HERBERT SMITH FREEHILLS

POLICYHOLDER INSURANCE HIGHLIGHTS 2017

In this issue

Introduction

Welcome to the third edition of Herbert Smith Freehills' Policyholder Insurance Highlights. In this publication, we have pulled together the learning opportunities and lessons for policyholders from the most relevant insurance cases decided over the last 12 months.

The key messages are:

- *Be prepared to pay more for directors' and officers' (D&O) liability insurance in light of the continuing proliferation of shareholder class actions.* Although the Federal Government has recently announced an inquiry into class actions and regulation of third party litigation funding arrangements, market conditions for D&O renewals are tougher than ever, with 'Side C' cover (for class action defence) the main reason for premium increases, as well as limitations on available cover. See pages 8-9 of this publication for key developments in this space over the last year;
- *Watch the continued emergence and development of cyber insurance products.* Cyber risk continues to be a focus for many Australian corporates and their boards, but there is still uncertainty and confusion about how cyber insurance products will respond to attacks and how they interact with existing, more traditional insurance cover such as public liability and business interruption insurance. This focus, and therefore discussion about and evolution of the benefits of different cyber insurance products, will intensify over the coming year as mandatory data breach reporting is introduced in Australia, leading to an expected increase in cyber insurance claims. See our commentary on cyber insurance and related claims overseas at page 14 of this publication which provides some insight into how these issues may develop locally; and
- *Be optimistic (and realistic) about recovering on difficult insurance claims, as the reported decisions continue to demonstrate a favourable environment for policyholders who need the assistance of the courts to resolve their disputed claims.* Unsurprisingly, many of the decisions turn on policy construction issues, but there have been a number of useful decisions in the last year for policyholders in relation to non-disclosure and breach of policy conditions. That said, a healthy degree of pessimism at the early stages of a claim can be useful as early advice and careful management of an insurance claim from the outset can help to minimise the long term expense and controversy associated with turning around insurer misconceptions once they have been formed. Similarly, it may be possible to avoid disputes about the meaning of policy terms if policy wordings are carefully reviewed and negotiated at renewal - for example, we have conducted 'health checks' of D&O policies for a number of our ASX-listed clients over the last year.

We hope that you enjoy this year's edition of Policyholder Insurance Highlights. Please contact a key member of our Insurance Team (details at the back of this publication) if you would like to discuss any of the cases or how they may impact your business in more detail.

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Our insurance practice

Our global insurance and reinsurance practice advises insurers, brokers and policyholders on all aspects of insurance and reinsurance matters, whether corporate, regulatory or contentious claims.

Herbert Smith Freehills' insurance practice in Australia is focussed upon representing the interests of our clients as policyholders in major claims.

We work with corporate policyholders on a range of matters including:

- assisting policyholders with major claims, including advice on coverage, preparation of claims submissions, and claims advocacy to secure settlement of the claim using the full range of dispute resolution processes;
- advising clients in relation to issues flowing from critical business events including environmental incidents; property damage; personal injury claims; corporate manslaughter charges and health and safety investigations;
- representing insured directors and officers and major corporates in defending claims covered by their insurance policy where they have rights to nominate their choice of legal representation; and
- advising clients on insurance and risk in the context of major transactions, projects and insolvency.

We also advise brokers on the full spectrum of issues that emerge from the role of the broker, including defence of professional negligence allegations.

Risky business – would disclosure of alleged relevant information have made any difference?

Stealth Enterprises t/as The Gentleman's Club v Calliden Insurance Limited [2017] NSWCA 1270 (5 April 2017)

The Facts

Stealth Enterprises owned and operated a brothel in the ACT, and was owned by persons associated with the Comancheros motorcycle gang. Calliden Insurance provided property damage and liability coverage for Stealth under an Adult Industry Insurance Policy. Calliden knew that Stealth was operating a brothel, but did not know that its owners were associated with the Comancheros.

The brothel was damaged by fire and a claim was lodged by Stealth. Calliden denied liability on the basis that it alleged it would not have renewed the policy had it been informed of the policyholder's association with the Comancheros, and also that the brothel's registration under the *Prostitution Act 1992* (ACT) had lapsed. On that basis, Calliden argued its liability for the claim should be reduced to nil to reflect the prejudice it had suffered by reason of the alleged non-disclosure.

The Decision

At first instance, the Court found in favour of the insurer. However, on appeal, the Court found that Calliden was liable to cover the claim.

First, the Court of Appeal concluded that a reasonable policyholder in Stealth's position could not have been expected to know that an association with the Comancheros, without anything further, would be relevant to Calliden's decision to insure.

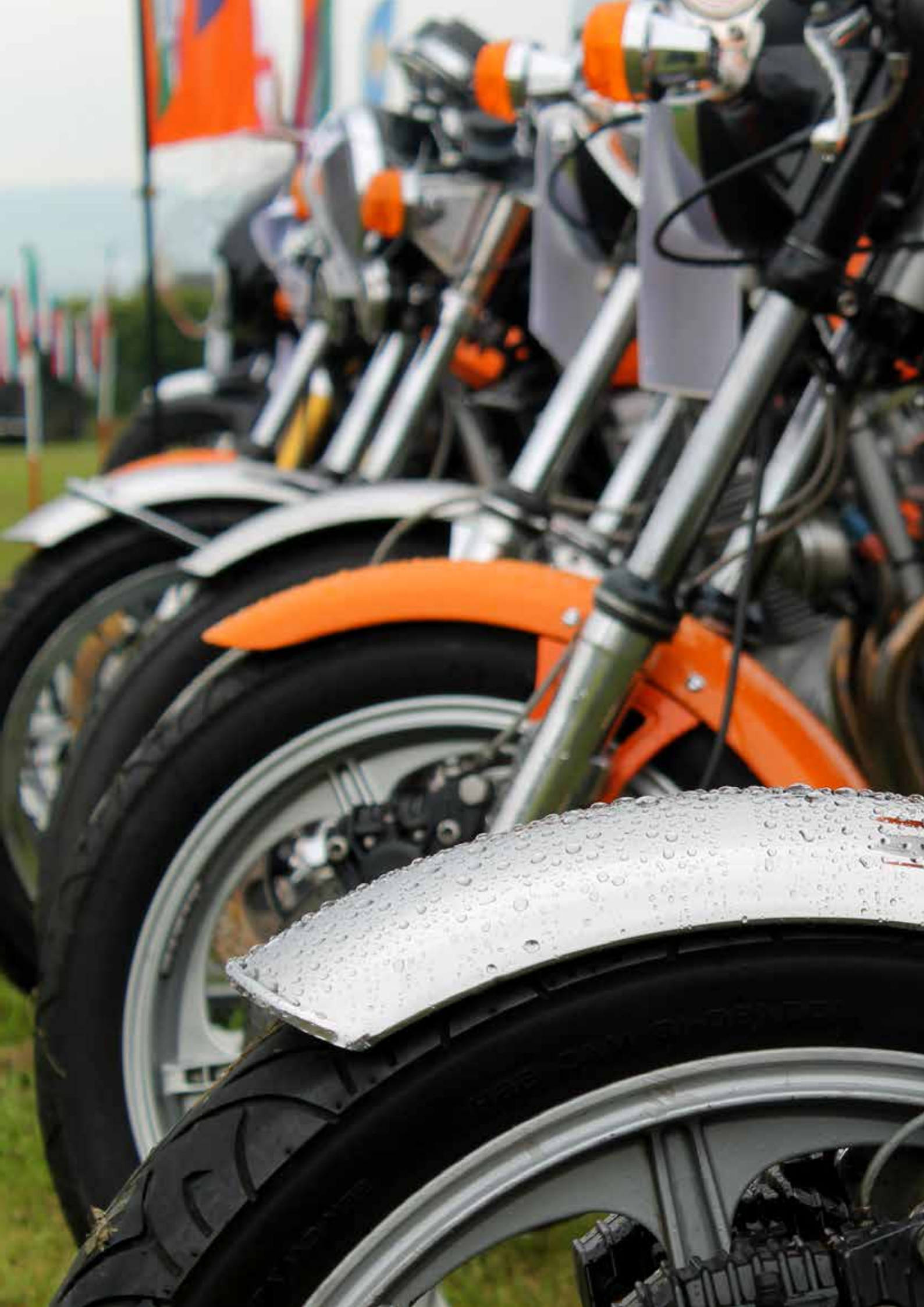
The mere suspicion that the information might have been relevant was not enough. Since Calliden was providing adult industry insurance and would therefore have been aware of the risks associated with operating a brothel, the Court considered Calliden was aware of the nature of the business it was insuring and that Stealth did not have to volunteer the further information about its association with a bikie gang in the absence of any questions addressed to that subject.

Secondly, Calliden failed to provide sufficient evidence in support of its contention that it would not have renewed the policy had the association with the Comancheros been disclosed. Oral testimony of an employee, unsupported by any objective evidence such as underwriting guidelines from the relevant time, was not enough evidence for to the Court to accept Calliden's assertion that it would not have renewed. The policyholder's claim therefore had to be paid.

Lessons for Policyholders

If a policyholder fails to disclose information they could reasonably be expected to know to be relevant to the risk for which they are seeking insurance, the insurer may reduce its liability for a claim by the extent of any prejudice resulting from the non-disclosure.

However, even if the policyholder is guilty of non-disclosure, the insurer must still prove that it has been prejudiced – namely that it would have made a material change to the terms of the policy had the information been disclosed. Often this presents evidential challenges for insurers as it is much easier to assert with hindsight that the information would have made a difference than it is to prove that it would in fact have made a difference. Policyholders should press insurers who complain of non-disclosure for objective evidence (such as underwriting guidelines) which establishes what the insurer would have done had the full facts been disclosed – and policyholders may be emboldened to press on with the claim in the absence of a satisfactory response.



Failure to comply with Australian Standards not fatal to claim

Manitowoq Platinum Pty Ltd & Anor v WFI Insurance Ltd [2017] WADC 32 (17 March 2017)

The Facts

Manitowoq engaged Boss to perform the fit-out of a restaurant. Boss retained a subcontractor (Millstream) to perform plumbing works. The plumbing works were defective and caused significant water damage requiring rectification. Manitowoq sued Boss for breach of contract and negligence.

Millstream's plumbing work was found to be non-compliant with Australian Standards and the Court was required to determine whether Boss's liability for its subcontractor was covered under its insurance policy with WFI. The policy:

- contained a condition that Boss was required to *"comply with legislation and Australian Standards"*; and
- stipulated that if Boss did not meet that condition, the insurer *"may be able to refuse or reduce any claim or cancel [the] policy"*.

The Decision

Davis DCJ found that the insurer was not entitled to refuse indemnity to Manitowoq on the basis of Boss' failure (through its subcontractor) to comply with the policy conditions.

The Judge found that the policy was ambiguous about the consequences of a failure to comply with legislation and Australian Standards. The condition was not expressly stated to be a condition precedent – it merely warned that a breach of the condition may permit the insurer to reduce or refuse a claim (consistent with the operation of section 54 of the *Insurance Contracts Act 1984 (Cth)*). If the parties had intended compliance to be a strict obligation which overrode the terms of the insuring clause, this should have been made clear.

The Judge also confirmed the fundamental principles of interpreting provisions of insurance contracts that (1) it must take into account the context of the specific risks covered and (2) the interpretation must give business efficacy to commercial purpose of the policy, and held that these principles are sufficiently powerful to permit a Court to read down a condition to avoid a situation where the purpose of a policy would be substantially defeated.

Accordingly, the Judge held that the condition should be read down to be a requirement *"to take reasonable care to comply with legislation and Australian Standards"*.

The Judge also held, by reference to previous authority on clauses requiring the policyholder to exercise 'due diligence' or take 'reasonable precautions' to avoid loss, it is sufficient that the policyholder does no more than to avoid recklessness. The Judge made a factual finding, based on the expert evidence, that a reasonably competent builder, having relied upon the representations of Millstream that the works were compliant with relevant standards, would not have been aware of the defects in the plumbing works. Boss was not therefore reckless, had not breached the condition, and the claim was covered.

Lessons for Policyholders

Allegations of failure to take precautions/comply with Australian Standards and legislation will only have consequences where the breach was reckless.

The Courts are reluctant to rob an insurance policy of its commercial purpose (which is to indemnify the policy holder when things go wrong) which may result in these conditions being read down to excuse policyholders for all but reckless conduct.

Insurer huffs and puffs but claim stands

Bigby v Kondra & Anor [2017] QSC 37 (14 March 2017)

The Facts

The plaintiff homeowners' property suffered an explosive over-pressurisation during a severe summer storm, when wind gusts deflected the windows inwards, allowing the air pressure to build up inside until the roof came off and the internal walls failed. The plaintiff sued its builder for the loss, who held a 'Business Insurance' policy covering all sums which the builder became legally liable to pay *"in respect of: ... property damage; ... happening during the period of insurance... as a result of an occurrence in connection with [its] business or products"*. The builder's insurer denied coverage on two grounds:

- *first*, the insurer alleged that the property damage was caused by the storm, not the builder's negligence, so was not as a result of an *"occurrence in connection with [the builder's] business"*; and
- *secondly*, if the loss was in connection with the business, the insurer alleged that the house was the builder's product so it sought to rely on an exclusion for *"property damage to products if the damage is attributed to any defect in the product"*.

The Decision

Both the insurer's arguments failed.

On the first issue, the Court held that it was not the storm per se which damaged the house, nor did the defectively installed windows directly damage the remainder of the house. Rather, the Court found (based on expert evidence) that the window failure (which derived from the builder's negligence) was causative of the explosive over-pressurisation, and determined that that the explosive over-pressurisation was, *"in a real and practical sense, the event which directly did the damage"*. The loss was therefore an occurrence in connection with the builder's business, and the builder was prima facie entitled to be indemnified.

On the second issue, as to whether the exclusion applied, the Court held that the plaintiffs' house was not a 'product' of the insured's building supervisory services for two reasons:

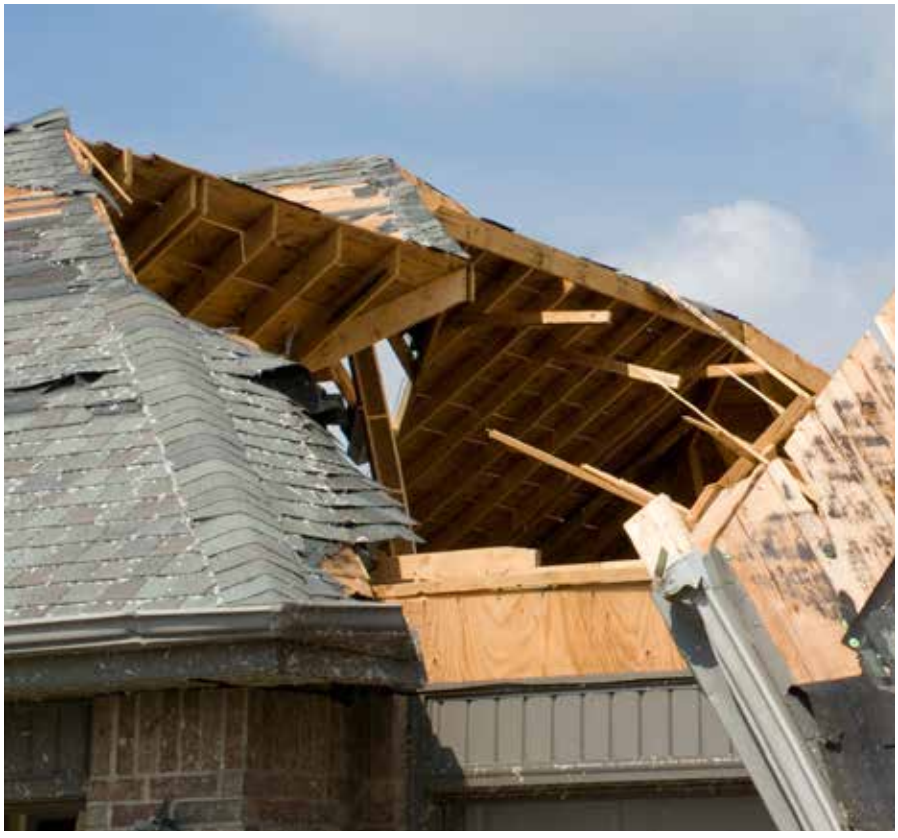
- *first*, while there was authority that a building could be a product, such a conclusion in this case would potentially rob the insurance policy of its fundamental purpose of covering the builder for liability in connection with its building business; and
- *secondly*, the policy contained a specific exclusion in respect of construction work except where the value was less than $500,000, so a broad 'defective products' exclusion would render this exception meaningless.

The plaintiff was therefore able to recover its loss.

Lessons for Policyholders

Courts will adopt a common-sense approach to determine 'in a real and practical sense' what caused damage, rather than a more technical approach which seeks to bring the claim outside policy coverage or within the scope of an exclusion.

This approach again recognises the principle that the fundamental purpose and object of an insurance policy will be relevant in interpreting its terms.



Clean-up your act (voluntarily)

Amashaw Pty Limited v Marketform Managing Agency Ltd [2017] NSWSC 612

The Facts

Petrol had leaked from a service station operated by the policyholder, Amashaw, causing an explosion in a nearby water sewer and contamination in other underground services. Amashaw acknowledged its responsibility for the leak, and undertook works to rectify the damaged sewer and to prevent future petrol leakage before either the regulator or the sewer main's owner had commenced any form of proceedings against it for the damage.

Amashaw sought indemnity for the cost of the works from its public liability insurer, which covered its liability to pay damages arising out of damage resulting from pollution, which included damage resulting from 'conversion, trespass [and] nuisance'.

The key issue was whether the cost of undertaking the remedial works voluntarily could be characterised as a liability to pay 'damages' covered by the policy. The insurer declined the claim, arguing that Amashaw had statutory obligations to make good the consequences of the leak, and argued that it was therefore obliged to do so regardless of any other obligation it may have had to the sewer main's owner in nuisance.

The Decision

The NSW Supreme Court found in favour of the policyholder for at least those costs that it would have been liable to pay as damages on the basis that:

- *"Amashaw's liability in damages for nuisance crystallised, at the latest, … when petrol from Amashaw's service station site, having entered the sewer main, exploded and caused damage"*;
- while it was true that Amashaw had a statutory obligation to remediate the damage, there was nothing in the relevant environmental protection statute to *"suggest that liability under it abrogate[d] or discharge[d] [Amashaw's] liability … to pay damages for negligence or nuisance"*;
- regardless of any notice from authorities, *"Amashaw was liable to [the sewer main's owner] in nuisance for the damage caused to the sewer main. Amashaw rectified the damage, and incurred costs in doing so. By acting in that way, Amashaw effectively discharged its liability to pay damages for nuisance. Amashaw could have stood by and permitted [the sewer main's owner] to do the work, and awaited service of the inevitable demand for payment"*;
- there was no reason *"why, in terms … of the policy, Amashaw should be in any worse position because it undertook the works itself"*.

Interestingly, it does not appear that the Court was asked to consider a UK decision on a similar issue *(Bartoline v Royal Sun Alliance Insurance PLC)* which arrived at a contrary conclusion that legal liability had to be established (not be a possibility), albeit on a different policy wording. Our view is that the NSW decision should be preferred, including because to find otherwise might be seen to encourage parties not to proactively address pollution incidents in order to preserve their insurance position (which does not sit well with public policy considerations) - why should the liability insurance policy only respond if the policyholder sits back and waits to be sued rather than mitigating the loss by pro-actively remediating the damage?

Lessons for Policyholders

A policyholder's costs of 'voluntarily' remediating accidental damage (contamination) to third party land may be recoverable under a public liability insurance policy on the basis that it would have been liable to pay damages that would have been covered by the policy had it not remedied the damage.

It is however important to be proactive about establishing the insurance claim for the inevitable liability in the early aftermath of an incident and to clearly distinguish between costs incurred to remediate damage that would otherwise be the subject of a compensation claim by third parties from costs incurred to prevent future damage (as only the former but not the latter is likely to be covered).

Comma sense prevails

Zhang v ROC Services (NSW) Pty Ltd [2016] NSWCA 370 (22 December 2016)

The Facts

An individual, injured when a metal ramp attached to a stationary trailer fell on top of him, sought to advance a claim directly against the insurer of the vehicle involved, National Transport Insurance.

The ramp had failed due to a defect, leading the insurer to decline the claim based on an exclusion 'for any liability for death or bodily injury arising out of or in any way connected with a defect in Your Motor Vehicle or in a Motor Vehicle, but in Queensland only if it causes loss of control of the vehicle whilst it is being driven ...'. The injury occurred in NSW whilst the vehicle was not being driven so the Court was asked to determine whether the qualifying words 'whilst it is being driven' only applied to incidents in Queensland (in which case the exclusion would apply) or applied to the entire preceding words of the exclusion (in which case the exclusion would not apply, as although the injury arose from a defect the vehicle was not being driven at the time). There was much attention given to the absence of a comma before the words 'whilst it was being driven'.

The Decision

The NSW Court of Appeal affirmed the decision of the trial judge that in the context of the policy the words 'whilst it is being driven' applied to all vehicles, not just those being driven in Queensland, such that the exclusion did not apply.

The leading judgment addressed the following key principles of insurance policy interpretation:

- the process of interpretation involves three stages: (1) discerning the literal or grammatical meaning or meanings of the relevant clause; (2) discerning which of those literal meanings comprises the definitive legal meaning of the clause; and (3) applying the legal meaning to the facts of the case;
- the literal meaning of the clause was ambiguous. This ambiguity was not resolved by the grammatical structure of the clause (as argued by the insurer), specifically the use of commas, because the use of punctuation elsewhere in the policy did not support a conclusion that punctuation was used "*consciously and not haphazardly*";
- while the more natural reading of the clause as a matter of English favoured the insurer's position, it did not follow that this was the legal meaning of the clause – this looks beyond simply the words and grammar and involves consideration of those words in the broader context of the whole policy, the surrounding circumstances and purpose and object of the policy;
- the legislative context in which the policy was entered into (being cover for liability not covered by the statutory regime for compulsory third party insurance in the relevant States) may be taken into account in interpreting the provisions of the policy. In that context, it was clear that the commercial purpose of the policy was to not achieve double insurance, but rather supplement (and complement) compulsory statutory insurance cover in cases to which it did not extend;
- where two meanings are open, it is proper to adopt the meaning that will avoid irrational or unjust consequences (even though it may not be the most obvious or grammatically accurate construction) – the meaning argued by the claimant (standing in the shoes of the policyholder) avoided the capricious and arbitrary result that stationary defects liability is excluded throughout Australia, except Queensland, and was therefore the proper legal meaning; and
- even if he was incorrect and there could be said to be "*genuine ambiguity*" in the legal meaning of the clause (because there were two legal meanings, one supported by textual considerations and the other by contextual and purposive considerations), the exclusion ought be interpreted contra proferentem against the insurer (as drafter of the policy), in which case the same outcome applied.

Lessons for Policyholders

Prevention is better than cure – ideally, insurance policies like all contracts should be free of ambiguity and clearly reflect the parties' intention as to coverage to minimise the likelihood of costly and lengthy disputes in the event of a claim.

However, even if the policy wording looks like it might be against you, if that would give a result contrary to the intent of the policy viewed in its proper context – look again. The Court might support you regardless.

Insurance and class actions

Insurance in the context of securities class actions has been a focus of much attention in the past year. We have identified below the key points of interest for policyholders who may find themselves the subject of a securities class action.

D&O insurance market

Many policyholders observed a shift in the dynamics of the D&O insurance market during their 2017 renewals, particularly around securities class action cover (commonly referred to as 'Side C' cover).

The key indicators associated with this shift were insurers (1) reducing their participation on primary insurance layers (including coming off primary risk altogether in some cases), (2) increasing premiums and/or (3) ceasing to provide any Side C cover to some policyholders (even on an excess layer).

This shift has been driven by very significant increases in shareholder class action claims in the last 5 years, and the settlements of those claims (as well as sometimes significant defence costs) many of which have likely involved significant insurance contributions. D&O insurers' loss ratios (the ratio of premium to paid claims) which are used to indicate profitability are worsening – loss ratios for the 2016 policy year may end up in a range of 200-300% (80% being a reasonable benchmark for a profitable portfolio).

This shift in the dynamics of the market has caused some concern amongst directors about the cost and availability of Side C cover, and whether it would be a breach of their duties to the company if they elected not to purchase Side C cover at all, on the basis of escalating cost and perhaps because one view is that the presence of the cover itself may make the company a more attractive target. It has also led to an increased focus on the structure of limits under D&O programs (and the risk associated with policy limits being shared between directors' defence costs and Side C cover, with the risk that the latter may erode the former), as well as exactly who has the benefit of cover beyond directors and officers.

Given the developments in the class action landscape over the last year, and predictions for the year to come, this dynamic seems likely to continue absent legislative reform or a significant judgment adverse to the interests of plaintiff law firms and funders. Policyholders would do well to increase their focus on risk culture, continuous disclosure practices and compliance to seek to reduce the front end risk of securities claims, and improve their ability to secure affordable Side C insurance.

NSW abolishes statutory insurance charge regime

In June 2017, the NSW Government introduced the *Civil Liability (Third Party Claims Against Insurers) Act 2017* (the **Act**) in order to address widespread concerns with existing legislation (dating back to the mid-1940s), which permitted third party claimants to obtain a statutory charge over liability insurance policy proceeds of the defendant in certain circumstances. In light of the introduction of The Act, it would be prudent for policyholders to consisder its impact on their existing insurance arrangments.

The now repealed legislation had caused widespread concern amongst policyholders and insurers (particularly in a class action context), when a series of judgments in New Zealand concerning similar legislation indicated Australian claimants may be able to effectively freeze the policy proceeds and prevent the relevant insurer from advancing defence costs to defend the very same claim in respect of which the funds had been frozen. D&O insurers then took the unusual step of running an expedited case in the NSW Court of Appeal to obtain some clarity on the issue – they were successful, but some uncertainty remained.

The Act:

- replaces the concept of a statutory charge with a direct right to claim against the insurer once certain preconditions have been met, and subject to leave of the Court being obtained; and
- provides that the right does not operate in respect of the defence costs payable to the defendant (addressing the previous source of concern).

The NSW Supreme Court has since handed down its first judgment in relation to the legislation. In *Zaki v Better Buildings Constructions Pty Limited* [2017] NSWSC 1522, the Court confirmed that:

- while the Act makes substantive changes to the previous law, the Court's general discretion to grant leave would continue to be exercised in the same way as formerly; and
- Section 6 of the Act did not alter the settled law that a defendant (in this case insurer) raising a statutory bar imposed by the Limitation Act carries the legal onus of proof.

Use of 'after the event' insurance in class actions

It is becoming increasingly common for plaintiffs and/or funders in class actions to offer after the event (**ATE**) insurance as security for the costs of the class action defendant – ATE insurance is, as the name suggests, a product which covers the risk of adverse legal costs order being made after litigation has been commenced.

While Australian Courts have confirmed that ATE insurance is, in principle, an acceptable form of security for costs, in a welcome judgment for defendant policyholders and their D&O insurers, a Court has also made clear that not all ATE policies are made equal.

In *Petersen Superannuation Fund Pty Ltd v Bank of Queensland Limited* [2017] FCA 699, a plaintiff was ordered to pay traditional security for costs (by way of a payment into Court or bank guarantee) and its attempt to rely on an ATE policy for this purpose was rejected. The Court assessed the risks associated with the defendant actually being able to recover under the policy and it was found wanting – in particular:

- the defendant had no direct right to claim as an insured under the policy;
- the defendant did not have the ability to compel the applicant to sue on the policy;
- the policy contained a significant number of exclusions from liability;
- the policy allowed the insurer to reduce its liability (including to nil) in the event of a non-disclosure by the applicant, and also to cancel the policy in certain circumstances which might arise prior to the making of a cost order (both of which were outside the control of the defendant); and
- the applicant was impecunious, and there was doubt over the ability of the respondents to access the policy proceeds in the event of an insolvency.

In order to address these issues, it is common for ATE policies to provide a mechanism for the ATE insurer to enter into a direct deed of indemnity with the defendant which is not subject to the same perceived shortcomings as the ATE policy itself. Defendants should insist on this as a minimum where an ATE policy is being offered as security.

Evident intent to exclude

Guastalegname v Australian Associated Motor Insurers Ltd [2017] VSC 420

Facts

The plaintiff was a homeowner and holder of a home insurance policy with AAMI which covered loss, damage or destruction to the building caused by a number of insured events, including storm. During a heavy storm, rain water pooled around the building and seeped under the concrete foundations, causing the clay soil underneath to expand. This 'heaving' lifted the building's concrete slab, walls and roof frames, which in turn caused cracking and other damage. The plaintiff's claim under the policy was denied on the basis of an exclusion for damage caused by "*soil movement or settlement*".

Decision

The Court agreed that the soil movement exclusion applied.

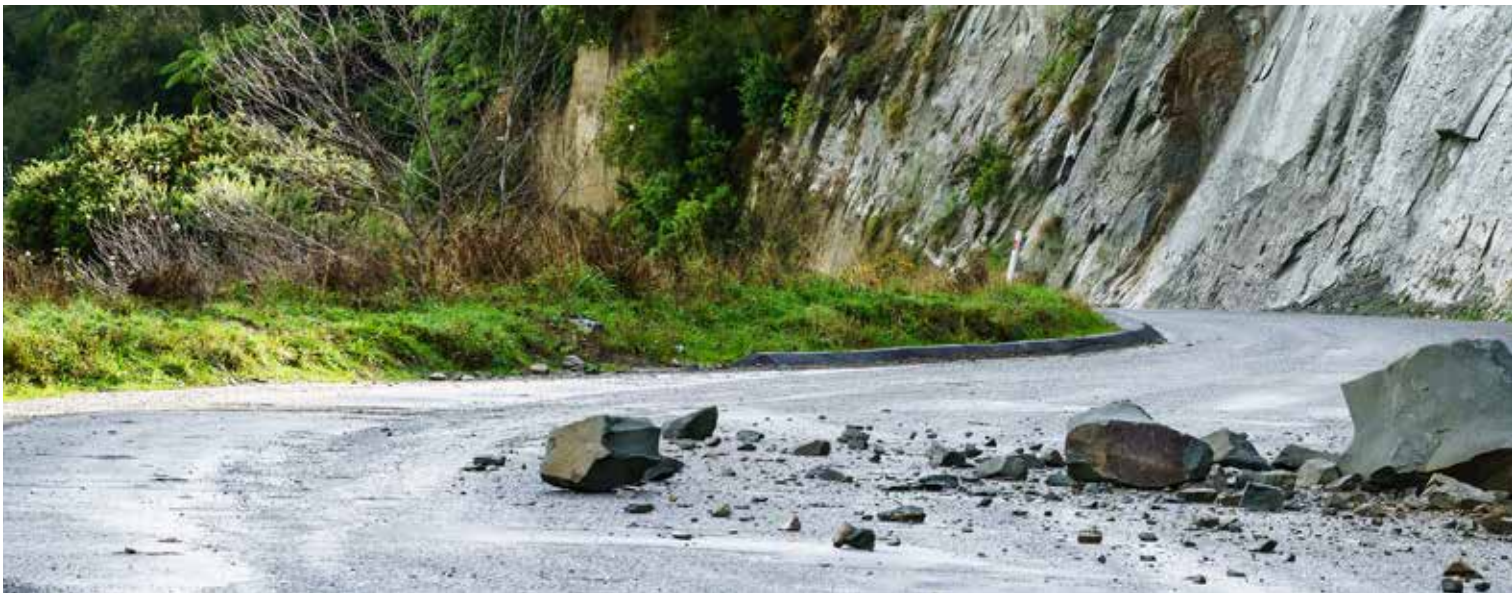
While it acknowledged the application of well-established principles of contractual interpretation such as construing clauses according to their natural and ordinary meaning in light of the contract as a whole, applying a commercially sensible construction and construing ambiguous terms contra proferentem against the party seeking to rely on them, the Court found that when the words "soil movement" are given their natural and ordinary meaning, there is no ambiguity.

It was clear that the insurer "*intended to exclude indemnity for building damage caused by soil movement of whatever kind*", rather than just where, as the plaintiff contended, soil "changed location" in the sense of a landslide. This reflects the principle that if the words in a contract are unambiguous and do not give rise to commercial nonsense or commercial inconvenience, the Court must give effect to them, even if it may be suspected that the parties intended something different.

Lessons for Policyholders

These two decisions highlight that, while the general principles relating to the interpretation of exclusion clauses tend to favour policyholders, they cannot displace the 'evident intent' of an exclusion.

It is important for policyholders to carefully review their coverage at the time they procure it and make sure it is 'fit for purpose' so there are no nasty surprises in the event of a claim.



Malamit Pty Ltd v WFI Insurance Ltd [2017] NSWCA 162

Facts

Treetops Lismore contracted in 2008 with Malamit for the provision of project development services. Treetops and Malamit were connected through their ownership structures. An individual director-shareholder held 50% of the shares in Blue Dolphin (which wholly-owned Malamit) and he also held 100% of the shares in Treetops.

WFI, the insurer, issued a professional indemnity policy to two named insureds: Blue Dolphin (as trustee for an investment trust) and its subsidiary, Malamit. That policy also included a definition of 'Insured' which extended to other individuals (including the director-shareholder) and entities.

There was a landslip at the relevant project development. Treetops commenced proceedings against a number of parties, including Malamit. WFI was successful at first instance in denying liability to Malamit in respect of the Treetops claim, including on the basis that the policy excluded claims brought 'by, on behalf of or for the benefit of' a 'Subsidiary' of an 'Insured', which included Treetops (this is colloquially known as an 'insured v insured' exclusion). Malamit appealed the decision.

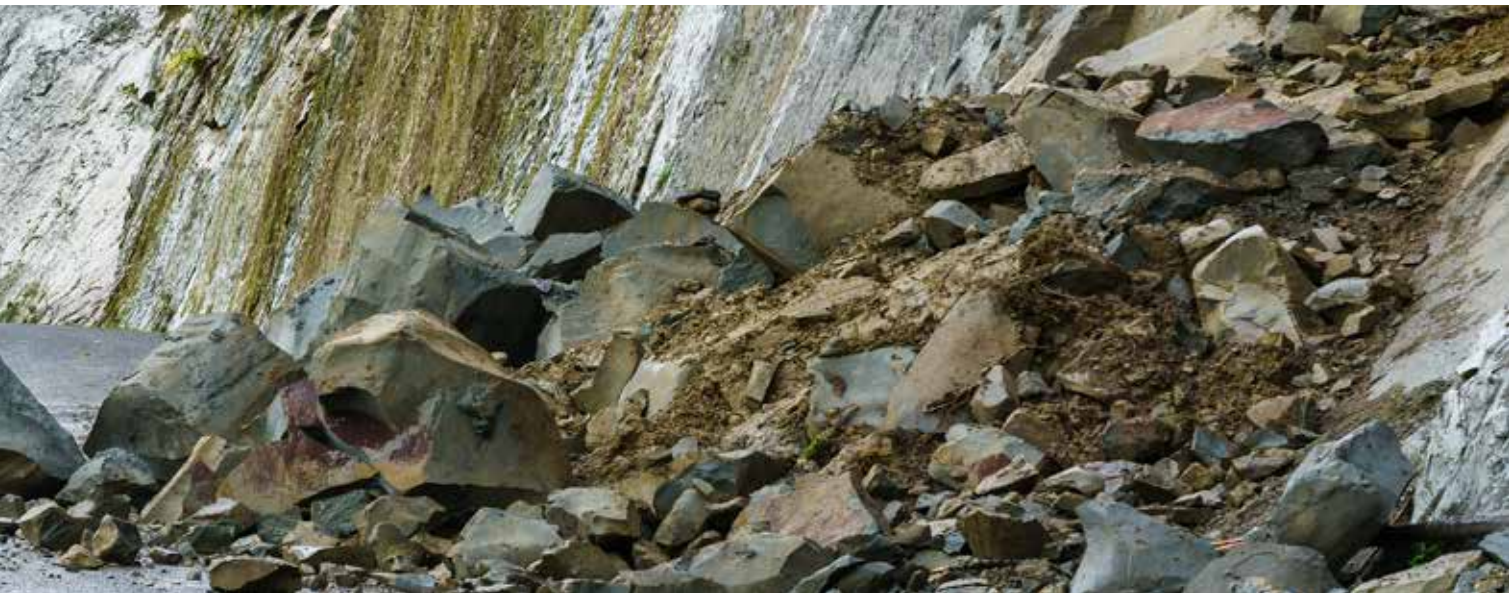
Decision

On appeal, Malamit successfully argued that Treetops' claim against Malamit was a claim by a third party which triggered the insuring clause, despite the association between the entities. In reaching the conclusion that Treetops was a 'third party', it specifically had reference to the terms of the 'insured v insured' exclusion.

However, while this exclusion assisted Malamit to prevail on its first argument, it ultimately proved to be its undoing on its second argument. If Treetops was a 'Subsidiary' of another policyholder (because it was owned or controlled by the director shareholder who was also a policyholder), cover for the claim was excluded.

Both Malamit's arguments on the exclusion were rejected:

- the legal entity bringing the claim was Treetops not, as Malamit argued, the investment trust. Malamit's sole director was an 'Insured' policyholder, based on the policy definition, and owned all of Treetops' shares. Treetops was therefore a subsidiary of an 'Insured' so its claim was excluded; and
- the purpose of excluding cover for claims made by 'Subsidiaries' against 'Insureds' was to avoid the risk of collusion or assistance between the parties. In order to give effect to "*the evident intent of the exclusion*", the term 'Insured' in the definition of 'Subsidiary' must refer to all persons described in the definition of 'Insured' not, as Malamit argued, just the named entities in the policy schedule.



Be specific when it comes to project insurance

Liberty Mutual Insurance Company v Kellogg Brown and Root Pty Ltd [2017] NSWSC 1519

The Facts

As part of the Australian Pacific LNG Gladstone Pipeline Project, a project-specific professional indemnity policy was purchased to apply to six named insureds, including Kellogg Brown & Root (KBR). Relevantly, the project policy (1) incepted in 2012 with a 10 year policy period; (2) had a limit of liability of $50 million and an excess of $1 million; and (3) included a clause providing that it responded in excess of any 'Additional Insurance' (which was specifically described in the policy schedule).

One of the Additional Insurances was an "Annual Professional Indemnity" policy taken out by KBR with a 2012 reference number. KBR was the subject of a claim that attached to KBR's 2013-2014 professional indemnity policy. KBR argued that because the Additional Insurance referred to in the project policy was the 2012 KBR policy, the Additional Insurance clause did not apply and KBR could pursue its claim under the project policy (which had a lower excess/ deductible). The project policy insurer sought a declaration from the Court that the project policy only applied in excess of the subsequent renewal of the 2012 KBR policy.

The Decision

The Court rejected KBR's argument. The description of the 2012 KBR policy as an "Annual Professional Indemnity" policy created an ambiguity in the context of the Additional Insurance clause which permitted consideration of the mutually known surrounding circumstances to resolve that ambiguity.

Those surrounding circumstances demonstrated that the insurer and the proposed insureds (either directly, or through their broker) knew that (1) KBR and the other insureds were contractually obliged to maintain their own professional indemnity insurance for a period equivalent to that of the project policy; and (2) the 2012 KBR policy was obtained to discharge that obligation (albeit there was a mistaken belief it would be maintained throughout (and beyond) the construction phase of the Project).

The Court therefore concluded that a reasonable business person in the position of the parties would have understood that the project policy was to be in excess of *any* insurance effected and maintained in accordance with the contractual insurance obligations in the project documents.

A Court must give a business-like interpretation to the policies - it seemed highly unlikely that the parties would have intended the project policy to have a commercially inconvenient operation which would defeat the purpose of the "Additional Insurance" structure.

Lessons for Policyholders

It is important for policyholders to carefully document the intended relationships and hierarchy between a project-specific insurance policy and the insurance policies which are held by the various participants in the project. This can avoid costly disputes and potentially damage to the commercial relationships between project parties.

Don't settle for second best

Delta Pty Ltd v Team Rock Anchors Pty Ltd & Anor [2017] QSC 115

The Facts

Delta Pty Ltd subcontracted Team Rock Anchors Pty Ltd to carry out work on retaining walls for basement excavation ahead of construction of a high rise building. The work carried out by Team was allegedly negligent, leading to unacceptable movement in one of the retaining walls and resulting in the entire basement excavation needing to be backfilled. Delta claimed certain costs of the backfilling from Team.

Team held an insurance policy including cover for 'amounts which [an insured] become legally liable to pay in compensation for ... Property Loss', 'Property Loss' being 'physical loss, damage or destruction of tangible property'. Team made a claim under the policy, although it was declined by the insurer on number of policy coverage grounds.

Delta subsequently entered into a settlement agreement with Team which provided that:

- Team agreed to pay $2.5 million to Delta on a no admissions basis in full and final settlement of Delta's claim; but
- while Team remained liable to Delta for that full amount, its liability was limited to any amount actually recovered by Delta under Team's insurance policy as assignee of Team's insurance claim.

Delta advanced claims against Team's insurer on two alternative bases: first, that it was an actual insured under the policy and, secondly, that it had the benefit of the claim assigned to it by Team (as contemplated by the settlement agreement).

The Decision

While Delta succeeded in overcoming a number of the policy coverage arguments raised by the insurer, both bases for its claims under the Team policy ultimately failed.

In relation to the direct claim under the policy as an insured:

- Delta did establish that it was an insured 'principal' for the purpose of the third party liability cover under the policy, in that it was a superior contractor to Team in the contractual chain (albeit not the head contractor or project principal);
- However, Delta did not establish that it had a liability to pay compensation (in fact, it had settled the claim by the head contractor by accepting a reduced amount under the head contract which took into account the costs associated with the additional works). Nor did it establish that any such liability was in respect of 'Property Loss' – rather, the liability would be for economic loss being the cost of delay and additional works.

In relation to the claim under the policy as assignee of Team's rights:

- The Court accepted that Team's 'secondary right' to receive the proceeds of the policy (as opposed to the primary obligations under the policy) could be assigned. However, to establish that right, Delta had to demonstrate that the assigned claim was for an amount Team was 'legally liable to pay in compensation for ... Property Loss';
- The Court accepted that a reasonable and bona fide settlement of the claim could, in theory, satisfy the insuring clause requirement for a legal liability to pay on the basis that Team's insurer had denied liability for Team's claim prior to Team settling with Delta and assigning that claim;
- However:
  - The structure of the settlement between Delta and Team meant that Team would never become liable to pay any amount to Delta. Accordingly, the settlement deed was not, in practice, capable of establishing liability under the policy;
  - Further, Delta did not establish that the settlement with Team was reasonable, in the sense that it represented a reasonable evaluation of the prospects Team had in defending the claim by Delta. No evidence was led as to the legal advice received, process of reasoning or negotiation of the settlement by Team. Further, the financial capacity of Team was an 'extraneous reason' which likely influenced the settlement as it would tend to incline Team to agree to a higher settlement sum than it otherwise would.
- In any event, as with the direct claim, the claim by Delta against Team which formed the basis for the assigned insurance claim, was for economic loss and not 'Property Loss' within the meaning of the policy.

Lessons for Policyholders

Claimants should exercise significant caution when seeking to structure settlements of claims by reference to insurance recoveries, particularly accepting the benefit of insurance claims assigned by a defendant. The issues raised are complex and if handled incorrectly may result in any assigned insurance claim effectively being worthless.

Cyber insurance claims – the overseas experience

Lessons for Policyholders

There remains a significant degree of uncertainty around policy cover for losses resulting from cyber breaches – claims may be covered by existing, more traditional, policies or by more novel cyber insurance policies, or in some cases, both. It is important to understand exactly what protection for cyber risks you are getting from your policies, especially the gaps and overlaps with other policies. What would be the financial consequences of a breach (think in terms of business interruption costs, ransom demands by hackers and liability to third parties for compromised data)? Do any of your policies cover those consequences? Would a cyber insurance policy assist?

An increasingly common aspect of cyber crime is 'social engineering' – manipulating employees to perpetrate a cyber breach. The overseas cases dealing with cover for more traditional social engineering fraud (resulting in a direct transfer of funds to the perpetrator) suggest policyholders should have clear policies and procedures around IT security and ensure diligent compliance of employees with those policies and procedures, or risk compromising insurance coverage.

Innovak International, Inc. v The Hanover Insurance Company (D. (Florida – Middle District), November 17, 2017

The Facts

Innovak was the developer of payroll software. The software was hacked by third parties who stole the personal information of a number of employees of Innovak's customers. Those employees brought a class action claim against Innovak, alleging that it had failed to adequately protect the information or disclose the data breach to them in timely manner. Critically, the employees at no point alleged that Innovak had published the information.

Innovak held a Commercial General Liability Insurance Policy with Hanover which included coverage for 'personal and advertising injury claims'. This was defined to include *'injury... arising out of... Oral or written publication, in any manner, of material that violated a person's right of privacy.'* The policy required Hanover to take over the defence of any underlying action covered by the policy. When Hanover refused, Innovak sought an order compelling it to do so.

The Decision

The Court held that the policy required publication of the personal information before the policy responded to the loss.

Because the underlying action did not allege publication of the personal information, it was not covered under the policy.

The Court further held that, in any event, the policy required the publication to have been by Innovak and not by third party hackers. The use of the phrase 'in any manner' referred to the manner of publication and not to who published the information.

Social engineering

This year has seen a number of insurance cases centred around social engineering fraud. Social engineering fraud refers to a scheme in which an employee is tricked into transferring funds.

The Brick Warehouse LP v Chubb Insurance Company of Canada, 2017 ABQB 413:

In June 2017, the first Canadian case on this issue was decided in favour of the insurer. After considering a funds transfer clause, in the policyholders crime coverage policy the court concluded that the policy required the policyholder to have neither consented to nor have knowledge of the transfer. As the policyholder's employee, not the fraudster, performed the transfer (albeit induced by the fraud), the loss was not covered.

Medidata Solutions, Inc. v Federal Insurance Co. (D. Southern New York July 21, 2017):

In July 2017, a US Court decided a similar case in favour of a policyholder. Part of the decision included considering an almost identical funds transfer clause. However, the Court concluded that there was no knowledge or consent of the transfer by the policyholder as the knowledge and consent was only obtained as a result of a trick.

American Tooling Centre, Inc. v Travelers Casualty and Surety Company of America (D. Eastern Michigan August 1, 2017):

In August 2017, a different US Court decided the same issue in favour of an insurer. The Court concluded that the loss was not covered as the fraud did not 'directly' cause the loss as required by a computer fraud policy. Despite fraudulent information being provided to the employee, it was the company that authorised the transfer and was therefore the direct cause of the loss.

The key difference between the decisions appears to be the level of diligence exercised by the employee. This suggests that a policyholder could place itself in a more favourable position in the event of a claim if it demonstrates robust internal safeguards to protect against fraud.

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Market recognition – awards and accolades

AUSTRALIAN LAW FIRM OF THE YEAR
CHAMBERS ASIA PACIFIC AWARDS 2016

LAW FIRM OF THE YEAR (>500 EMPLOYEES)
AUSTRALASIAN LAW AWARDS 2016 -2017

BAND 1
IN DISPUTE RESOLUTION GLOBAL – WIDE
CHAMBERS GLOBAL 2017

TIER 1 DISPUTE RESOLUTION AND TIER 2 INSURANCE
ASIA PACIFIC LEGAL 500 2018

BAND 1
IN DISPUTES RESOLUTION – AUSTRALIA
CHAMBERS ASIA-PACIFIC 2017-2018

BAND 2
IN INSURANCE POLICYHOLDER AUSTRALIA
CHAMBERS ASIA-PACIFIC 2017-2018

Mark Darwin – Leading individual in Insurance,
AUSTRALIA CHAMBERS AND LEGAL 500 ASIA-PACIFIC 2018

Gareth Thomas – Leading individual in Insurance,
CHINA/HONG KONG, CHAMBERS ASIA-PACIFIC 2018

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