAI BROKERAGE REGULATIONS

New regulations, effective from 1 January 2012, have been introduced by the Thai insurance regulator, the Office of the Insurance Commission. The changes should generally be welcomed by insurance brokerages, particularly the relaxation of foreign investment limits from 25% to 49% and greater flexibility on corporate objectives than had been previously mooted.

However, there are some lingering concerns about the role of foreign executives. The regulations state that “management authority of… insurance brokerage business operation” may only be exercised by the holder of a personal brokerage licence. With those licences typically being held only by Thai nationals, it will be interesting to see how the regulator interprets this. Following preliminary discussions we have had with the regulator, we have recommended to our broker clients that any documentation that could be perceived as relating to an exercise of management authority over the brokerage business operation should, at a minimum, be jointly signed or jointly issued by the holder of a personal brokerage licence as well as existing management (where that existing management does not hold a brokerage licence). A favourable interpretation also suggests that the restriction relates only to the management of the core insurance brokerage business operation; management of peripheral or supplementary operations may not fall within the restriction. It remains to be seen how the regulator will give effect to these provisions in practice and we will be monitoring the position closely.

Some other key points of the regulations include:

- A holder of a corporate insurance brokerage license continues to be deemed a licensed insurance brokerage.
- There is no longer any express requirement that an insurance brokerage issue ordinary shares only.
- Existing and new brokerages must file business plans with the regulator.

Other regulations relate to the banking of premiums, corporate registrations and notification of any change of branch manager or branch executive officer. Suffice to say brokerages in Thailand need to stay alert and ensure compliance during the coming year.

Peter Shelford
Partner and Head of Insurance, Asia
T +662 686 8533
peter.shelford@dlapiper.com

Jonathan Goacher
Consultant
T +662 686 8554
jonathan.goacher@dlapiper.com
FOFA REFORMS CONTINUE

The focus on the reform of the regulation of financial services advice continued in 2011 with the release of draft legislation.

The proposed commencement date of the Federal Government’s Future of Financial Advice (FOFA) reforms is 1 July 2012, however there has been considerable pressure from stakeholders to delay this start date to give the financial services industry more time to comply.

The terms of the draft legislation generally reflect the successful lobbying of the insurance and broking industry in relation to the ban on conflicted remuneration (including volume and profit share arrangements). This ban will not apply to general insurance or life insurance other than certain superannuation fund-related life risk policies.

Focus has turned to the terms of the “best interest” duty set out in the draft legislation and its risk and compliance impact on advice models.

Will such a duty enhance the quality of advice that consumers receive about insurance products or reduce the availability of tailored advice? Will the best interests duty be consistent with, and continue to allow, scaled advice?

On 13 December 2011, ASIC released its plans for publishing regulatory guidance on the impact of the FOFA reforms.

Assuming the FOFA legislation is passed before 1 July 2012, ASIC will release regulatory guidance before 1 July 2012 on, among other things, ASIC’s expectations for meeting the best interests duty, ASIC powers (in particular expanded powers to cancel or suspend an Australian Financial Services (AFS) licence and ban representatives) and, possibly, regulatory guidance on FOFA’s anti-avoidance provisions.

ASIC has anticipated that it will consult directly with stakeholders in early 2012 as well as seeking industry feedback through its usual formal consultation process.

GENERAL INSURANCE TELEPHONE SALES

General insurers and their issuing agents will be amending their call centre scripting to take advantage of Product Disclosure Statement (PDS) relief issued in the form of ASIC class order CO 11/842 on 28 October 2011.

This class order modifies the time for giving a PDS for a general insurance product when a retail client is given a quote for the policy during a solicited telephone call. It does not apply to unsolicited calls, when the anti-hawking rules must be followed.

This modification is required because a quote will, in some circumstances, amount to an invitation to apply for a general insurance product, triggering the obligation to give the PDS at the time the quote is given.

This relief will enable quotes to be provided without the need for a PDS to be given. It will ensure that the quote stage of a telephone sales process can be completed without the provisions of a PDS until after the call (if at all). This will assist product comparison by removing compliance hurdles for “full” quotes, allowing consumers to continue to “shop around” for insurance cover.

Of course, if during any phone call the client proceeds past quote stage to acquire the policy on the call, additional obligations apply to the provisions of the PDS.

ASIC CONSULTS ON SCALING ADVICE

Consumers want advice and insurers want to give it. Insurers have long asked for changes to the law, or guidance from the regulator, to reduce unnecessary legal hurdles to their provision of advice to clients about their own products.

In July 2011, ASIC released Consultation Paper 164 on scaling advice, which will lead to regulatory guidance on this issue. On 13 December 2011, ASIC announced that it aims to release that regulatory guidance before 1 July 2012 as part of the package of FOFA guidance referred to above.

Insurers, like others in financial advisory industries, will need to keep an eye on the FOFA reforms to assess its impact on scalability. However, the consultation paper includes some helpful examples that demonstrate the regulator’s distinction between factual information, general advice and personal advice.

With FOFA pending, the importance of “staying within the lines” is likely to increase.

GENERAL INSURANCE CLAIMS HANDLING

In August 2011, ASIC released Report 245 about its review of general insurance claims handling and dispute resolution processes. The review involved consideration by the regulator of claims handling and Internal Dispute Resolution (IDR) statistics and documents from eight different general insurers, with a focus on key motor vehicle brands and markets. The report card for these insurers, and the industry generally, was good.

ASIC’s high-level findings were “generally positive”. However, ASIC made nine general recommendations that should make their way through, where appropriate, to claims and dispute resolution practices and product disclosure content. These included recommendations about the role of “frontline” (or call centre) staff in claims decision-making, denials in particular, the provision of written responses to clients of complaint decisions made before stepping into the formal IDR stage and improved disclosure of no-claim discount scheme operation.

Samantha O’Brien
Partner
T +61 7 3246 4122
samantha.obrien@dlapiper.com
NEW ZEALAND - INSURANCE (PRUDENTIAL SUPERVISION) ACT 2010

New Zealand insurers have spent much of the past 12 months gearing up for licencing pursuant to the Insurance (Prudential Supervision) Act 2010 (Act). Under that Act, the Reserve Bank of New Zealand is the prudential regulator and supervisor of all insurers carrying on insurance business in New Zealand. It also administers the Act. Numerous insurers have been granted provisional licences with some moving to a full licence. A register is available on the Reserve Bank website, listing insurers that have had licence applications approved. All insurers that carry on business in New Zealand must be provisionally licensed by the Reserve Bank by 7 March 2012 and fully licensed by 7 September 2013. The Reserve Bank has released a number of standards and guidelines under the Act, including:

- Solvency standards
- Policy position paper to accompany the solvency standard for non-life insurance business
- Fit and proper certificate (template for application for a licence and template for licenced insurer)
- Exemption for small insurers guideline
- Carrying on business in a prudent manner guideline
- Fit and proper policy guidelines
- Risk management programme requirements.

HONG KONG’S PROPOSED INDEPENDENT INSURANCE AUTHORITY

In July 2010, the Hong Kong Government issued a consultation paper to gather public views on a proposal for the establishment of an Independent Insurance Authority (IIA). On 24 June 2011, the Government released a further paper setting out the consultation conclusions and enhanced proposals on the proposed establishment of an IIA.

Currently, the insurance industry in Hong Kong is regulated by a government department: the Officer of the Commissioner of Insurance (OCI). In addition, insurance intermediaries (brokers and agents) are supervised and regulated by three Self-Regulatory Organisations (SRO). Insurance intermediary activities conducted by banks are regulated by the Hong Kong Monetary Authority.

The current regulatory regime in Hong Kong has been criticised for not being in-line with international practice (such as in Australia, Singapore and the UK), where financial regulators are independent, both operationally and financially, of government and the industry. The OCI, which has about 90 staff members, has no power to control insurance intermediaries that are regulated by any one of the three SROs. This affects policyholder and public confidence in the sector.

This is where the proposed IIA comes in. Under the proposed new regime, the IIA will be the sole independent authority to regulate the insurance industry, including all insurers, insurance intermediaries, banks and their employees. It will also be the sole authority to set down conduct standards and regulatory requirements. The IIA will also take over the role of the three SROs in relation to the licensing and regulation of insurance intermediaries.

It is envisaged that the proposed IIA will increase protection for policyholders, enhance public confidence in the industry and bring regulations in line with international practices.

It is expected that a Bill will be drafted in early 2012, which will then be submitted to the Legislative Council later in the year. If the Bill is approved, a new IIA may be established in 2013.

Ann Leung
Associate
T +852 2103 0537
ann.leung@dlapiper.com
2011 saw continued judicial consideration of proportionate liability laws, adding to the body of case law that is gradually being developed. Legislative reform occurred in New South Wales and significant steps were taken towards creating more nationally consistent proportionate liability laws.

**PLEADING REQUIREMENTS**

It was already well established that a defence of proportionate liability needs to plead all of the material facts to show that the alleged concurrent wrongdoer has a liability to the claimant. In *Perpetual Trustees Australia Limited v Paladin Wholesale Funding Pty Limited* [2011] FCA 473, the Federal Court considered whether it should be a requirement that the identity of a concurrent wrongdoer should be pleaded in a defence. One of the concurrent wrongdoers was a fraudster. The claimant unsuccessfully applied to strike out this paragraph of the defence. Emmett J doubted that it was necessary for an individual to be identified by name to satisfy the pleading requirements for a proportionate liability defence.

**APPORIIONABLE CLAIMS - THE NEED FOR THE SAME LOSS OR DAMAGE**

The New South Wales Court of Appeal considered this issue and provided guidance on how to determine whether wrongdoers had caused the same loss or damage in *Mitchell Morgan Nominees Pty Limited v Vella* [2011] NSWCA 390. At first instance, Justice Young found that fraudsters who had forged mortgage documents were concurrent wrongdoers together with the lender’s solicitors, who negligently prepared the mortgage documents that did not provide for indefeasibility of title. His Honour held that the fraudsters had an overall liability of 87.5% whereas the solicitors’ liability was apportioned as 12.5% of the lender’s loss.

A five-member bench of the New South Wales Court of Appeal overturned his Honour’s decision on the basis that the fraudsters did not cause the same loss and damage as the solicitors. This meant that whilst the lender’s claim against the solicitors was still an apportionable claim, the fraudsters were not concurrent wrongdoers in respect of it. The solicitors were therefore liable for 100% of the lender’s loss.

In reaching this decision, the Court of Appeal noted there is a well-recognised difference between “damage” (being the personal, proprietary or economic interest that is harmed) and “damages” (being the money sum that is awarded in respect of that harm). Whilst damage can be difficult to identify and characterise in cases of pure economic loss, the Court of Appeal held that, on the facts of the case, the damage caused by the fraudsters comprised of the lenders paying out money (ie advancing the loan funds) when they would not otherwise have done so; whereas the damage caused by the solicitors’ negligence was that the lenders did not have the benefit of security for the money paid out. In reaching its decision, the Court of Appeal approved the Victorian decision of *St George Bank Ltd v Quinerts Pty Ltd* [2009] VSCA 245.

The Court of Appeal’s decision has potentially wide-reaching ramifications, particularly as comments were made as to how to characterise damage suffered in other cases of pure economic loss, and arguably reduces significantly the circumstances in which proportionate liability defences will be available.

**BASIS OF APPORTIONMENT**

Two cases were decided in 2011 that, whilst fact-specific, illustrate the considerations that may be taken into account by the courts when apportioning liability between concurrent wrongdoers. In *Kayteal Pty Ltd v Dignan* [2011] NSWSC 197, Brereton J apportioned 40% of liability for a lender’s losses on a loan transaction between a valuer who significantly undervalued the security property (partly as a result of misidentifying the property); 12.5% to the lender’s solicitors, who ought to have identified issues with the valuation as a result of their title enquiries; and 47.5% to the borrower, whom his Honour found must have known that the valuation (and therefore his statement of assets and liabilities in support of the loan application) was wrong.

In *Perpetual Trustee Company Ltd v Milanex Pty Ltd (in liquidation)* [2011] NSWCA 367 (Milanex decision), the Court of Appeal apportioned 65% of liability to a mortgage broker that engaged in misleading and deceptive conduct in submitting a loan application to a lender and 35% to a solicitor. The solicitor was found to have engaged in misleading and deceptive conduct by representing that he had provided independent legal advice about a loan transaction to the borrower. The fact that the solicitor’s wrongdoing may have had less causative potency (as the borrower could possibly have been pressured into signing a waiver of legal advice) was an important consideration for the court.
Proportionate liability continues to dominate the professional indemnity legal scene in Australia.

SETTLING PROPORTIONATE LIABILITY CLAIMS

Some intricacies associated with settling claims subsequent to proportionate liability laws received further consideration in 2011. In the Milanex decision, the Court of Appeal held that where a concurrent wrongdoer had already paid monies to the claimant, if the amount paid does not exceed the concurrent wrongdoer’s share of liability then credit for that payment is not taken off the damages assessed in total but applied to the concurrent wrongdoer’s share of liability. However, the court held that if the concurrent wrongdoer had paid an amount that exceeded its share of liability, the damages assessed in total must be reduced by the amount of the excess so as to prevent the claimant from obtaining double recovery.

The principle of preventing double compensation was also applied in GEJ & MA Geldard Pty Ltd v Mobbs (No 2) [2011] QSC 33 and GEJ & MA Geldard Pty Ltd v Mobbs (No 3) [2011] QSC 297. In this matter, some parties who were originally defendants to the proceedings resolved the claims against them prior to trial for a sum of money (the settling defendants). The remaining defendants argued at trial that the settling defendants were concurrent wrongdoers and that any liability had to be apportioned between the remaining defendants and the settling defendants. This argument was unsuccessful as the remaining defendants did not call evidence to establish the liability of the settling defendants. The court initially ordered that the remaining defendants pay 100% of the assessed damages as no liability was apportioned to the settling defendants. However, in a subsequent decision, the court held that the settlement amounts paid by the settling defendants must be taken into account to avoid the remaining defendants compensating for a loss for which the claimant had already been partly compensated.

This case, as well as Angas Securities Limited v Valcorp Australia Pty Ltd [2011] FCA 190, serves an important reminder that, regardless of the pleadings, the liability of each alleged concurrent wrongdoer to the claimant must be established at trial for a proportionate liability defence to succeed.

HOME BUILDING ACT CLAIMS

Whether the proportionate liability provisions in the Civil Liability Act 2002 (NSW) (Civil Liability Act) apply to claims for damages for breach of the statutory warranties implied into building contracts pursuant to the Home Building Act 1989 (NSW) (Home Building Act) received further judicial and, subsequently, legislative attention during 2011.

In Owners Corporation Strata Plan 65757 v MJA Group Pty Ltd [2011] NSWCA 236, the New South Wales Court of Appeal doubted, but did not finally determine, that claims for breach of the statutory warranties were subject to the proportionate liability provisions in the Civil Liability Act on the basis that they may not amount to actions for damages arising from a failure to take reasonable care. This case can be contrasted with an earlier decision of Owners Corporation SP 72357 v Dasco Constructions Pty Limited [2010] NSWSC 819, in which Einstein J found that it was at least arguable for the purposes of determining an interlocutory application on pleading issues that a claim for breach of the statutory warranties was an apportionable claim.

The New South Wales Legislature subsequently passed the Home Building Amendment Act 2011 (NSW), which introduced subsection 3A into section 34 of the Civil Liability Act to provide that Part 4 of the Civil Liability Act does not apply to a claim in an action for damages arising from a breach of a statutory warranty pursuant to the Home Building Act. The amendment commenced operation on 25 October 2011 and applies to civil liability arising before its commencement but not so as to affect proceedings commenced prior to that date.
In a significant step towards achieving greater national consistency in proportionate liability legislation in Australia, the Standing Committee of Attorneys-General (SCAG) released consultation draft model proportionate liability provisions together with a regulation impact statement in September 2011. SCAG is now reviewing the public submissions received to consider whether the consultation model laws should be amended.

Some of the key matters contained in the consultation model provisions included the following:

- Apportionable claims are defined to mean claims for economic loss or damage to property in an action for damages arising from a failure to take reasonable care or an action for damages for breach of a statutory prohibition or duty in relation to misleading or deceptive conduct.
- Expanding the definition of concurrent wrongdoers to those who cause “substantial or materially similar loss or damage” and not just the same loss or damage.
- Quite detailed and strict requirements for notifying claimants of potential concurrent wrongdoers and the provision of a discretion allowing courts to order that wrongdoers who fail to comply with the notice requirements are severally liable for any award of damages made.
- Allowing courts to apportion responsibility to non-parties (which would represent a substantial change from existing law in Victoria).
- Excluding consumer claims from proportionate liability laws (under existing laws, only Queensland and the Australian Capital Territory have a similar exclusion). This proposed exclusion is a significant issue and, if the provision is implemented, insurers will lose some of the benefits of proportionate liability they currently enjoy.
- Prohibiting contracting out of the proportionate liability provisions except for contracts above a certain figure (the figures of $5 million and $10 million were raised as possibilities).

**James Berg**
Partner
T +61 2 9286 8193
james.berg@dlapiper.com

**Carolyn Coventry**
Senior Associate
T +61 2 9286 8225
carolyn.coventry@dlapiper.com
MORE TRIPS, LESS STUMBLIES

The year saw a positive trend of courts reverting to a stricter interpretation of civil liability legislation; a development that may give litigants greater certainty regarding the application of the law. There was a decrease in overall filings of initiating processes in all courts, but a notable increase in claims for compensation arising out of public liability incidents.

In New South Wales, the proposed amendments to Part 2A of the Civil Liability Act 2002 (NSW) (CLA), requiring parties to take reasonable steps to resolve disputes before they commence court proceedings, have been postponed for 18 months. The amendments, requiring parties to engage with one another in order to narrow or resolve a dispute before commencing proceedings, have been postponed in order to enable the success of similar provisions commenced in the Federal Court to be monitored.

There were a number of decisions in 2011 of interest to insurers.

VOLUNTARY ASSUMPTION OF RISK

Rockhampton City Council was unsuccessfully sued by a plaintiff rendered quadriplegic after striking his head on the bed of the Fitzroy River following a jump from an improvised rope swing. In Felhaber v Rockhampton City Council [2011] QSC 023, the Queensland Supreme Court found the exercise of reasonable care did not require the defendant council to take the steps the plaintiff submitted as the activity was a voluntary recreational activity, the risk was obvious and the council did not encourage persons to engage in the activity.

It was submitted for the plaintiff that the council should have made a greater response to the activity, for example by removing the tree or erecting signs prohibiting use of the swing. The court did not believe that that particular hazardous place should have been singled out from the significant area of parkland and waterway for which the council was responsible. The court also considered the defence of voluntary assumption of risk and asked “whether there was any compulsion or obligation on the plaintiff to accept the risk, or no opportunity to avoid incurring it”. In finding the answer to be no, the court found the defence made out.

BMX BIKE RIDING A “DANGEROUS RECREATIONAL ACTIVITY”

In Vreman and Morris v Albury City Council [2011] NSWSC 39, the plaintiff alleged the defendant was negligent in painting the concrete surface of a skate park, which allegedly caused the plaintiff to fall from his BMX bike whilst attempting a jump.

The New South Wales Supreme Court considered the application of section 5L of the CLA, whether BMX bike riding was a dangerous recreational activity and whether the plaintiff’s injuries were the materialisation of an obvious risk. In finding for the defendant, the court found that BMX bike riding at the skate park was a dangerous recreational activity and that a reasonable person would have been aware that the slippery surface of the skate park would have increased the risk of injury, and the risk of injury was obvious.

OCCUPIER OF SHOPPING CENTRE NOT LIABLE FOR CLEANER’S INJURY

In Elphick v Westfield Shopping Centre Management Co Pty Ltd [2011] NSWCA 356 (Elphick decision), the Court of Appeal dismissed the appeal brought by Mr Elphick against Westfield as the occupier of his place of employment where he had suffered a work injury. Mr Elphick was employed by All Cleaning & Security Pty Ltd (ACS) as a cleaner at a Westfield shopping centre. The accident occurred in the loading dock when Mr Elphick was removing cardboard boxes from an unstable cage. The terms of the contract between ACS and Westfield were critical in determining the role of each party and whether a duty of care had been breached.

Westfield as occupier was held to have no liability to Mr Elphick because it was not responsible for supervising the system of work put in place by ACS. In accordance with the contract, ACS was responsible for devising, implementing and supervising the system of work. Westfield’s duty of care only extended to taking reasonable care for Mr Elphick’s safety as an entrant upon the premises.

There were a number of decisions in 2011 of interest to insurers.
The Elphick decision also considered the unique legal issue of dual legal representation for one party. ACS was represented by different solicitors in both the District Court and the appeal proceedings. One solicitor defended ACS’ contractual liabilities and the other prosecuted ACS’ workers compensation insurer’s entitlement to recovery of workers compensation payments made to Mr Elphick as a result of his injury.

Even though there are no specific rules permitting or forbidding separate representation, the Court of Appeal emphasised the general rule that insurers cannot have separate representation and a court must grant leave for separate representation to occur. Any assumption that there is an entitlement to separate representation was a “myth... that must be exploded”.

DON’T OVERLOOK SECTION 5B OF THE CLA
The Court of Appeal reaffirmed the importance of addressing the elements of section 5B of the CLA in determining whether there has been a breach of duty of care under the CLA in Bader v Jelic [2011] NSWCA 255. Section 5B provides that a person is not negligent in failing to take precautions against a risk of harm unless the risk was foreseeable, the risk was not insignificant and in the circumstances a reasonable person in the defendant’s position would have taken those precautions.

Mr Jelic, a telecommunications mechanic, visited the Baders’ home to undertake some work. He mistook a glass window for a door, stumbled into it and broke the glass window. The Court of Appeal considered it of significance that no similar accident had occurred in the five years prior to Mr Jelic’s accident. That factor was considered relevant to the question of whether a reasonable person in the Baders’ position would have taken precautions such as pulling the blinds down over the window.

The Court of Appeal also considered that whilst a cautious and observant home owner might have identified a significant risk, that does not mean the reasonable person would necessarily have identified the risk and taken steps to avoid persons like Mr Jelic having an accident. The Court of Appeal also considered that causation would not be proved by Mr Jelic as it was mere speculation as to whether he would not have stumbled on the rug had the blind been down.

AMBIGUOUS AMBULANCE RECORD INADMISSIBLE
In Lithgow City Council v Craig Jackson [2011] HCA 36, the High Court ruled that an ambiguous and obscure note made by an ambulance officer about the cause of an accident was inadmissible. In the early hours of the morning of 18 July 2002, Mr Jackson was found injured and unconscious in a drain in Lithgow. On the northern side of the drain was an unfenced headwall. There were no witnesses and Mr Jackson has no recollection of how he came to be in the drain. The only evidence of what might have occurred was a note contained in the ambulance retrieval record that stated “? fall from 1.5m onto concrete”.

The Court of Appeal had accepted that the ambulance note was evidence of how Mr Jackson came to be in the drain, despite the ambulance officer not being called to give evidence at the trial or provide any information as to how he came to hold that belief.

The council appealed to the High Court on the basis that the ambulance note represented an opinion pursuant to section 76 of the Evidence Act 1995 (NSW) (Evidence Act) in circumstances where the ambulance officer was not an eyewitness to the incident, and therefore inadmissible. The High Court held the note was ambiguous and so shrouded in obscurity it was not possible to find that the note stated an opinion that Mr Jackson fell from the headwall. Further, the note said nothing about what the ambulance officer observed or perceived as to the location of Mr Jackson’s body in relation to the physical features of the location, thereby not overcoming the exception to the hearsay rule in s. 78 of the Evidence Act. The note was held to be inadmissible.

COUNCIL LIABLE FOR DANGEROUS DOG ATTACK
Despite the developments outlined above, there continue to be examples of cases decided in favour of plaintiffs that offer a surprising extension of the duty of care of defendants such as local councils.

An example is the District Court’s decision in the matter of Dylan Kuehne, by his tutor Peter Kuehne v Warren Shire Council [2011] NSWDC 30. Tyra Kuehne, a child, had been mauled to death by dogs in a backyard and a claim for psychiatric injuries was made by Tyra’s brother and father as a result of the circumstances of Tyra’s death.

Prior to the accident, the council had received a number of complaints about dogs roaming and defecating in the streets. However, there was no evidence council had received any complaints about these dogs, and the dogs had only been moved to the backward two weeks before the incident.
The court found that the council had breached its duty of care owed under the Companion Animals Act 1998 (NSW) to make a dangerous dog declaration over the dogs. The provisions of this Act created an obligation on the council to exercise its powers and a reasonable council would have issued a dangerous dog declaration over the dogs. Most surprisingly, the court held that Tyra’s accident would not have occurred if the council had issued the dangerous dog declarations and removed the dogs from the property. The court also accepted that the council’s failure to act caused Tyra’s death and, as a result, the plaintiff’s injuries.

Council’s appeal to the NSW Court of Appeal is listed for hearing in early 2012.

**DUTY TO PREVENT OTHERS DRIVING YOUR DEFECTIVE VEHICLE**

In Harmer v Hare [2011] NSWCA 229, Mr Hare suffered injuries whilst driving Mr Harmer’s car. Mr Harmer had been too intoxicated to drive. The tyres of Mr Harmer’s vehicle were bald and it had also been raining on the day of the accident. Mr Harmer had not told Mr Hare about the state of his vehicle’s tyres. As Mr Hare drove through a roundabout, he lost control of the vehicle and crashed into a telegraph pole, suffering severe injuries as a result. The evidence established that Mr Hare lost control of the vehicle because they tyres were bald.

The Court of Appeal placed the standard of care of owners of defective vehicles high, finding that the duty of care is not simply to warn others of the defect, but also to prevent others from driving the defective vehicle.

In the absence of any reasonable cause to suspect a defect, the driver themselves is not required to ask the owner whether a vehicle they are about to drive is roadworthy.

**THE YEAR AHEAD**

With legislation and the courts taking a greater role in pre-litigation and also pre-hearing steps, we can expect the time between commencement of proceedings and judgment to consistently to decrease. We can also expect more pressure on parties to have cases properly prepared for hearing and penalties for any lapses.

Samantha Kelly
Partner
T +61 2 9286 8032
samantha.kelly@dlapiper.com
Courts are increasingly being asked to decide whether injuries sustained by an employee while engaging in activities seemingly unrelated to their work arose “out of or in the course of the employee’s employment”. These cases are rarely straightforward.
In July 2011, a Federal Government employee's case against the Government was heard before Justice John Nicholas. The employee was suing for compensation after being injured while having sex with a colleague on a work trip. The woman was injured when a glass light fitting came away from the wall above a bed in 2007 and struck her in the face.

The court heard that she was staying in a country town to go to a work meeting the next day and as such, she argued, activities in her hotel room were out of or in the course of her employment.

ComCare, the Federal Government workplace safety body, disagreed and denied her compensation on the grounds that sexual activity was not an ordinary incident of an overnight stay like showering, sleeping or eating. She appealed to the Federal Court.

During the case, the judge commented that the case was “by no means easy” and posed the question - would it be compensable if the woman had been injured in a motel gym on an exercise bike? He has reserved his decision.

In another, rather sadder, case an employee's widow has failed to convince the New South Wales Court of Appeal that she is entitled to claim death benefits compensation pursuant to s25 of the Workers Compensation Act 1987 (NSW) (Act).

On Sunday 15 February 2009, Mr Van Wessem was fatally injured while riding in Sydney's Ku-ring-gai National Park. His wife subsequently claimed death benefits. The issue for determination by the New South Wales Court of Appeal in Van Wessem v Entertainment Outlet Pty Ltd [2011] NSWCA 214 was not only whether the injury was suffered in the course of employment, but also whether the employment concerned was a substantial contributing factor to the injury.

Mr Wessem was the sole working director of the respondent. He had no office or business premises and often worked outside normal working hours, including weekends.

In his judgment, Giles JA described Mr Van Wessem as “an active, sports-loving man who would take his phone with him, and make and receive business calls and SMS communications, whilst cycling, kayaking, going to coffee shops, or wherever else he might be on a given day... he was an avid bicycle rider. He usually rode three times a week into the Ku-ring-gai National Park.” He received messages while riding and would generally return calls when he stopped at the visitors' centre in the park.

However, his employment did not require him to use a bicycle, he did not use the phone during the course of the ride and he would have undertaken the ride irrespective of his work obligations. In other words, there was a high probability of a similar injury occurring, irrespective of his employment, suggesting Van Wessem's employment was not a factor, let alone a significant contributing factor to the injury.

The Court of Appeal found that whilst the injuries may have been sustained in the course of employment, employment was not a substantial contributing factor. The judgment distinguished two other decisions of the New South Wales Court of Appeal: Badawi v Nexon Asia Pacific Ltd t/as Commander Australia Pty Ltd [2009] NSWCA 324 (Badawi); and Da Ros v Qantas Airways Limited [2010] NSWCA 89 (Da Ros).

In Badawi, the worker was visiting the snowfields for work and was injured while skiing. Skiing had nothing to do with the business reason for her trip, but whilst skiing, her supervisor phoned and asked her to return to the resort for business matters. It was on this return trip that she fell and was injured. The court found that the injuries sustained on the snowfields arose in the course of employment and that employment was a substantial contributing factor to them.

In Da Ros, a Qantas flight attendant sustained injuries whilst riding a Qantas flight staff recreation club mountain bike in LA during slip-time. In overturning the decision of the Workers Compensation Commission, the court found that the bicycle accident was an incident to which the applicant was exposed in the course of his employment and to which he would not otherwise have been exposed. It was thus open for the appellant's employment to be considered a substantial contributing factor. The factors that influenced that finding included the fact that the mountain bike belonged to the Qantas flight staff recreation club, the encouragement by Qantas that Mr Da Ros familiarise himself with slip ports (so he can talk to passengers about destinations) and maintain his physical fitness (in the case of an emergency on flight). Thus, employment was a substantial contributing factor to the injuries sustained. The fact that the accident itself was caused by another cyclist did not detract from the fact that employment was a substantial (ie real and of substance) contributing factor.

Ivan Medak
Partner
Tel +61 2 9286 8027
ivan.medak@dlapiper.com

Jenne Tzavaras
Partner
Tel +61 2 9286 8324
jenne.tzavaras@dlapiper.com
This year, the courts have provided clarity in relation to various issues in the context of reinsurance, such as challenging an arbitral award and claiming litigation privilege over documents. However, equally, certain questions have been left open for future consideration. The most interesting of these is whether an insured or reinsured may present losses in a way that maximises the available cover under an insurance programme, which is likely to be the subject of further debate in the future.

**CAN AN INSURED MANIPULATE THE ORDER IN WHICH IT PRESENTS LOSSES TO MAXIMISE THE AVAILABLE COVER?**

In December 2011, the England and Wales Court of Appeal delivered its decision in *Teal Assurance Company Ltd v WR Berkley (Europe) Insurance Ltd & Anor [2011] EWCA Civ 1570*. The case related to the allocation of liability claims against a “tower” of underlying insurance policies and an excess “top and drop” policy. The issue was whether the losses to the insured could be ordered in a way that maximised the cover available to the insured. The reinsurers were successful at first instance and on appeal.

Teal Assurance Company Ltd (Teal) was the captive insurer of Black & Veatch Corporation (BV). Teal and another insurer provided US$60 million of cover (tower), subject to a self-insured retention by BV of US$10 million on any one claim (with an annual aggregate of US$20 million). On top of the tower, Teal issued a further “top and drop” policy to BV with a limit of US$10 million on each and every claim (with no aggregate limit) for liability in excess of the tower (the top layer), which it reinsured with WR Berkley and Aspen (reinsurers). The tower covered both US and non-US claims, but the top layer covered only non-US claims. Liability to pay under the top layer only attached once the insurers of the tower had paid, admitted liability or been held liable to pay the full amount of their indemnity.

A difficulty arose because of the fact that the tower provided worldwide cover, but the top layer excluded US claims. Four large claims were made against BV in the relevant policy period: two in the US and two outside the US. All four claims fell within the scope of the tower, but the US claims were not covered by the top layer. Teal argued that BV can choose the order in which it presents claims to Teal and that Teal can choose the order in which the claims are settled. Reinsurers argued that once the tower is exhausted, the top layer “drops down” to become the primary layer and Teal is liable once a claim against BV is established (by settlement, judgment or award). Therefore, claims must be met in the order in which they are established against BV.

At first instance, the Commercial Court found in favour of reinsurers. This was upheld on appeal. The Court of Appeal preferred reinsurers’ construction and pointed out that it was the commercially sensible construction. The court held that it was clear from the wording that once the indemnity provided by the underlying policies is exhausted, the top layer will “drop down” and become the underlying policy. The insurer under the original underlying policy is liable once claims are established against BV by settlement, judgment or arbitration, and this will continue up the tower. As liability arises when losses are established (not when claims are paid), an insured or reinsured has no ability to manipulate liabilities, except insofar as it is able to hasten or delay settlement of claims or the litigation process, subject of course to the duty of utmost good faith.

**CHALLENGING AN ARBITRAL AWARD**

In the recent decision of *Westport Insurance Corporation v Gordian Runoff Ltd [2011] 281 ALR 593*, the High Court overturned the NSW Court of Appeal’s decision in relation to what constitutes a “manifest error of law” in an arbitral award. The High Court also considered the application of s18(1) of the *Insurance Act 1902* (NSW) (Insurance Act).

The dispute arose out of a reinsurance contracts between Westport Insurance Corporation (reinsurers) and Gordian Runoff Ltd (Gordian), which reinsured Directors and Officers (D&O) liability policies written by Gordian for FAI Insurance Ltd, including a seven-year D&O runoff policy. Under the reinsurance contract, cover was limited to underlying policies with a term not exceeding three years. A number of claims had been made and notified to Gordian within the seven-year period under the D&O runoff policy. All but one of those claims were made and notified within three years. Reinsurers argued that the reinsurance contract did not respond to the claims made on Gordian under the D&O runoff policy because it covered claims made and notified...
within an extended period of seven years, rather than three years, and the risk reinsurers had agreed to cover was limited to underlying policies with a term not exceeding three years. Gordian disputed this and relied upon section 18B of the Insurance Act, which limits the application of exclusion clauses in contracts of insurance.

The dispute was referred to arbitration and the arbitrators found in favour of Gordian on the basis that section 18B of the Insurance Act would apply to the claims made within three years and would thereby preclude reinsurers from denying indemnity to Gordian. Reinsurers successfully appealed to the Supreme Court of New South Wales, but subsequently lost in the Court of Appeal.

Reinsurers were granted leave to appeal to the High Court. Reinsurers submitted to the High Court that there had been a manifest error in law in the failure of the arbitrators to give adequate reasons for their decision regarding section 18B(1) of the Insurance Act and that as such reinsurers should have been given leave to appeal the arbitrators’ award. The majority of the High Court agreed.

The High Court held that as the arbitrators had treated section 18B of the Insurance Act as a critical element in reaching their award, they were obliged to succinctly explain their reasons in relation to the interpretation and application of that complex statutory provision, but failed to do so. It was held that because the arbitrators failed to succinctly explain the reasons for their decision, there was a manifest error of law on the face of the arbitral award, as required by the Commercial Arbitration Act 1984 (NSW).

The court also held that s18B did not apply because the treaties did not exclude or limit the reinsurers' liability to indemnify Gordian, because the FAI policy was for seven years, not three.

This decision provides guidance as to what will be considered a manifest error of law, as well as confirming the importance of arbitrators giving adequate reasons in relation to all aspects of an arbitral award.

LITIGATION PRIVILEGE IN THE CONTEXT OF REINSURANCE

In Axa Seguros SA de CV v Allianz Insurance Plc & Ors [2011] EWHC 268 (Comm), the High Court of England and Wales considered the issue of litigation privilege in the context of reinsurance.

The claimant (Axa) wrote an insurance policy that covered risks of physical damage to certain roads in Mexico. That risk was reinsured with the defendant reinsurers.

In early October 2001, a highway in Mexico was damaged by torrential rainfall caused by a hurricane. The insured notified a claim to Axa under the policy. A loss adjuster was appointed on behalf of Axa and the reinsurers to investigate the loss. In addition, the insured appointed an engineering firm and reinsurers appointed their own engineering firm (Halcrow).

In September 2002, the claim was referred to arbitration and the arbitral award required Axa to pay approximately US$14.8 million to the insured. Axa claimed an indemnity from reinsurers, who denied that they were liable to indemnify Axa. The primary ground for denying indemnity was that it was a condition precedent to coverage under the reinsurance contract that the roads were to be constructed to internationally acceptable standards, and that some or all of the relevant sections of the highway were not constructed to those standards.

Axa then applied to the court for inspection of the Halcrow reports. Reinsurers claimed litigation privilege over the reports. In order for each of Halcrow’s reports to be protected by litigation privilege, reinsurers needed to establish two conditions:

- At the time the document was created, litigation was reasonably in prospect and was not a mere possibility; and
- The document must have been made with either the sole purpose or the dominant purpose of using it for obtaining legal advice about actual or anticipated litigation.

The court considered that there was a reasonable prospect in January 2002 that the Halcrow reports would reveal that the roads were not constructed to an acceptable standard, with the result that reinsurers would reject the claim and litigation would ensue. The court was therefore persuaded that there was a reasonable expectation in January 2002 of litigation between Axa and reinsurers. Importantly, the court stated that the perception of the reinsurer or its lawyers at the time was some guide as to whether there was a reasonable prospect of litigation.

However, the court held that reinsurers had not established that the Halcrow reports were made for the dominant purpose of anticipated litigation between Axa and reinsurers. Rather, Halcrow was instructed for the dual purposes of:

- Assessing whether the highway had been constructed to internationally acceptable standards
- Determining the extent to which any damage had been caused by the hurricane and verifying the correctness of the quantum figures for remedial work.

The court considered that neither of those issues was dominant and that the Halcrow reports were not privileged. This decision shows that it is important for insurers/reinsurers to be aware that where there might be an issue in relation to policy coverage and they wish to obtain their own report that is subject to privilege, they should be careful to avoid obtaining a report for dual purposes rather than only the dominant purpose of obtaining legal advice.

John Goulios
Partner
Tel +65 6512 9517
john.goulios@dlapiper.com

Sarah Fountain
Solicitor
Tel +61 3 9274 5256
sarah.fountain@dlapiper.com
TRADE
AND TRANSPORT
MARINE

2011 was a relatively quiet year in the courts for Australian marine insurers, with no significant decisions to be reported. However, the decision in the UK Supreme Court in Global Process Systems Inc v Syarikat Takaful Malaysia Berhad [2011] UKSC 5 was noted by the local market with considerable interest. That decision further explored the meaning of “inherent vice”, supporting the conclusion in Soya Gmbh v White [1983] 1 Lloyd’s Rep 122. The UK Supreme Court agreed that “inherent vice” meant the risk of deterioration of goods shipped as a result of their natural behaviour in the ordinary course of the contemplated voyage without intervention of any fortuitous accident or casualty. However, the complex judgments overlayed this definition with findings that the “ordinary course of the voyage” did not encompass all weather conditions that the ship could foreseeably encounter and that there should be no limitation applied to the requirement of a fortuitous external accident. The consequence is that loss will not be attributable to inherent vice if there was any fortuitous external causal event.

The litigation over the APL Sydney and the damage it caused to a submarine pipeline in Port Phillip Bay was successfully resolved.

AVIATION

There was more activity in aviation litigation, with the Queensland Court of Appeal reviewing the first instance decision in QBE Insurance (Australia) Limited v Cape York Airlines Pty Ltd [2011] QCA 6. In dismissing the appeal, the court reiterated the requirement that the insurer make a “valid election” to pay for damage to an aircraft or to pay the cost to repair it. However, there was a small amount of good news for the insurer, because the claim for loss of use of the aircraft was reduced as it amounted to a double recovery.

QBE Insurance has also found itself embroiled in an ongoing battle of jurisdictions with litigation in both Australia and the US in relation to claims arising from the 2005 accident at Lockhart River, which killed 13 passengers and two pilots. A limited anti-suit injunction was granted by Bergin CJ in the New South Wales Supreme Court in favour of the insurer in QBE Insurance (Australia) Limited v Hotchin & Ors [2011] NSWSC 68. Bergin CJ found that litigation in Cook County, California, was “unconscionable, vexatious and oppressive”, noting that the choice of law clause in the policy provided for Australian law and the geographical cover of the policy was Australia and surrounding countries.

In Rosengarten v American Airlines Inc [2011] VCA 1535, the Victorian Civil and Administrative Tribunal dismissed an application from a passenger on an American Airlines flight whose baggage was lost. The tribunal itself lacked jurisdiction for the claim as it was not a “court”, as required under Article 33 paragraph 1 of the Montreal Convention 1999.

THE YEAR AHEAD

We expect 2012 to be generally one of “plain sailing” in the marine sector, with no sign of implementation of the long talked about amendments to the Marine Insurance Act 1909 (Cth).

In aviation insurance we continue to keep an eye on the outcome of the review of carriers’ liability and insurance conducted by the Department of Infrastructure, Transport, Regional Development and Local Government.

The issue of whether third-party surface damage insurance should be made mandatory will no doubt be an area of interest to insurers. The preliminary findings of the review suggested that a compulsory third-party scheme should be implemented, although government was seeking additional data from industry before a decision is made on whether to proceed with that proposal.

Andrew Tulloch
Partner
T +61 3 9274 5825
andrew.tulloch@dlapiper.com
GROUNDING OF RENA

The New Zealand maritime scene has been dominated by the grounding of the Rena at Tauranga, by which an environmental oil pollution disaster was threatened, but largely averted. The salvage continues, and only time will tell as to where liabilities lie, but we offer some thoughts on that issue.

Meanwhile, the High Court has provided a useful clarification of the application of domestic legislation relating to the carriage of goods.

The Rena grounded on the Astrolabe reef just outside Tauranga Harbour in the early hours of 5 October 2011. Thankfully nobody died or was injured, and the focus has been on the potential environmental damage from bunker oil, though only about 200 of the 1,300 containers on board have so far been salvaged, and cargo losses will be heavy.

The Hague Visby Rules govern liability between cargo and carrier. On the limited information available so far, arguably the direct cause of the grounding was a navigational error in grounding on the reef. For cargo claims to succeed, the court will have to find on the balance of probabilities that either:

- By want of due diligence, the ship was unseaworthy at the commencement of the voyage (ie in her crew or equipment); or
- The grounding was not a navigational error and no other exception to liability applies.

By contrast, the Crown’s costs of clean-up are recoverable as a debt to the Crown. So all the Crown has to do is justify them as reasonable and make a demand. The New Zealand Government has made much of its intent to hold the owners and also the charterer of the vessel, Mediterranean Shipping Company (MSC) accountable for the cost of cleaning up the oil pollution damage. The costs as at early December 2011 were estimated at NZ$19.5 million.

However, under the Convention of Limitation of Liability for Maritime Claims 1976 as enacted in New Zealand, any liability on the part of the carrier is limited to about NZ$12 million. The 1996 IMO Protocol would have applied a limit of about NZ$28 million, but has not been enacted. In light of this casualty, the Protocol is likely to be enacted as soon as the parliamentary calendar permits, though it is unlikely to apply to the Rena.

If the clean-up costs are subject to limitation, naturally the New Zealand Government will have an eye on recovering as much of this fund as possible, though it may have to share in the fund if cargo interests succeed in a recovery action against the owners and/or MSC.

The Transport Accident Investigation Authority is undertaking an independent investigation into the cause of the accident. It has gathered all the documents and the electronic recordings of events on the bridge of the ship. It is expected to issue its preliminary report shortly. It will be interesting to see how events play out.

Application of the Carriage of Goods Act to export cargo

Domestic carriage in New Zealand is governed by a strict liability regime under the Carriage of Goods Act 1979 (Act). The Act applies a package limit of liability of NZ$1,500, with limited exceptions. As a result, there is little litigation over domestic carriage of goods. However, the New Zealand High Court has clarified how that limitation applies when cargo is ostensibly damaged prior to export, but then also suffers further damage during the international carriage of the goods.

On 7 December 2011, the High Court delivered its decision in GVI Logistics Limited v Goat NZ Limited. Goat NZ Limited instructed GVI to arrange carriage of 648 cartons of goat meat to Japan in a reefer container set at -1.5°C. The freight forwarder, GVI, provided incorrect written directions to Auckland Metro Port (where the cargo was to be loaded on board the vessel) to set the container at +1°C. Metro Port followed the booking instruction and as a result, when the meat arrived in Japan it had deteriorated and the entire consignment was rejected by the receiver. The temperature monitors inside the container showed that the temperature of the meat had increased to +1°C in New Zealand, before the container was loaded on board the vessel.

The High Court considered the meaning of “loss of or damage to” goods under section 9 of the Act and confirmed that section 9(1) was intended to identify and confine liability under the Act to loss or damage occurring in New Zealand.

The court applied the Tasmanian Supreme Court decision in Ranicar & Anor v Frigmobile Pty Ltd [1983] 2 ANZ Insurance Cases 60-525, Green CJ, which defined the phrase “damage to” (in the context of a contract for insurance) as “…a physical alteration or change, not necessarily permanent or irreparable, which impairs the value or usefulness of the thing said to have been damaged”.

In the absence of evidence in this case that the meat had lost its value or functionality while it was in New Zealand and as the change to the temperature setting did not prevent the meat from being exported, GVI had not proved the damage occurred in New Zealand and it was unable to limit its liability under the Act, and so was liable for the exporter’s loss of NZ$108,012.27.

Although somewhat dependent upon its facts, the case is a helpful guide in the prosecution or defence of similar claims.

Neil Beadle
Partner
DLA Phillips Fox
T +64 9 300 3865
neil.beadle@dlapf.com

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A GOOD YEAR FOR MEDICAL INDEMNITY INSURERS

Insurers and underwriters continue to see the Australian medical indemnity market as a positive and profitable marketplace, even though existing underwriters are under competitive premium pressure from aspiring entrants.

Current insurers and aspiring entrants will be encouraged by events of the past year. Firstly, the High Court’s ruling that damages cannot be recovered for the “loss of a chance” has been applied in the District Court of NSW. This is because previously there was good state authority to say damages for loss of a chance were recoverable. This decision will have a positive impact on the balance sheet of insurers.

Secondly, new released claims data confirms that medical indemnity claims are resolved cheaply. 40.1% settled with no payment, 29% for less than $10,000 and 8.8% for between $10,000 and $30,000. These statistics will reinforce to those insurers presently on risk that their claims are well managed. Equally, it will encourage and incentivise insurers wishing to enter the market.

END OF “LOSS OF A CHANCE” (OR IS IT?)

The High Court’s decision in Gett v Tabet [2010] HCA 12 has now settled the question of whether a plaintiff can recover for a “loss of a chance” following a negligent medical mishap. The effect of the High Court ruling is now being felt by those plaintiffs unable to prove that their injury was more probably than not (ie a greater than 50% probability) caused by the medical error. Previously, the uncertainty in the law allowed some plaintiffs to recover even when the probability of the better outcome was less than 50%. In Clothier v Dr Fenn & Greater Southern Area Health Service [2010] NSWDC 96, the District Court of New South applied the High Court’s ruling that a plaintiff will not be able to recover damages for the loss of a chance unless it is proven that a defendant’s negligence more probably than not caused the plaintiff’s injury.

Commentators have questioned whether a plaintiff can still succeed in proving a “loss of a chance” case through contract law, as opposed to the law of negligence. Strictly speaking, the door is not closed on this. That said, the court might be averse to holding a defendant to an entirely different standard simply because a plaintiff pleaded his or her case in contract rather than in negligence.

For now, Australian courts will not award damages for a negligent medical mistake where the negligence simply meant the plaintiff lost a less than 50% chance of a better outcome. The plaintiff must prove on the balance of probabilities (ie a probability of greater than 50%) that the negligence caused the injury complained of.

LIABILITY OF MEDICAL PRACTICE SERVICE COMPANIES

In recent years, there has been a trend towards groups of medical practitioners (usually general practitioners) practising out of the same premises, either individually or in partnership, to enter into agreements with companies for the provision of administrative services. This provides a number of benefits to the practitioner, including shared administrative, office and reception services, accounting and bookkeeping, debt collection and computer systems. Often the medical practitioners have an interest in the practice company.

Traditionally, patients who alleged they had been negligently treated by their general practitioner practising at a clinic have named the general practitioner as the sole defendant. However, the practice company providing services to the clinic is not immune from liability. This is illustrated by the New South Wales Supreme Court decision in CS v Anna Biedrycka [2010] NSWSC 1213. In that case a patient of a medical centre had unprotected sex with the plaintiff (who was not a patient of the medical centre) and transmitted to the plaintiff the HIV virus. The patient consulted a doctor at the medical centre who ordered tests. The tests came back equivocal, with the pathologist suggesting retesting. Two opportunities to notify the patient of the need for retesting were missed:

■ Firstly, the doctor asked the administrative staff at the medical centre to send a letter to the patient advising her of the need to re-attend, but the letter was sent to an old address and did not reach the patient.
■ Secondly, when the patient attended the medical centre to receive the test results the doctor who saw her on the first occasion was unavailable, so she was seen by the next available doctor. That doctor failed to read the note on the patient’s record and told her that her tests were clear. The patient subsequently had unprotected sex with the plaintiff, who contracted HIV.
The plaintiff's case against the doctors was settled. The doctors then sought contribution from the company that provided the administrative services to the medical centre. The doctors argued that by failing to confirm the patient's address the company was in breach of its duty to the plaintiff and in breach of the contract between them.

The court held that the company breached its duty of care by failing to maintain accurate records to ensure effective and timely contact with patients after pathology testing. The administrative staff failed to comply with New South Wales legislation requiring a medical practice to maintain accurate medical records and the medical centre's procedure requiring confirmation of a patient's current contact details. The company was ordered to contribute 40% towards the damages owed to the plaintiff.

The other interesting point of the case was that the plaintiff was not the patient but the person to whom the patient transmitted the HIV virus. It is a timely reminder that the duty owed by medical practitioners and companies providing services to those practitioners is not confined to the patients they treat.

Australia has a sophisticated and competitive insurance market, offering professional indemnity insurance to doctors. However, even though service companies are becoming more prevalent, the insurance market for this risk is less competitive and often restricted to public liability cover. This case suggests that insurers of practice companies should review the policies traditionally offered and consider a broader policy covering more than just public liability.

The decision also provides scope for insurers of medical practitioners to recover losses from practice companies. In this instance, the recovery was confined to the negligence of the company in the manner it delivered administrative services, as was the extent of the services provided by the company. However, the court has previously found a practice company to be responsible for medical errors of a medical practitioner where that practitioner is an employee of the company. On this point, both the agreement and course of dealings between a medical practitioner and a company can be influential in determining where the responsibilities lie. It is important for insurers to be fully informed of the relationship between a medical practitioner and a company providing services to them before agreeing to insure either party.
Of interest are the statistics on the size of settlements. 1,067 of 2,663 finalised claims (40.1%) settled for no payment, 29% for a payment of less than $10,000 and 8.8% for between $10,000 and $30,000. This means that over three-quarters of all claims finalised in the 2007-08 period settled under $30,000. This low settlement figure is difficult to interpret. It might mean that several years after tort reform there are still many small claims being made or were made several years ago and only now being finalised. Alternatively, it might reflect the difficulty and complexity of medical negligence litigation and that the modest settlements reflect the difficulty experienced by plaintiff’s proving negligence and causation. The very large claims that garner a great deal of public attention account for a very small number of all claims made (only 2.6% settled for over $500,000).

Data is available for each of the specialty areas reviewed by AIHW. The clinicians subject to the largest proportion of all finalised claims were gynaecologists (15.7% of all finalised claims) and general practitioners (15.5%). General surgeons and emergency medicine clinicians were responsible for 9.8% and 9.6%, respectively.

THE YEAR AHEAD

The medical indemnity market will remain competitive. There has been no catastrophic event to send chills to the market. The entrenchment of the High Court case of Gett v Tabet [2010] HCA 12 rendered 2011 a good year for containing compensation payouts and its effect will flow on into future years.

The AIHW data for 2007-08 shows that medical negligence claims continue to be settled for relatively modest amounts. There is opportunity for insurers to benefit from the trend of medical practitioners to enter agreements with companies, including for the provision of administrative services. Insurers should be aware of opportunities in this area to provide broad policies to the companies, and the possibility of recovering losses from the companies if the practitioner has been found liable in negligence.

Michael Regos
Partner
T +61 3 9274 5437
michael.regos@dlapiper.com
On 9 December 2011, the High Court granted special leave to Newcrest Mining Ltd to appeal the controversial decision of the Western Australian Court of Appeal in *Thornton v Newcrest Mining Ltd* [2011] WASCA 92.

Michael Thornton alleged he was injured while working at a mine occupied by Newcrest Mining. At first instance, Mr Thornton did not seek damages from Newcrest Mining, instead claiming workers compensation payments from his employer. He later commenced an action against his employer in the District Court of Western Australia. The action was settled by way of a consent judgment against the employer. The employer paid the settlement sum in full and the judgment was discharged. A year later, Mr Thornton commenced a separate and new action against Newcrest Mining and three other defendants in the District Court. In this second action, he claimed damages against the defendants as a result of the same work accident and the same injuries.

Newcrest Mining applied for summary judgment in light of the settlement of the first action. The District Court granted the application on the basis Mr Thornton had already been awarded damages in respect of the same injuries and therefore could not be awarded damages again. When reaching this decision, the District Court also found that at no time prior to the settlement of his claim against his employer did Mr Thornton expressly reserve his rights to pursue a claim against any other tortfeasor.

Mr Thornton appealed this decision to the Court of Appeal. The appeal focused on the interpretation of the *Law Reform (Contributory Negligence and Tortfeasors’ Contribution) Act 1947* (WA) (Law Reform Act), which is designed to preclude plaintiffs from being awarded damages for the same injury in successive actions. The question before the Court of Appeal was whether Mr Thornton had been “awarded” damages in his first action against his employer when the consent to judgment was entered.

The Court of Appeal held that a payment further to a consent judgment was not an award of damages. As such, the court found there was nothing to stop Mr Thornton from bringing his further claim against Newcrest Mining. In doing so, the Western Australian Court of Appeal reached the same conclusion as the New South Wales Court of Appeal in *Nau v Kemp & Associates* [2010] NSWCA 164, which addressed the interpretation of a similar provision in the *Law Reform (Miscellaneous Provisions) Act 1946* (NSW). Newcrest Mining’s appeal to the High Court will be heard in 2012. In the appeal, the High Court will be asked to consider whether the restrictions on recovering damages in multiple actions under the Law Reform Act (and its equivalent legislation in New South Wales, Queensland and the Northern Territory) only apply to damages awarded by a court following a judicial assessment, or if the provisions have broader application and apply to a judgment entered by a court by the consent of the parties. Needless to say, if the decisions of the Western Australian and New South Wales Courts of Appeal are not overturned, parties to litigation will need to give careful consideration to the mode in which actions are resolved prior to trial. This will be particularly relevant to insurers, who may be forced to pay out multiple settlements in successive actions commenced against named insureds and third-party beneficiaries if the first settlement does not extinguish the plaintiff’s right to seek further damages.

*Melissa Joyce*
Special Counsel
T +61 8 6467 6030
melissa.joyce@dlapiper.com
A BRIDGE TOO FAR?

The recent Auckland High Court decision of Steigrad and others v BCFL Limited and others CIV (Bridgecorp decision) has shone the spotlight on the Directors and Officers (D&O) liability policy in both legal and insurance circles. This article considers what this policy is meant to cover, what the legislation intended and the way forward for policies to overcome their deficiencies, as demonstrated by the Bridgecorp decision. The New Zealand decision is of great significance because the charge on the policy that brought about the result is available in New South Wales, the Australian Capital Territory and the Northern Territory.

**EFFECT OF SECTION 9 OF THE LAW REFORM ACT**

Section 9 of New Zealand’s Law Reform Act 1936 (and its counterparts in NSW, the ACT and the NT) is typically relied upon in disputes where the defendant is bankrupt or in liquidation, but held applicable public liability insurance at the relevant time.

Section 9 applies to “… a contract of insurance (that indemnifies) against liability to pay any damages or compensation”. It creates a charge over that policy in favour of the claimant at the date of the alleged wrongdoing by the insured under the policy. This is despite the fact that, at this point in time, neither the liability nor the amount of it has been determined.

Section 9 goes on to say that the charge attaches to all insurance money payable, “…in respect of (the alleged) liability”. The meaning of the words “in respect of” is wide. Clearly damages are payable in respect of the liability. The court in the Bridgecorp decision found defence costs are also caught by those words. This must be so. But for the alleged liability, there would be no defence costs.

A charge can be asserted over any liability policy. Therefore this issue is not limited to D&O and professional indemnity policies. In any claim where a plaintiff suspects inadequate insurance cover, a charge could be asserted over the entire policy limit, leaving an insured without access to defence costs.

The mischief section 9 is addressing is the dilution of the benefit of the liable party’s liability policy amongst other claimants later in time or amongst the insured’s creditors. It is clearly not intended to give those people better rights under the policy than the insured had.
SOLUTION

The reasoning in the Bridgecorp decision was based on the structure of the particular D&O policy in question. There are some details in the judgment about this. They are as follows:

“[7] The Bridgecorp companies have held a directors and officers insurance policy (the “D & O” policy) with QBE, the third defendant, since 1996. The current limit of indemnity under the D & O policy is $20 million. In broad terms, the policy indemnifies the directors in respect of any civil and criminal liability that they might incur as a result of their acts or omissions as directors. It also provides cover in respect of any costs that they might incur in defending civil and criminal proceedings seeking to establish such liability (“defence costs”).

…

[16] “Loss” is defined in cl 2.0 of the policy as:

All sums that the Insured Person becomes legally liable to pay on account of all claims made against the Insured Person for any Wrongful Act to which this insurance applies, including but not limited to Defence Costs.”

(Emphasis added)

It appears from this that the full NZ$20 million sum insured was potentially available for all “loss” and was not divided, in any way, between the legal liability part of the cover and the defence costs part of the cover. By implication, this meant the section 9 charge could attach to the whole $20 million potentially available for legal liability. A by-product of this was that nothing was left for defence costs where that charge exceeded the $20 million sum insured.

Some insurers are already introducing enhancements to their D&O and professional indemnity policies to ensure their insureds do not lose their entitlement to defence costs. There are at least two solutions to this shortcoming in the cover.

Separate contracts

One solution is to divide the liability cover and the defence costs cover into two or more separate, but interrelated, contracts. The cover under the defence costs cover would be triggered by a covered claim under the liability cover. Legal costs for investigations and enquiries may be well another contract, such cover not needing a claim to trigger it.

This will be effective because the section 9 charge can only attach to a contract of insurance that indemnifies against liability to pay damages and compensation. The defence costs policy only indemnifies the insured’s defence costs. Therefore, section 9 cannot apply to it and it remains outside a section 9 charge.

Sums insured in separate “towers” of cover

A second solution is to structure the policy differently so that the entire sum insured for the policy is not potentially available to indemnify against liability to pay damages or compensation. Rather, the sum insured is split into two “towers” of cover. One tower is for liability cover only and the other is for defence costs cover only. It appears the policy in the Bridgecorp decision was not structured this way. This is a critical difference.

The limit fixed between the insurer and the insured for liability will be the liability sum insured tower only. Therefore, reading these two sections together leads to a strong argument that the charge should also be limited to the same amount. Otherwise the insurer becomes liable under the policy (via the charge) for a sum greater than that fixed by the contract, and greater than the insured was ever entitled to. This is clearly contrary to the legislation.

CONCLUSION

Where directors or employees are sued for amounts in excess of the sum insured under their D&O policy, the Bridgecorp decision has revealed a potential deficiency in the cover.

However, this deficiency can be overcome with reasonable ease by structuring the two key covers under the policy in such a way that the section 9 charge can only apply to part of the sum insured available under the policy and not all of it.

This preserves some defence costs cover under the policy for the directors and employees, regardless of the amount for which they are being held liable.

Crossley Gates

Partner
DLA Phillips Fox
T  +64 9 300 3823
crossley.gates@dlapf.com

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D&O DEVELOPMENTS
KEEPING US ON OUR TOES

2011 was another interesting year for directors, officers and their insurers. While the trends identified in recent years continued, some new issues arose both in judicial decisions and regulatory changes. One case, Bridgecorp (see page 43), had underwriters immediately reaching for their pens to enhance existing cover.

The claims environment remained active. In that regard, many long tail claims following the credit crunch and the Global Financial Crisis are still progressing through the system. The various agri-investment class actions are but one example. We have continued to see a rise in employment practices claims against companies and their directors, including for unfair dismissal, harassment and bullying.

The regulatory supervision to which directors are subject continued to increase with the introduction of new legislation and regulations. Regulators are vigilant and willing to investigate and prosecute.

From an insurance perspective, capacity for Directors and Officers (D&O) risks continued to increase and broader cover is being provided at more competitive prices. There have been a number of new entrants into the market.

We have also witnessed the rise and rise of the management liability insurance policy, catering particularly for risks associated with small-to-medium enterprises.

CASES

Two particular cases grabbed the headlines, causing ripples across the industry for their potential impact.

Bridgecorp

Many are still scratching their heads about the New Zealand High Court’s decision in Steigrad & Ors v BFSL 2007 Limited & Ors (Bridgecorp decision), not necessarily because of the decision itself but wondering why it has taken so long for this issue to be raised.

The Bridgecorp decision involved the New Zealand equivalent of Section 6 of the Law Reform (Miscellaneous Provisions) Act 1946 (NSW) (Section 6). The Australian Capital Territory and Northern Territory have similar sections.

Section 6 provides that a statutory charge attaches to insurance moneys payable in respect of a claim, in practice allowing the third-party claimant to sue the insurer directly in the event that the claimant is unable to pursue the insured (eg if the insured is in liquidation).

In the Bridgecorp decision, the relevant D&O insurer was prevented from advancing defence costs to the directors, on the basis that the various Bridgecorp claimants had asserted a charge over all of the available insurance moneys under the D&O policy. On the basis that their potential claims exceeded the available limit under the policy, nothing was available to advance to the directors by way of defence costs.
The Bridgecorp decision is currently being appealed to the New Zealand Supreme Court. Although it has not yet been considered in an Australian court, it has caused significant concern to directors and their insurers. The Bridgecorp decision has far-reaching implications for directors, given the often significant costs required to defend claims or investigations by regulators.

Insurers have moved quickly to develop solutions to “ring fence” defence costs to avoid the potential implications of the Bridgecorp decision. The industry will be watching the New Zealand Supreme Court appeal closely. For further commentary on the Bridgecorp decision, please see Crossley Gates’ article on page 43 or visit our Insurance Flashlight blog at www.insuranceflashlight.com.

Centro decision

ASIC v Healy (Centro decision) is about a company’s financial reporting and the role and responsibilities of directors in relation to that task.

The case concerned the board’s approval of the 2007 financial statements of two companies within the Centro Group. Middleton J found that the financial statements failed to disclose significant matters, in particular:

- Centro Properties Group failed to disclose $1.5 million of short-term liabilities by classifying them as non-current liabilities instead of current.
- Centro Retail Group failed to disclose $500 million of short term liabilities that had been classified as non-current.

The integrity and bona fides of the directors was not in issue and questions of credit did not arise. The central question was the extent to which the directors were entitled to rely on advice given to them by senior managers of the company and its auditors. While Middleton J acknowledged that directors are entitled to rely on others and commented that “there was no suggestion in this proceeding that the reliance on others was not warranted”, he found that directors cannot substitute reliance upon the advice of management for their own attention and examination of an important matter that falls specifically within the board’s responsibilities as with the reporting obligations. They cannot delegate or abdicate that responsibility to others.

In this case, Middleton J found that the directors relied too heavily and, in fact, completely on the processes in place and their advisers.

This case has and will cause many directors and their insurers some concern. While the principles enunciated in the decision are not new, the circumstances of this case served as a stark warning that directors, at the apex of the company’s management structure, have the overarching duty to ensure that a company’s financial records are accurately reported. While many of their responsibilities may be delegated, they cannot completely absolve themselves of their obligations.

Ultimately, the penalties awarded were much lighter than those agitated for by the Australian Securities and Investments Commission (ASIC). In his reasons, Middleton J had regard to the fact that the directors were intelligent, experienced, conscientious and honest.

Other cases

Other cases of note include:

- Smart v Westpac Banking Corporation [2011] FCA 829. This case considered whether the statutory duty of good faith under section 13 of the Insurance Contracts Act 1984 (Cth) extended to an “insured person” under a D&O policy. Jagot J of the Federal Court affirmed that the statutory duty does not extend beyond the parties to the contract.
- Buzzle Operations Pty Limited (in liq) v Apple Computer Australia Pty Limited [2011] NSWCA 109. This case considered circumstances under which a creditor of a company might be a shadow director.
The High Court’s granting of special leave to Andrew Forrest to appeal ASIC’s successful prosecution of him for misleading and deceptive conduct and breaching the disclosure laws in relation to statements about various contracts between his company, Fortescue Metals, and Chinese entities. Together with the James Hardie appeal, which is also likely to be heard in 2012, the High Court will now consider two cases in 2012 that deal with market disclosure issues. This is anticipated to be agenda-setting.

LEGISLATIVE DEVELOPMENTS

Some of the major legislative developments impacting on directors and officers that have been introduced in 2011 include the following.

Australian Consumer Law

The Australian Consumer Law commenced earlier this year, revamping consumer and trade practices law in Australia. This law introduced new liabilities for directors and officers, particularly in relation to consumer protection.

ASIC or the Australian Consumer and Competition Commission will now be able to seek orders disqualifying directors and managers if they breach these consumer protection provisions. They also face significant fines if they are “knowingly concerned” in breaches of the legislation.

The Australian Consumer Law introduces new prohibitions against a company indemnifying a director for pecuniary penalties and legal costs if they are found personally liable for contraventions of consumer protection provisions. Nothing prevents an insurer from indemnifying a director for these penalties and costs.

Harmonisation of occupational health and safety

Progress has also been made in the harmonisation of occupational health and safety laws around Australia, including in New South Wales following the election of the Liberal Government earlier this year. With the exception of Western Australia, laws based on the harmonised Model Law will commence around Australia in early 2012.

While the Model Law removes strict liability for directors, it imposes a new positive due diligence obligation and increased penalties on directors.

Carbon emissions trading scheme

The Federal Government has introduced its carbon emissions trading scheme, which was passed in Federal Parliament in 2011. The Clean Energy Act 2011 (Cth) and associated legislation will commence on 1 July 2012. The scheme will cover emissions from the statutory energy, industrial processing, resources and waste sectors.

For directors, this will introduce new liabilities, along with expanded obligations to comply with their existing duties, such as reasonable care and diligence and their duties around disclosure.

THE YEAR AHEAD

The agenda for directors, officers and their insurers in 2012 is likely to be dominated by the fallout from the sovereign debt crisis in Europe and the impact that could have on the availability of capital worldwide.

It seems unlikely the claims trend will reduce next year, but it remains to be seen whether global events will cause the D&O insurance market to contract and premiums to finally start to rise.

Jacques Jacobs
Senior Associate
T +61 2 9286 8284
jacques.jacobs@dlapiper.com
Many Australians have little understanding of just how fragmented and unfair our current disability care and support system is. Severely disabled people require enormous levels of lifetime care and support. The level of care you receive depends on what state or territory you live in and what caused your disability, leaving many without adequate care, means of transport or appropriate housing. Even those “lucky” enough to have someone to sue face inevitable delays, up-front costs, divergent opinions concerning legal, medical, technical issues and uncertainty of court outcomes, making the process fraught and uncertain.

It was in recognition of these shortcomings that the Federal Government asked the Productivity Commission to report on and make recommendations for a national disability care and support scheme. The Productivity Commission released its final report (Report) into Disability Care and Support in August 2011, which has received in principle bipartisan support, albeit muted.

At whom is the scheme directed?
People with significant disabilities, regardless of how the disability occurred.

Like no-fault compensation?
Not really. It is not a compensation scheme. However, the scheme will provide funding for care and support such as funding for carers, wheelchairs, modifications to homes and respite care.

The Report recommends that primary care and hospital (inpatient and outpatient) based services and medical and pharmaceutical products remain outside the scope of the scheme.

So it doesn’t apply to people with low or moderate disabilities?
Correct.

Who will still be able to sue for personal injury?
Everyone. There is only one common law or statutory right affected by the scheme - it removes the catastrophically injured’s right to sue for their future care and support. All other heads of damage, such as general damages and loss of income, remain intact. People with less severe injuries, who are not eligible for the scheme, will retain their right to sue for care and support costs, along with all of their other existing rights.

So anyone thinking they won’t need liability insurance for personal injury claims has got it wrong?
Absolutely. Brokers and insurers will need to understand the proposals so they can educate their customers of the need to retain liability insurance because we are not going down the New Zealand path, not yet anyway.

What about work-related injuries?
Work injuries will be excluded from the scheme. The existing arrangements are already no-fault and provide periodic payments. As they say, if it ain’t broke...

Claims for care are sometimes the biggest head of damage in large claims. This sounds like good news for insurers.

Yes - the risk for care and support in catastrophic injury claims will transfer from the insurers to the scheme. However, the scheme will in part be premium-funded from the mandatory classes of insurance such as Compulsory Third Party (CTP) and medical indemnity insurance. A less obvious benefit may be that some of the less meritorious claims (in legal terms) may not be brought given that the person’s most important need – long-term care and support – is already being met.

It sounds complicated. How is it going to work?
A lot still needs to be thought out and it will be very costly if or when it is implemented. So it won’t begin to be rolled out until mid-2014.

In fact, the Report recommends that two new national schemes should be introduced - the National Disability Insurance Scheme (NDIS) and the National Injury Insurance Scheme (NIIS). The NDIS will provide care and support cover for all Australians in the event of significant disability (not accident-related).
NDIS would fund long-term care and support for people with significant disabilities. It would be funded by government and overseen by a single agency - the National Disability Insurance Agency. While it would assess and fund care and support, NDIS would not be a care provider.

The NIIS will be a no-fault scheme providing fully funded care and support for all cases of catastrophic injury - such as major brain or spinal cord injuries. NIIS will not be a care provider.

**Why two schemes?**

It has a lot to do with funding. Under the NDIS, care and support for disability arising from non-accident related causes such as physical illness, Downs Syndrome and mental illness will be publicly funded out of consolidated revenue.

However, under the NIIS care and support arising from catastrophic injury will be “premium-funded” from a variety of sources, including CTP premiums, transport levies and surcharges, increase in council rates and contributions from the insurance (including self-insurance) arrangements of hospitals and the medical indemnity premiums of physicians for medical treatment accidents.

Another reason the schemes are separate is that catastrophic injuries such as major brain or spinal cord injuries often require not just lifelong support, but also initial intensive clinical treatment, early interventions and rehabilitation. The NIIS will coordinate these services and support.

**How will it impact on medical indemnity?**

With one exception, care and support for serious medical accidents will be covered by NIIS, however all other components of a medical negligence claim will remain with the medical indemnity insurer.

The exception would be cerebral palsy related to pregnancy or birth. This would be covered by the NDIS, which means children born with severe disabilities, whether or not it is attributed to medical negligence, will be covered by the NDIS. This is because most cerebral palsy is not caused by an “accident” and in circumstances where it may be caused by a medical accident, it can be very difficult to prove.

It is hoped that the removal of the insurance costs associated with the lifetime care and support of cerebral palsy cases will sufficiently outweigh the additional costs associated with the inclusion of no-fault catastrophic injuries. However if premiums increase as a result of the scheme, the Report recommends that any such increases should be gradually phased in. It is further recommended that state and territory governments should fund any gap between premium income and catastrophic medical injury claims.

Regardless, it is recommended that the Federal Government subsidy schemes should continue to safeguard the affordability of medical indemnity cover.

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**Is this the beginning of a no-fault compensation scheme?**

In the long run, possibly. The Report recommends that once the schemes have been operating for a few years, they should be reviewed to see if they should be widened to include less serious disabilities and also cover non-economic and economic loss. But that is a long way off.

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**CASE HISTORY - HOW THE CURRENT SYSTEM “WORKS”**

1984
Birth trauma leads to spastic quadriplegia. Child wholly dependent on single mother for care

2001
Supreme Court proceedings commenced against three defendants. Complex and controversial medical and legal arguments arise. Liability and contribution contested

2004
Mediation fails

2006
Six week hearing in the Supreme Court

2007
Judgment given in favour of all three defendants

2008
Court of Appeal - overturns judgment, all three defendants found liable

2009
High Court refuses leave to appeal and compensation in excess of $7 million paid to plaintiff aged 25 years

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Kerry Hogan-Ross
Consultant
T +61 2 9286 8326
kerry.hogan-ross@dlapiper.com
It has been a turbulent 12 months for insurers operating in the Australian market. The extreme weather events in Queensland in January and February have come at an enormous cost to the private insurance industry. However, litigation by insureds against insurers in relation to these events is yet to reach the courts. In the major coverage cases in 2011, the courts continued to focus on the commercial purpose of the insurance contract. In the main this has favoured insureds.
A TURBULENT YEAR FOR AUSTRALIAN INSURERS

EXCLUSION CLAUSES
In two cases this year, subject exclusion clauses have been read down so as to retain the commercial purpose of the policies.

In Mainstream Aquaculture Pty Ltd v Calliden Insurance Ltd [2011] VSC 286 (Mainstream decision), Mainstream Aquaculture Pty Ltd (Mainstream) conducted a commercial fish breeding business involving the growing and sale of fish and had a business interruption policy with Calliden Insurance Ltd (Calliden). On 26 October 2008, the property experienced a loss of electrical power supply due to the failure of a fuse, which resulted in the death of a large portion of Mainstream’s fish stock. Mainstream claimed under clause three of its policy with Calliden, which provided cover for losses arising from the failure of supply from public utilities.

However, the policy contained an exclusion that stated that “we will not pay for... interruptions or interference to your business arising from loss or damage caused by... mechanical, electrical or electronic breakdown or breakages”. Croft J held that the property damage required to trigger the failure of supply provisions would necessarily be mechanical, electrical or electronic in nature. If the electronic breakdown exclusion operated in such circumstances, it would render the failure of supply cover devoid of meaning and clearly out of line with the “commercial purpose” of the parties. Croft J also held that the fuse could constitute property within the meaning of the policy and that it had sustained damage (damage to the electricity provider was a prerequisite to cover under clause 3), despite it “tripping” as it was designed to.

A similar approach to an exclusion clause was adopted in Major Engineering Pty Ltd v CGU Insurance Ltd [2011] VSCA 226 (Major Engineering decision). Major Engineering Pty Ltd (Major) was initially sued by Timelink Pacific Pty Limited (Timelink). Timelink claimed damages arising out of the failure of two hydraulic cylinders that were supplied by Major and fitted Skandia, a 30-metre ocean racing yacht, owned by Timelink.

After a trial, an appeal, a question being remitted to the trial judge and another appeal, Major was ultimately successful in defending Timelink’s claim. Major subsequently sought indemnity for the costs it incurred, claimed at $1,026,010.55, in defending the litigation pursuant to a costs extension clause contained in a policy of Broadform Liability Insurance issued by CGU Insurance Ltd (CGU). Amongst other things, CGU argued that the professional advice and service exclusion applied.

Bongiorno JJA (with whom and Hansen JJA and Kyrou AJA agreed) held that, as a commercial contract, a policy of insurance should be given a business-like interpretation, with attention being paid to the language used by the parties, the commercial circumstances that the document addresses and the objects that it is intended to secure.

With respect to exclusion 19(a), Bongiorno JJA found that Major was not providing a professional service, much less professional advice. It was simply operating its business, as defined (ie the design, manufacture and sale of general engineering and hydraulic equipment). To construe otherwise would be repugnant to the commercial efficacy of the policy. Accordingly, Bongiorno JJA upheld Major’s appeal, set aside the trial judge’s decision and entered judgment for Major for the declaration sought and the agreed sum.

COMMUNICATION WITH INSUREDS
Imprecise and incomplete communications between a broker and an insurer has led to an insurer being found on risk even though, as the judge observed, “no policy was prepared; no invoice was sent; no premium was paid”.

In the Victorian Supreme Court decision of Leading Synthetics Pty Ltd v Adroit Insurance Group Pty Ltd & Anor [2011] VSC 467, Leading Synthetics Pty Ltd (Leading) instructed its broker, Austbrokers, to obtain a policy against the risk that one of its customers, Signum, might fail to pay under its trading account. By 28 April 2008, the broker and the insurer had negotiated all essential terms. Specifically, in its email of 28 April 2008, Artadius sought confirmation from the broker that the policy commencement date was 1 April 2008. Austbrokers replied that the date was acceptable.

A few days prior to 28 April 2008, Artadius sent an “indication of terms” document, expressed to be “without commitment on the part of Artadius until such time we provide you with written confirmation that we are on risk for your transaction and agree to issue a policy”. Artadius argued that the email exchange of 28 April 2008 did not constitute written confirmation that it was on risk.

On 5 May 2008, the broker emailed Artadius about various risks it was then placing for Leading and noted that the cover for the Signum risk was “placed awaiting outcome on others prior to processing”. The email sought Artadius’ confirmation of that but when Artadius replied, it did not address the Signum risk. There matters lay until November 2008, when warnings of Signum’s impending failure rose.

The only issue in dispute was whether there was an intention to create legal relations.

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Macaulay J found that while Atradius had conveyed that it did not wish to be bound by contract until it confirmed such in writing, he did not believe the written confirmation had to be in any particular form of words. For other credit risk covers, Atradius had used language to confirm when it was on risk, such as “the policy set to live” or “cover commences”. In considering all the circumstances including the sense of urgency that characterised the final stage of negotiation, his Honour found that Atradius’ email of 28 April 2008 referring to a commencement date of 1 April 2008 constituted the insurer’s advice that risk had commenced. The court found that even if there had been no policy in place, Atradius was estopped from denying that such a contract of insurance had been entered into because it had induced the assumption that insurance had been placed.

Atradius also argued that Leading’s failure to disclose Signum’s worsening payment record was a material non-disclosure, however that argument was rejected. Therefore, despite the insurer issuing no policy, no invoice and no premium being paid, Atradius was ordered to pay the insured loss of $720,000.

Herde v Oxford Aviation Academy (Australia) Pty Ltd [2011] NSWCA 385 is of relevance to insurers who might sometimes fail to consult with their insured about the terms on which they settle subrogated claims. Oxford Aviation Academy (Australia) Pty Ltd (Oxford) was the owner of an aircraft that crashed on a test flight, fatally injuring the pilot and significantly damaging a plane owned by the plaintiff. The plaintiff’s insurer, QBE, settled its claim against the defendant’s insurer, Hemisphere, for damage to the plane in the amount of $73,408 under the terms of a release. Oxford was a releasee, however any liability the pilot may have was not considered. This would not normally have been a problem, but Hemisphere was unable to pay QBE and QBE therefore obtained summary judgment directly against Oxford for the $73,408 owing to it.

Oxford appealed, arguing that the trial judge had incorrectly entered summary judgment. The sole issue on appeal was whether the defendant’s insurer had authority to enter into the release on his behalf.

In the appeal, the plaintiff relied upon clause five of the Hemisphere policy, which stated:

“The company shall be entitled… to take absolute control of all negotiations and proceedings and in the name of the Insured to settle, defend or pursue any claim”.

Despite the meaning and effect of that clause being clear, Giles JA held that “it cannot be said that clause five is so obvious a source of authority that the judge came to the correct result”. Giles JA held that Hemisphere’s failure to investigate whether the defendant or the pilot had both incurred liability for the damage suffered by the plaintiff potentially demonstrated conduct not taken in the common interest of the insurer and insured and therefore arguably not on the authority given by the defendant to Hemisphere.

NON-DISCLOSURE AND FRAUDULENT MISREPRESENTATION

In Moore v The National Mutual Life Association of Australia Limited [2011] NSWSC 411, Dr Moore commenced proceedings against The National Mutual Life Association of Australia Limited (National Mutual), claiming benefits he did not receive between 2002 to age 65 pursuant to a policy of life insurance he obtained from National Mutual. National Mutual cross-claimed against Dr Moore, seeking to avoid the contract for fraudulent misrepresentations and non-disclosure and sought repayment of amounts it did pay to Dr Moore between 1995 and 2002.

At the time the insurance application form was completed, Dr Moore represented that:

- He was a self-employed psychiatrist
- His annual income was $90,000
- He had never received advice or treatment for a mental disorder
- He had not used or injected himself with any drug not prescribed by a doctor.

In fact, Dr Moore was a psychiatric registrar earning only $52,000 (at the time) with a long history of depression and intravenous injection of pethidine. He had been suspended from the register of medical practitioners in Tasmania, discharged from the Australian Army for misappropriating pethidine reserves and charged on two occasions in connection with the use of pethidine.

Ball J found that Dr. Moore was guilty of each of the misrepresentations and that the misrepresentations were made “with the intention that they be acted upon in the knowledge they were false” and therefore fraudulently. He held that pursuant to section 29 of the Insurance Contracts Act 1984 (Cth), National Mutual was entitled to avoid the contract.
As to whether National Mutual had affirmed the contract, Ball J noted that Dr Moore had to prove that National Mutual made an unequivocal election between inconsistent rights, which was communicated to Dr Moore and made with knowledge of all relevant facts. Ball J held that the mere payment of benefits with some knowledge of Dr Moore’s drug use and depression was insufficient in that regard. However, he did hold that given Dr Moore would have mitigated his living expenses or tried to obtain alternative employment had the benefits not been paid, he had “altered his position” and that it would be unjust to require him to refund the payments.

The claim and cross-claim were dismissed.

CONCLUSION

The commercial approach of the courts to the interpretation of exclusion clauses, as was demonstrated in the Mainstream and Major Engineering decisions, will often result in an interpretation that is favourable to the insured. However, when an exclusion clause is unambiguous and in line with the commercial purpose of the insurance contract, the courts seem prepared to strictly apply the exclusion against the insured. Insurers should be aware of these decisions when drafting exclusions clauses.

Robert Crittenden
Partner
T +61 2 9286 8151
robert.crittenden@dlapiper.com

Travis Luk
Solicitor
T +61 2 9286 8361
travis.luk@dlapiper.com
The average number of defamation cases in the High Court is usually only one per year. The contender for 2011 was *Cush v Dillon* [2011] 279 ALR 631. This case was rather unremarkable in terms of public interest and concerned false rumours of an affair within the workplace. The respondent, Mrs Dillon informed the chairman of the board of a water catchment management authority (Authority) that it was common knowledge that the General Manager, Ms Cush was having an affair with one of the board members, Mr Boland.

In fact, this was false and Mrs Dillon did not believe it to be true when she told the chairman. The question for determination was whether the communication to the chairman was protected by qualified privilege and whether the statement concerning the affair was relevant to such an occasion.

The Court of Appeal found that the communication was made on a privileged occasion on the basis that Mrs Dillon was raising concerns about the nature of a relationship between a member of the board and an employee in the context of a complaint about the Authority’s grievance process. This finding was not challenged. The appellant’s argument was that saying that the affair was common knowledge within the organisation made the statement extraneous to - and therefore not relevant to - the privileged occasion.

There are limits to what may be said on an occasion of qualified privilege, the test being the connection between the statement and the subject matter under privilege. It was held that Mrs Dillon had a duty to make the communication, which included communication of the existence of the rumour, which was therefore connected to the occasion of qualified privilege.

A claim for malice was made to defeat the qualified privilege defence. However, both the Court of Appeal and High Court held that in the circumstances it was not appropriate for the appeal courts to evaluate the evidence of Mrs Dillon on this issue. Therefore the matter was remitted to a new trial restricted to the issue of malice. Given the costs already expended, it may well be that this matter will be settled rather than go through another round of litigation.

Two cases have already been lined up for hearing in the High Court in early 2012. The first is *Trad v Harbour Radio* [2011] NSWCA 61, which concerns a derivative of the defence of qualified privilege known as “reply to attack”. This defence enables a person to reply to an attack within the same medium as the attack itself and be protected by qualified privilege (even where the attack was in a newspaper published to the world). In 2005, at a rally following the Cronulla riots, Mr Trad made a speech attacking Radio 2GB, claiming that it was whipping up fears and that it was racist. Radio 2GB responded to this attack and Mr Trad sued for defamation. A number of imputations were found to be conveyed, including that Mr Trad incites people to commit acts of violence and to have racist attitudes.
At first instance, the trial judge found a number of imputations were true or contextually true, or made by way of comment, and that the whole publication was made under qualified privilege without malice. The Court of Appeal overturned that decision with respect to truth, contextual truth and comment. With regard to qualified privilege, the court upheld the defence partially for five of the eight imputations and remitted the matter for assessment of damages in respect of those three imputations only.

The issues for the High Court will be firstly, whether a reply to attack must be proportional to the attack itself (in Penton v Calwell [1945] 70 CLR 219 the High Court said that the law permits a vigorous and aggressive response including one that impugns the general veracity of the attacker); and secondly, where an imputation invites a value judgment (here that the plaintiff was a disgraceful individual), is the test one of general community standards adopted by hypothetical right-thinking members of the community, or some other test?

The second case is Papaconstantinos v Holmes a Court [2011] NSWCA 59. This was a decision of a full bench of five judges of the NSW Court of Appeal. An issue had arisen as to whether a number of previous Court of Appeal decisions had to be overruled, and so a full bench was convened. The issue was whether a proposition put forward by McHugh J as part of a dissenting judgment in Bashford v Information Australia [2004] 218 CLR 366 was correct in law. That proposition was that where a communication is voluntary (in the sense that it was not made under a duty or in response to a request for information), then ordinarily it will not be privileged unless there was a pressing need at the time to make it. The Court of Appeal held unanimously that this proposition did not reflect the law and should not have been followed by the trial judge.

Finally, there were also a number of damages awards worthy of mention:

- Shandil v Sharma [2011] NSWDC 273 – an allegation that the plaintiff, a school teacher in Hindi language studies, forged the signatures of two teachers on certain forms, when in fact those teachers gave him permission to sign on their behalf. $80,000 in damages, including $20,000 for three republications of the libel.
- Higgins v Sinclair [2011] NSWSC 163 – allegations that the plaintiffs’ invention (an electrical conductor system) was unsafe and that the plaintiff had stolen the intellectual property from the defendant. The unrepresented defendant failed on a truth defence. $100,000 in damages to each of the two plaintiffs.
- Cantwell v Sinclair [2011] NSWSC 1244 – an allegation that the plaintiff, an employee of a dragon boat racing association, misused her position to block the defendant’s attempt to move up the grades as an international umpire and appointed her female friends in key positions. The defendant sent two defamatory emails to as many people as he could throughout Australia who were involved in the sport. $75,000 including aggravated damages.

- Bui v Phung [2011] QDC 239 – a dispute about fund-raising for the repair of a flagpole outside premises belonging to the Vietnamese Community of Australia, where the plaintiff was accused of being deceitful and untrustworthy. $20,000 damages were awarded.

THE YEAR AHEAD

It has been four years since the introduction of national defamation laws and overall it seems the objectives remain valid. With the increased reliance on social media, we can expect the defamation laws to be used more frequently and the provisions of the 2005 legislation fully tested. The key message for persons and organisations engaged in social networking is to remember their remarks are subject to the same legal requirements as any other media and the ease of posting comments, even if thought to be anonymous, will most likely generate an increase in online defamation claims.

Samantha Kelly
Partner
T +61 2 9286 8032
samantha.kelly@dlapiper.com
The depth of our insurance sector knowledge combined with our strength in the corporate and commercial areas means that we are uniquely positioned to provide the full range of legal services. In Australia, we provide solutions in a broad range of areas.

AVIATION
We have significant experience in this area and provide the following services to our aviation clients: air transport regulation; industrial relations; airport; and aviation insurance and litigation.

CONTRACT WORKS
We have considerable experience in handling claims involving contract works insurance policies and have advised both insurer and insured clients, head contractors and subcontractors. Such building-related contracts require careful consideration of indemnities and insurance clauses and a proper analysis of the entities indemnified by a contract works policy.

CORPORATE/REGULATORY
Our full range of services includes applications for approval to operate insurance businesses, ongoing licensing and implementation issues including product disclosure statements, transferring portfolios, industry regulation by the Australian Prudential Regulatory Authority and the Australian Securities and Investments Commission, reinsurance issues and distribution of products through intermediaries.

DEFAMATION AND CONTEMPT
Our services in this area range from pre-publication review and advice through to acting for plaintiffs and defendants in litigated matters. We provide pre-publication review and advice to most major book publishers in Australia, which includes contempt as well as defamation issues.

DIRECTORS AND OFFICERS (D&O)
Our lawyers have been acting and advising on D&O insurance issues across Australasia since D&O insurance first appeared in Australia in the 1970s. We have drafted a number of D&O policies and advised on the impact to insurers of legislative implications and recent corporate governance legislation.

EMPLOYMENT LAW
We have a strong understanding of the responsibilities and obligations of employment law, including unfair dismissals and discrimination claims. We provide comprehensive legal representation to employers, insurers and self-insurers and are the preferred solicitors for a large number of employers in the government, hospital and private sectors.

GENERAL POLICY WORK
We have extensive experience in advising clients on risk management and risk allocation. This includes the structuring and implementation of appropriate insurance. We often advise and draft policy wordings and other policy documents and consider the most appropriate insurance to meet the client’s risks.

INDUSTRIAL SPECIAL RISKS
Our lawyers are experienced in all classes of property-related claims, including industrial special risks. The claims have involved coverage disputes, double insurance, claims quantification issues and recovery actions.

INTERNATIONAL TRADE
We are experienced in all areas of international trade law and are backed by a global network of trade lawyers. We have expertise in areas of customs and quarantine, the sale of goods and trading terms, transport and logistics, security and payment, regulation and international conventions.

MARINE
We are recognised internationally for our expertise in all areas of law affecting the marine sector. Our marine industry clients include marine cargo, hull and liability insurers and brokers, vessel operators and owners, carriers and forwarders, terminal and port operators, government agencies involved in the regulation or the purchase of maritime transport services, importers and exporters.
MOTOR
We are regularly retained to advise on interpretation of motor vehicle policies by a range of general insurers in the context of the Insurance Contracts Act 1984 (Cth), which limits the liability of an insurer to rely on exclusion clauses. Such exclusions must be considered very carefully.

PRODUCT LIABILITY
We have extensive experience in the handling of claims under product recall policies and product liability policies. Many of these claims involve difficult issues of loss and damage as well as complex technical matters. We also have particular expertise in the area of the attachment of the loss (“the happening of the occurrence”) and the operation of the various interlocking exclusions to cover customarily found in these policies.

PROFESSIONAL INDEMNITY
We have a team of leading professional indemnity practitioners across a wide range of professions. Our expertise includes claims defence, coverage advice and disputes, and risk management.

PROPERTY
We have a long history of providing advice to our insurance clients in relation to property coverage. This includes advice in relation to physical or material damage, and the consequential loss covers that flow from it, such as business or income interruption. We also have established relationships with the specialist firms of adjustors in this area.

REINSURANCE
Our Reinsurance Team includes lawyers with strong international reputations in this area. We are experienced in claims defence, coverage advice and disputes, and corporate and regulatory advice. Our team has been involved in a large proportion of Australia’s leading reinsurance disputes and claims for local and international clients. The corporate advisory members of our team provide specialist corporate and regulatory advice to the industry.

RISK MANAGEMENT
Our team is recognised internationally for its risk management expertise. One of our distinct strengths in this area lies in our ability to identify potential risks before they manifest into issues, problems or claims. Consistent with our view that avoidance and early detection of potential legal problems is the most effective way of managing legal risk, we develop training and preventative programs for many of our key clients.

Our International Insurance Team
Our Insurance and Reinsurance practice advises a broad range of international insurers and reinsurers on all aspects of transactional, regulatory and litigation matters. Our expertise in regulation and knowledge of the industry gives us a unique perspective on all aspects of risk, which enables us to anticipate problems and assist clients with restructuring, acquisitions and dispute resolution.

Our unrivalled geographical reach enables us to offer a truly international and cross-jurisdictional service to the insurance and reinsurance industry. Our lawyers are located in each of the firm’s major offices in Continental Europe, Asia, the United Kingdom, the Middle East and Australia. We also have offices located in numerous cities across the United States, as well as strong links with law firms in Latin America and Africa.

As well as being truly international in our reach, we believe in delivering local expertise in each jurisdiction in which we practice through lawyers with deep experience of the local legal and business environment.

NOTE: Please note that legislation in some Australian jurisdictions effectively prohibits practitioners from promoting legal services for personal injury claims.
EVERYTHING MATTERS
DLA Piper is the truly local, truly global law firm where everything matters. In Australia, we have more than 600 lawyers based in offices across Brisbane, Canberra, Melbourne, Perth and Sydney who offer full-service capabilities to both Australian clients looking to expand their operations overseas, and international clients looking to enter the Australian market. Our lawyers are part of a network of over 4,200 lawyers in 31 countries and 77 offices throughout Asia Pacific, Europe, the Middle East and the US, giving us the capability to provide our clients with trusted local knowledge and access to seamless multi-jurisdictional legal capabilities across a full range of critical services and sectors.

CLIENTS MATTER
Everything matters when it comes to the way in which we support our clients.

Our lawyers are commercially savvy and technical leaders in their fields. We are experienced in complex, multi-jurisdictional matters and provide practical, innovative outcomes for our clients across the full spectrum of their business needs.

We offer our clients deep knowledge of the regulatory frameworks, issues and trends specific to the key Australian sectors. We have access to decision-makers in industry and government, having acted on some of Australia’s most high-profile matters. We can be your advocate and supporter in the industry debates that matter and help you to identify opportunities at a business and political level.

We pride ourselves on being down-to-earth, approachable and responsive. We’ll take the time to get to know you, your business and the sectors in which you operate. We will work collaboratively with you as a trusted legal partner, sharing your commitment to achieving the best commercial outcomes for your business.

GEOGRAPHY MATTERS
We operate as a single team throughout Australia, working seamlessly to provide you with a genuinely integrated one-stop shop for your legal needs.

Our global coverage also means that you also have access to one of the largest legal services organisations in the world. In jurisdictions where we do not have offices, we have alliances and relationships with independent law firms. We work with our international colleagues to deliver services to clients already operating overseas or looking to expand into emerging markets.

We make it easier for you to manage your legal affairs. You will avoid the risks and the costs that come with employing multiple lawyers in different jurisdictions. You will have a partner you know and trust, and one who knows your business, when you are dealing in less familiar geographic areas.

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We have experience across a full range of services and sectors and provide our clients with tailored know-how across a range of industries.

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- Litigation & Regulatory
- Real Estate
- Tax
- Workplace Relations, Employment & Safety

Sectors
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- Automotive
- Banking & Finance
- Construction
- Energy, Environment & Water
- Government
- Health Care
- Hospitality & Leisure
- Infrastructure
We also actively participate in the wider community, as individuals and as a firm.

We provide award-winning pro bono legal services to more than 100 Australian and international charities. Our lawyers have presented training programs for non-profit boards and management in areas such as risk management, insurance and governance. We also provide regular client updates on important current issues and provide advice and assistance with policy development, submissions to government and strategic business advice.

We have a long-standing commitment to corporate responsibility and are focused on important issues such as education, climate and international aid and development. We also aim to be pioneers in our industry through our global sustainability initiative and seek to achieve ISO 14001 certification wherever we operate.

“Challenging the big guys but at a fraction of the cost.”

(Asia Pacific Legal 500, 2012)

RECOGNITION MATTERS

- 20 leading lawyers in Australia (Chambers Asia Pacific, 2012)
- 27 Australian lawyers in the 2011 Best Lawyers guide
- Ranked #1 in the world among the Top 20 Global Law Firms (Law360, 2011)
- Ranked #1 legal adviser for announced transactions globally: 2011 (mergermarket)
- Corporate Citizen Law Firm of the Year 2010 (ALB Magazine Australasian Law Awards)
- Foundation member of the Australian Legal Sector Alliance (AusLSA)

“The best client service that I have had from a professional service firm ever.”

“The lawyers demonstrate diligence and great commercial awareness.”

“Professional, reliable and with international standard in quality.”

(All Chambers Global, 2011)
FOR MORE INFORMATION ON OUR SERVICES, PLEASE CONTACT:

AUSTRALIA

Russell Adams
Joint Head of Litigation & Regulatory
Asia Pacific
T +61 2 9286 8259
russell.adams@dlapiper.com

Michael Down
Joint Insurance Sector Leader
Asia Pacific
T +61 2 9286 8287
michael.down@dlapiper.com

ASIA

Peter Shelford
Partner and Head of Insurance
Asia
T +662 686 8533
peter.shelford@dlapiper.com

UK

Charles Gordon
Partner
T +44 20 7796 6541
charles.gordon@dlapiper.com

US

Michael P. Murphy
Partner and Global Head, Insurance/Reinsurance
T +1 212 335 4755
michael.murphy@dlapiper.com

BRISBANE

Level 28, Waterfront Place
1 Eagle Street
Brisbane QLD 4000
T +61 7 3246 4000
F +61 7 3229 4077
brisbane@dlapiper.com

CANBERRA

Level 3, 55 Wentworth Avenue
Kingston ACT 2604
T +61 2 6201 8787
F +61 2 6230 7848
canberra@dlapiper.com

MELBOURNE

Level 21, 140 William Street
Melbourne VIC 3000
T +61 3 9274 5000
F +61 3 9274 5111
melbourne@dlapiper.com

PERTH

Level 31, Central Park
152-158 St Georges Terrace
Perth WA 6000
T +61 8 6467 6000
F +61 8 6467 6001
perth@dlapiper.com

SYDNEY

Level 38, 201 Elizabeth Street
Sydney NSW 2000
T +61 2 9286 8000
F +61 2 9283 4144
sydney@dlapiper.com