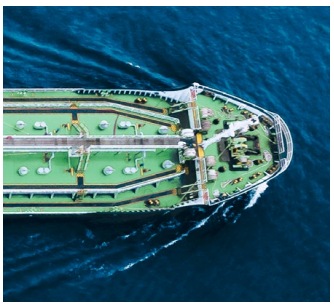
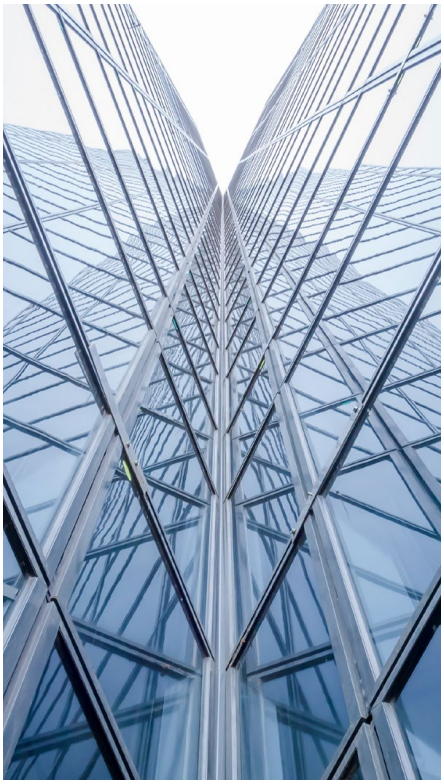
HERBERT SMITH FREEHILLS

POLICYHOLDER INSURANCE HIGHLIGHTS 2019

In this issue





Introduction

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

Consistent with the trends we identified in last year's Policyholder Insurance Highlights publication, the key messages this year are:

- **The insurance market continues to harden:** Australia has not seen a 'hard' insurance market for over a decade. Key indicators of a hard market are an increase in premiums, a reduction in capacity and scope of coverage offered by insurers and increased delays and difficulties in the payment of claims. We anticipate the trend will continue throughout 2020 as insurers deal with the economic slowdown, increased losses from natural disaster events (such as the recent tragic bushfires) and shifts in the liability landscape resulting from increased activities by regulators and litigation funders.
- **The volatility of the Directors' & Officers' insurance market:** consistent with the above, the D&O insurance market has experienced particularly significant continued hardening and volatility during the course of 2019. There are growing concerns within corporate Australia regarding the ongoing availability and cost of 'Side C' insurance within D&O policies to cover companies for shareholder class action claims, and the longer term impact of the heightening focus upon director's liability on the affordability of D&O insurance. In a post-Hayne regulatory enforcement environment, it is more important now than ever that directors ensure their D&O cover is fit for purpose.
- **Major insurance claims are more commonly delayed and often disputed:** our observation is that insurance coverage disputes for major claims (in particular) are increasing, as insurers' underwriting profit (premium received less claims paid) becomes more important as investment profit (returns on invested premium) slows with the economy. In light of this trend, it is even more important for policyholders to: (1) give very careful consideration to their policy wordings at renewal and seek to preserve the broadest and most appropriate cover available for their operations on clear terms, and (2) engage specialist advisers at an early stage to assist with claims notifications, preserve legal privilege, engage experts and advocate claims coverage issues so as to maximise entitlements under their insurance assets – be assured, insurers will 'lawyer up' early in major claims.

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

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 payment 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.

Mark Darwin
Partner
T +61 7 3258 6632
M +61 412 876 427
mark.darwin@hsf.com

Guy Narburgh
Special Counsel
T +61 2 9322 4473
M +61 447 393 645
guy.narburgh@hsf.com

Class aggregation

Bank of Queensland Limited v AIG Australia Limited [2019] NSWCA 190

Facts

A series of transactions undertaken by a financial planner, independent of the bank, defrauded bank customers, with the bank acting upon each email the financial planner had sent the bank. The customers brought a class action against both the financial planner and the bank, alleging that the bank ought to have identified the fraud. The bank ultimately settled the claim for $6 million.

The bank's liability policy had a $2 million deductible for 'each and every Claim', so lodged a claim for $4 million with its insurer. The insurer argued that each of the claims forming part of the class action proceeding related to separate transactions for each of the 114 individual customers, and therefore each attracted a separate deductible.

The policy's aggregation clause provided that:

> 'all Claims arising out of, based upon or attributable to one or a series of related Wrongful Acts shall be considered to be a single Claim'.

'Claim' was defined to include:

> '(i) any suit or proceeding, including any civil proceeding... against the insured... or (ii) any verbal or written demand... of any specified Wrongful Act.'

At trial, the Supreme Court agreed with the insurer and held that there were at least 3 separate 'Claims', therefore wiping out the entire $6 million settlement.

Decision

The Court of Appeal unanimously overturned the trial judge's decision, concluding that the Claims could be aggregated and that only a single deductible applied.

While each transaction was a separate alleged 'Wrongful Act' within the meaning of the policy, the determinative issue was whether they were sufficiently 'related'. The Court noted that the aggregation clause did not expressly refer to a causal relationship between the acts or Claims (as may sometimes occur in such clauses). Instead, the unifying factor required by the aggregation clause was that the alleged 'acts' were claimed to be 'wrongful' on the same basis.

For each claim, the basis of the allegation against the bank was the same – namely they were all based on its alleged knowledge of the financial planner's actions. As a result, even though the claims related to separate transactions for individual clients and there was no causal relationship between each of the claims, the claims were held to be 'related' because they were advanced on a common series of Wrongful Acts.

This finding meant that the multiple claims could be aggregated and treated as a single 'Claim' for the purpose of the policy's deductible (or excess), so the bank recovered the $4 million claimed.

Lessons for Policyholders

This decision is a welcome outcome for policyholders, particularly given the increasingly high premiums they are being charged for class action risks (both in professional indemnity and D&O policies). While it represents a commercially common sense outcome, as the decision notes, the application of aggregation clauses will be heavily dependent on the particular facts and policy wording in question. Policyholders and their brokers should carefully consider the class action risks to which the policyholder is exposed and, where possible, negotiate aggregation clauses tailored to provide the most favourable outcome to the class action scenario most likely to face the policyholder's business model.

Fact v Fiction

Globe Church Incorporated v Allianz Australia Insurance Ltd (2019) 20 ANZ Insurance Cases 62-207

Lessons for Policyholders

Whilst the outcome of this case may be somewhat surprising, it represents the current state of thinking of the NSW Court of Appeal (albeit by a 3-2 majority). Policyholders should be aware that the 6 year limitation period to commence proceedings against an insurer for a coverage dispute starts to run when the damage is suffered, and should take appropriate steps to protect their position, either by negotiating a 'standstill' of the limitation period in the context of a claim or by filing Court proceedings before 6 years has passed.

Facts

Globe Church was legally responsible for a number of church properties which were insured under an industrial special risks policy (property damage/business interruption) for the period 2007 to 2008.

In 2007, a severe thunderstorm caused property damage to the church. Globe Church made a relatively small claim under the policy for property damage and business interruption as a result of the storm, which was settled with insurers. In 2009, Globe Church discovered further structural damage had been caused by the 2007 storm, and made a further claim under the policy. In 2011, the insurer declined cover for the further claim. Negotiations ensued but failed to resolve the claim.

In 2016 Globe Church commenced Court proceedings against insurers seeking cover. In their defence, insurers contended that Globe Church's action was statute barred, alleging that the 6 year limitation period began when the property damage occurred in 2007/8.

Globe Church contended that its cause of action was not statute barred because it arose (and the limitation period began) in 2011 when insurers declined its further claim, or alternatively upon the lapse of a reasonable time for the insurers to make payment following the claim.

Decision

The issue (which was determined as a separate question before trial) was heard by a five-Judge bench of the Court of Appeal, which was split 3 to 2 on the decision.

The **majority** concluded (consistent with the English law position) that absent any specific provisions in a policy to the contrary, the promise to indemnify (or "hold harmless") in the context of a property damage insurance policy (and therefore the right to sue for breach of that promise) arises when the underlying property damage is suffered. Globe Church's claim was therefore statute barred.

While this approach creates the peculiar scenario where an insurer can be in breach of contract at a time when it may be completely unaware of the property damage (or knows of the claim and has not refused cover), the majority noted it is open to the parties to a contract of insurance to negotiate the terms, including (if so intended) stating in no uncertain terms that the making of a claim is a condition precedent to the insurer incurring liability (which was not the case here).

The **dissenting** judges took a "business-like" approach to the construction of the policy - under the express terms, the insurers' obligation was to indemnify by paying a sum of money ascertained in accordance with the policy (including basis of settlement, progress payments, and policy limits), and there was no obligation to, in some unstated way, "hold the insured harmless". The undertaking was to make good the insured loss after it had occurred by payment, that being a well-accepted sense in which the term "indemnify" is used, and the only sense in which such a promise to indemnify could be performed by the insurer. As to the timing of the obligation, the ordinary rule is that where the contract does not stipulate a timeframe for the obligation, it must be done in a reasonable time.

The dissenting minority added that neither the reasonable commercial expectation of the parties nor the language of the policy suggested that the payment obligation is to be performed immediately upon the happening of the damage. Furthermore, it was plain on the terms of the policy that the parties contracted on the basis that the event of loss would be followed by a period of adjustment to assess the insurers' payment obligations. Justice Leeming also added that he saw no reason to displace ordinary principles of construction of contracts with some "fundamental" principle about the nature of indemnity insurance, especially one which he regarded as "absurd".

It's about the journey, not the insolvency

AIG Australia Limited v Kaboko Mining Limited [2019] FCAFC 96

Facts

Kaboko Mining agreed to sell Zambian manganese to Noble Resources. An advance of $10 million was paid by Noble Resources with a condition that the money only be used for specified purposes. The money was not used for the specified purposes, and so Noble sought repayment of the advance.

When Kaboko was unable to repay, it went into receivership, and then administration (and entered into a Deed of Company Arrangement). The administrators brought an action against the directors of Kaboko alleging that they breached their duties in failing to use the money for the specified purposes.

The directors sought indemnity under their D&O liability policy with AIG. However, AIG denied indemnity on the basis of the following insolvency exclusion:

> '[AIG] shall not be liable under any Cover or Extension for any Loss in connection with any Claim arising out of, based upon or attributable to the actual or alleged insolvency of [Kaboko] or any actual or alleged liability of [Kaboko] to pay any or all of its debts as and when they fall due.'

The primary judge found that the insolvency exclusion did not preclude cover under the policy for the claims made by Kaboko. AIG appealed, arguing that the exclusion applied where there was any loss in connection with any claim arising out of, based upon or attributable to an insolvency event.

Decision

The Full Court of the Federal Court dismissed AIG's appeal, and construed the insolvency exclusion so that the directors were not deprived of cover.

The Court noted that the definition of 'Claim' related to a demand or a civil proceeding for a 'specified act, error or omission'. The term was not defined by reference to the motivation for the demand or proceedings. As a result, the Court concluded that the focus of the definition of 'Claim' was on the content, source and nature of any such demand or proceeding – not the motivation for it being brought.

As used in the insolvency exclusion, this meant that the insolvency had to be linked to the content, source and nature of the claim against the former directors. The basis of Noble's claims against Kaboko related to the failure to use the $10 million for the specified purposes, not for insolvent trading or because Kaboko was insolvent. The claims could in fact have been made even if Kaboko was solvent. Therefore, the Court concluded that the insolvency exclusion did not apply.

Lessons for Policyholders

This decision has proved an important reminder for policyholders that it is not enough for your insurer to invoke an insolvency exclusion where the insolvency merely motivated, or was the occasion for, a claim being brought. Careful consideration should be given to coverage debates before policyholders walk away from or settle claims.

Fire in the Hull: a ship, a flame and a reasonable settlement

Royal and Sun Alliance Insurance Plc v DMS Maritime Pty Limited [2019] QCA 264

Facts

The navy patrol vessel, 'HMAS Bundaberg', was destroyed by fire in August 2014 following a welding accident during repairs to the vessel by a sub-contractor to the policyholder. The policyholder's contract with the Commonwealth required it to 'replace or otherwise make good' the loss. There was some debate about how to value the 8 year old destroyed navy vessel, for there was no second hand market in which to acquire a replacement, and its depreciated book value would not have been enough to enable the Commonwealth to replace the vessel.

Following negotiations on the insurance claim, RSA entered into an indemnity settlement agreement which ceded responsibility for the settlement negotiations to the policyholder on terms which included that:

> 'The parties agree that settlement of the Commonwealth Claim shall not be determinative of the amount to which [the policyholder] is entitled to be indemnified for the HMAS Bundaberg Fire Claim under the Insurance Policies. Such amount to be indemnified shall be determined in accordance with the terms of the Insurance Policies alone.'

The policyholder subsequently received a settlement offer from the Commonwealth for $31.5m, being the cost of a similar replacement vessel, which the Commonwealth had commissioned and planned to finance by a chattel lease. RSA refused to consent to the settlement as being reasonable, and denied the policyholder's entitlement to prove its entitlement to indemnity via even a reasonable settlement. The policyholder accepted the offer and sued RSA for indemnity.

At first instance, the Supreme Court found in favour of the policyholder, and RSA appealed. It did so on the basis of various arguments, but essentially the dispute came down to two key arguments:

- that the obligation to 'replace or otherwise make good' the loss did not require the policyholder to pay for a replacement vessel, but could be satisfied by paying for the cost of leasing the replacement vessel; and
- that the above extracted clause in the indemnity settlement agreement meant that the policyholder was not entitled to establish its entitlement to indemnity from RSA by proving that the settlement was reasonable.

Decision

The Court of Appeal held that the obligation to insure (and the obligation to mitigate loss) must always be viewed in the context of the underlying contractual obligation and the particular loss in question.

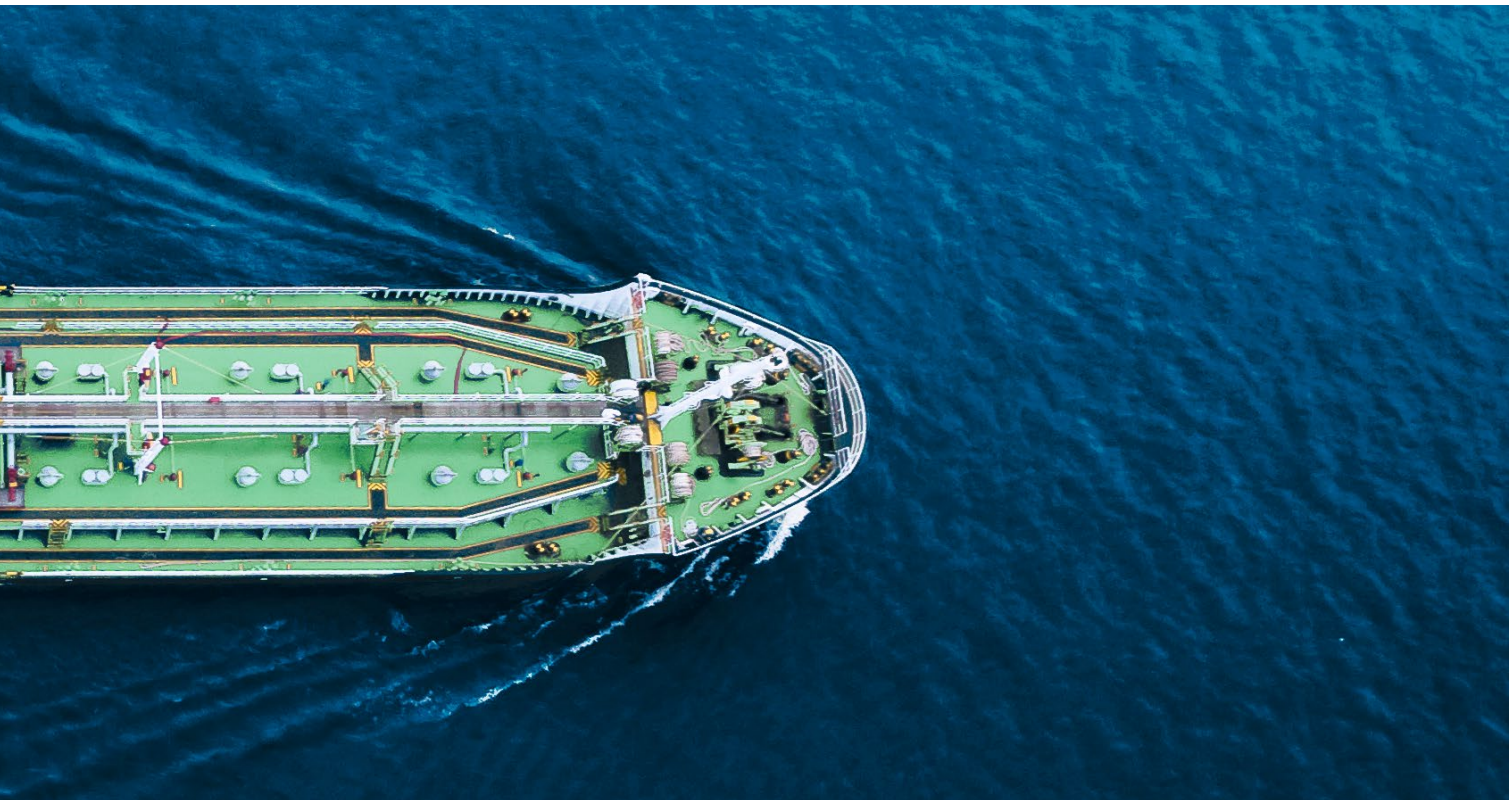
In this case, the obligation to 'otherwise make good' required the policyholder to replace the vessel or pay for a functional equivalent. Simply reimbursing the Commonwealth for the costs of leasing a replacement, even if for the remainder of the HMAS Bundaberg's service life, would not fulfil the obligation to replace a vessel which had been owned by the Commonwealth until it was lost.

Further, steps taken by the Commonwealth to address its loss (namely leasing a vessel) were not relevant to DMS' liability under the underlying contract. In other words, just because the Commonwealth had leased a replacement vessel, it did not mean that offering payment for the cost of the lease would be sufficient to discharge the policyholder's obligation.

The Court further held that the indemnity settlement agreement confirmed the insurer's obligation to indemnify DMS in accordance with the terms of the Policies, and nothing in it altered the general proposition that a policyholder may establish its entitlement to indemnity by reference to a reasonable settlement. As the settlement was reasonable, the policyholder was entitled to indemnity calculated by reference to its settlement agreement with the Commonwealth.

Lessons for Policyholders

The case represents a significant victory for policyholders and reinforces the principles on which a settlement can be used as a basis for coverage under a policy. It also highlights the importance of securing coverage for specific underlying contractual obligations to a third party if that be an integral part of the policyholder's business operations which are intended to be insured.



Insurance and class actions

Key developments: D&O insurance and class actions

D&O insurance

Predominantly as a result of the "double whammy" of continued proliferation of shareholder class actions and increased regulator activity during 2019, we have observed the following developments in the Australian D&O insurance market:

- a general reduction or withdrawal of capacity (amount of insurance available) for 'Side C' cover (being the cover which responds to a company's costs and liability in respect of a shareholder class action). In some cases, insurers are refusing to offer terms for any Side C cover at all;
- significantly increased premiums are being charged by those still prepared to offer Side C cover (and also increased premiums for director only cover), particularly on primary and lower excess layers where the risk of a claim is greatest;
- increased deductibles; and
- broad exclusions such as exclusions for exposures arising from the Royal Commission into Financial Services or insolvency.

Public Offering of Securities Insurance (POSI) (also referred to as IPO insurance), which offers similar protection to D&O insurance specifically in relation to a public offering of securities, has been similarly impacted. While, at the time of writing, IPO insurance is still available, it has become very expensive and insurers will generally not participate in a company's D&O program as well as issue IPO insurance (which makes it increasingly difficult for companies with large, diverse D&O programs to purchase IPO insurance). This has left some companies to rely on their annual D&O program, with the attendant risks that claims arising from capital raisings may impact the annual limits of the D&O program, and that cover for capital raising claims may be withdrawn at future D&O renewals (in circumstances where IPO insurance traditionally applies for a fixed period of 7 years).

Shareholder class actions

There have also been a number of significant developments in the class action landscape which will impact the Australian D&O insurance market going forward. In brief summary:

- 2019 has seen the settlement of a number of shareholder class actions, generally for amounts exceeding $30 million;
- the first judgment in a securities class action has been handed down in the Myer class action, providing support for the "fraud on the market" theory of causation and judicial guidance on issues such as continuous disclosure obligations and quantum. A further judgment in the WorleyParsons class action is anticipated in 2020; and
- the High Court handed down a decision in the BMW and Westpac class actions regarding the Court's power to make "common fund orders" (where litigation funders were entitled to deduct a commission from the "common fund" of damages settlements, despite some members of the claim not having agreed to a funding arrangement). The decision may have implications for the business models of litigation funders in Australia.

Further information on these issues and Herbert Smith Freehills' market-leading class actions practice is available at: https://www.herbertsmithfreehills.com/our-expertise/services/class-actions.

Case law developments

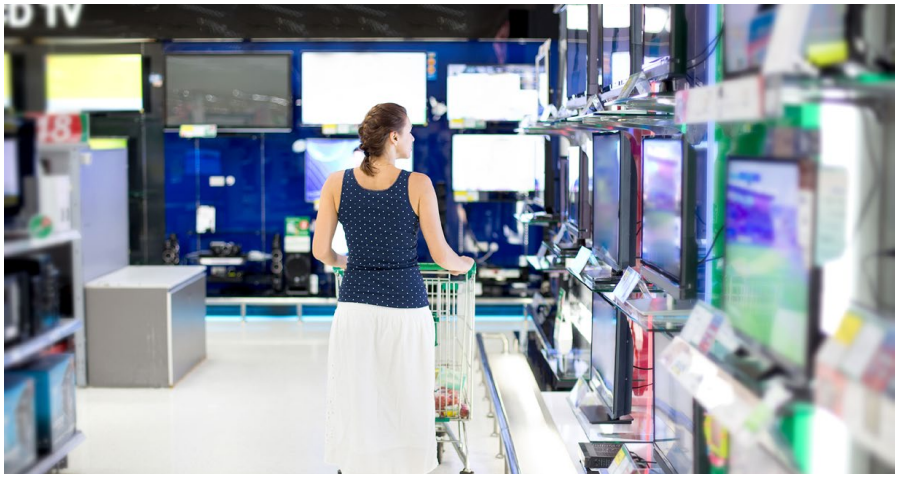
There were numerous cases in 2019 concerning the ability of plaintiffs to gain visibility over a defendant's D&O insurance as part of a class action.

Simpson v Thorn Australia Pty Ltd (t/as Radio Rentals) (No 4)

Facts

The applicant in the class action against Thorn Group (the ASX-listed parent company of Radio Rentals) claimed damages of more than $100 million for the company's "Rent, Try, $1 Buy" program.

Thorn's D&O insurer (AIG) was joined to the proceeding by order of the Court in a separate judgment which found that, in circumstances where AIG had declined cover to the former CEO of Thorn (Mr Marshall, who was the second respondent) there was a real possibility that, if judgment were obtained, he would not be able to meet it.



Prior to Court-ordered mediation and commencement of the trial, the applicant sought production of various documents relevant to Mr Marshall's insurance position, including D&O policies procured for his benefit by Thorn. Production was sought by way of Notice to Produce and subsequently the Court's general power pursuant to s 33ZF of the Federal Court of Australia Act to "make any order the Court thinks appropriate or necessary to ensure that justice is done in the proceeding".

AIG resisted production of the D&O policies contending that the request had no legitimate forensic purpose in circumstances where the policies were not currently in issue in the proceeding, and the insurer had denied liability to indemnify Thorn.

Decision

Justice Gleeson ordered that Thorn produce the insurance policies. Her Honour accepted that there was no legitimate forensic purpose for the Notice to Produce and that the insurance documents would confer a tactical advantage on the applicant to the detriment of AIG, but that pursuant to s 33ZF of the Act, it was "appropriate or necessary to ensure that justice is done in the proceeding".

In particular, her Honour considered the ability of the parties to engage in mediation, noting:

- there was a real issue that Mr Marshall and Thorn may not be able to satisfy a judgment;
- prospects of settlement were reduced if the applicant's legal representatives were required to assess any settlement offer without information about Mr Marshall's insurance position;
- if settlement was reached, Court approval would require evidence that the applicant's legal representatives be "satisfied the settlement is fair and reasonable and in the interests of the group members as a whole"; and
- in accordance with the Class Actions Practice Note (GPN-CA), an application for Court approval of a settlement will usually require the parties to address the ability of the respondent to withstand a greater judgment.

In light of those factors, her Honour found that the applicant would be at a "significant disadvantage" in the mediation without access to the insurance documents and, without them, may be unable to demonstrate that a proposed settlement is fair and reasonable and in the interests of the group members as a whole.

In September 2019, the parties settled the proceeding (subject to Court approval), whereby Thorn agreed to pay $25 million and its insurer agreed to pay $4 million.

Mallonland Pty Ltd & Anor v Advanta Seeds Pty Ltd [2019] QSC 250

Facts

The representative proceeding was filed on behalf of approximately 100 farmers who asserted that they had purchased contaminated seed from Advanta Seeds Pty Ltd ('**Advanta**') and allegedly consequently suffered infestations of a noxious weed, with an estimated loss of approximately $70 million.

The following information came to the plaintiffs' attention which suggested that Advanta would be unable to meet a potential damages award:

- Advanta had been in communication with its insurer about claims arising from the contaminated seed;
- correspondence between the parties' solicitors confirmed that Advanta was not insured against the claims; and

- the 2018 and 2019 annual reports obtained from ASIC relating to Advanta's financial position disclosed that Advanta's net assets and profits were less than the plaintiffs' estimated loss.

The plaintiffs filed an application for disclosure of Advanta's insurance policy and related documents dealing with the assertion that it was not indemnified in respect of the plaintiffs' claims. The plaintiffs relied on Gleeson J's decision in the Radio Rentals class action, submitting that the prospects of settlement at mediation would be reduced if the plaintiffs' lawyers were required to assess the reasonableness of a settlement offer without conclusive information about the insurance position.

Advanta argued that the application was a fishing expedition and should be refused because its real purpose was to challenge the absence of insurance cover – if the plaintiffs wished to pursue the insurer, they should have served the insurer with the application as its interests were involved. Advanta contrasted the position to that in Radio Rentals, where the insurer was already joined as a respondent.

Decision

Mullins J dismissed the application, holding that there were "significant differences" between Radio Rentals and the current proceedings for the following reasons:

- in Radio Rentals the insurer conceded that there was an arguable case against it for indemnity and the insurer was afforded the opportunity to respond to the disclosure application, so the question of insurance coverage was a legitimate area of inquiry and the insurer's interests were ventilated;
- here, the plaintiffs were asking the Court to go behind the stated position of Advanta about its lack of insurance based on mere speculation;
- the plaintiffs may have had the mistaken understanding that Advanta was insured, but that was not a reason to be given disclosure of the insurance policy when there was no dispute between Advanta and its insurer about the insurance position; and
- Advanta has substantial assets and continued to operate a profitable business, whereas in Radio Rentals there was evidence that the company's financial position was deteriorating and it was accepted that any judgment may not be met.

Lessons for Policyholders

While historically plaintiffs have been able to compel the production of defendants' (policyholders') insurance policies in limited circumstances, it may become more common for class action applicants to seek and successfully obtain production of insurance policies. Policyholders may now be ordered to produce insurance documents, particularly where:

1. there is a controversy about coverage between the policyholder and its insurer;
2. there is a real possibility that the policyholder may not be able to meet judgment if the insurance policy does not cover the claim; and
3. the parties are to participate in an imminent mediation.

"Defective" or "damaged": a sharp distinction applied to scratched windows

Corbett v Vero Insurance New Zealand Ltd [2019] NZHC 1823

Facts

The policyholder had engaged a builder to construct a house. The builder engaged a subcontractor to clean the entire house prior to practical completion (after construction was otherwise complete).

The construction of the house included bespoke, high quality, triple-glazed joinery windows from Germany. The windows were installed without any defect, but were damaged by the subcontractor during the final clean when dust and grit was rubbed into the glass, scratching the windows.

The policyholder claimed the cost of repair (estimated at $385,000), under a Contract Works Insurance Policy. Although covering damage to contract works, that policy excluded:

> 'the cost of repairing, replacing or rectifying any part of the contract works which is defective in material or workmanship.'

The insurer denied the claim on the basis that the windows were scratched due to shortcomings in the work performed on them and were therefore excluded as defective in workmanship. The insurer further argued that the purpose of the policy (and the exclusion) is not to insure the quality of contract works / the risk of poor performance of the construction contract. The policyholder didn't dispute that the subcontractor's workmanship was defective, but claimed the windows were damaged not defective.

Decision

The High Court of New Zealand found for the policyholder.

The Court noted that the exclusion clause was not directed to the insuring event itself (ie the physical damage) nor to the risk which causes the damage. The exclusion clause was directed to the particular state of the contract works – namely was any part of the contract works 'defective' due to the materials or workmanship?

The critical question was therefore the meaning of the word 'defective' and how that differs from 'damage'. The Court held that the term 'defective' conveys an inherent issue or fault with the windows or the way in which they have been built. On the other hand the term 'damage' refers to a detrimental physical change or alteration to the property concerned.

In this case, the windows were manufactured and installed correctly and there was no suggestion that they were not capable of performing and operating. Therefore, when installed, the windows were not defective. The windows then went through a physical transformation – they were scratched by the dust and grit when cleaned. This transformation did not render the windows 'defective' (ie they did not create an inherent fault in the window), but did render the windows 'damaged'.

As a result, the Court found that the windows were not a part of the contract works that was 'defective' due to workmanship, and so the exclusion did not apply (and the 'damage' was covered).

Lessons for Policyholders

This decision is an obviously good outcome for policyholders, and a reminder that exclusions which at first reading may appear to preclude a claim do not always operate that way upon closer analysis.

Although is based on a narrowly worded exclusion, this case (and a Canadian decision decided similarly) could be relevant in construing the introductory words to the more commonly used LEG2 and LEG3 exclusions, which begin by excluding the "costs rendered necessary by defects of material, workmanship, design, plan or specification...". Critical is the discussion about the distinction between 'defect' and 'damage' – the former typically excluded and the latter typically covered.

5 Star warranty

UDP Holdings Pty Ltd (subject to deed of company arrangement) (rec and mgr apptd) *v Ironshore Capital* [2019] VSC 645

Background

In 2013 UDP Holdings Pty Ltd purchased 5 Star Foods Pty Ltd for $70 million.

The acquisition was documented in a share purchase agreement (**SPA**) which included various warranties by the seller, including relevantly regarding the financial affairs and performance of the target of the transaction, 5 Star Foods. As is not uncommon for transactions of this type, the SPA provided that the purchaser's recourse in relation to loss from breaches of these warranties was not against the seller, but was confined to making a claim on warranty & indemnity (**W&I**) insurance (ie an insurance policy which paid out if a seller's warranty was found to be incorrect).

After completion of the transaction, UDP discovered 2 breaches of the seller's warranties, namely that the profit performance of 5 Star Foods had been overstated by the seller, and also that a major customer of the business had been overcharged and was seeking a substantial refund.

The business soon encountered rapidly increasing financial difficulties and receivers and managers were subsequently appointed. The receivers and managers eventually sold the business for only $22.5 million, crystallising a significant loss to UDP.

UDP made a claim on the W&I insurance, but this was rejected by the insurer pending the outcome of disputes between the seller and UDP which were the subject of a separate arbitration proceeding.

The arbitration took some time to reach a conclusion, but in September 2018 the arbitrator found in favour of UDP and issued an award of about $55 million. The basis of the award was the seller's breach of a clause of the SPA relating to completion, with the result that UDP had suffered a loss of opportunity to avoid the transaction altogether.

Shortly thereafter the Victorian Supreme Court made orders giving effect to the award as if it were a judgment of the Court. However, due to the financial impecuniosity of the seller, UDP did not recover on the arbitral award.

UDP pressed its claim on the W&I policy. It pleaded and relied upon many of the findings made in the arbitration, and asserted that the insurer was estopped from contesting these findings. The insurer contested the claim, arguing that the arbitrator's finding concerned the completion clause of the SPA, and could not be relied upon to establish 'Loss' as contemplated by the W&I insurance, being in effect loss suffered from a breach by the seller of warranties given by it in the SPA.

Decision

The Court accepted that the Loss covered by the W&I policy was loss for breach of warranty, and that this was technically not the subject of the arbitration outcome. The issue for the Court was the extent to which UDP needed to prove it had suffered loss by reason of the seller's breach of warranty, in circumstances where in the arbitration proceeding the arbitrator had found that UDP had relied upon the warranties given by the seller, that the seller had breached the warranties, and that UDP had accordingly had suffered loss, none of which was challenged by the insurer in the Supreme Court proceeding.

The judge adopted a pragmatic approach, and allowed UDP to introduce into evidence in the Supreme Court much of the evidence relied upon in the arbitration proceeding. On this basis, the Court found that the evidence overwhelmingly established that the seller intentionally and knowingly overcharged the major customer, and that the financial accounts and records of the company were misleading and deceptive at the relevant dates.

Accordingly, the Court found the seller to have breached the warranties in the SPA, that UDP had a contractual right to recover against the seller and therefore that UDP was entitled to recover under the W&I policy.

The Court also provided a useful summary on the principles applied in quantifying loss under a W&I insurance policy. In summary, once breach is established under the policy, the Court must determine the amount necessary to put the buyer in the position it would have been in assuming that the seller's warranties were true. This can be done by reference to the difference between the price paid and the real value of the assets (shares etc) at the time of the transaction. (UDP had argued for a higher amount, reflecting the 'no transaction' case it had sought to make, but this was not accepted by the Court as appropriate in the circumstances).

Applying the principles above, the Court found that the loss suffered by UDP was $30.85 million, comprised of the price paid less the 'true value' of the shares, plus an allowance for the liability for the major customer overcharging.

Lessons for Policyholders

This decision highlights the complexities which often arise in claims under W&I insurance policies. W&I insurance policies require the insured to first establish that there would have been a liability to the purchaser arising from a breach of warranty (which may involve a significant evidential burden) as well as the proper quantum of that liability, and then that the policy responds to the purchaser's loss. While the policyholder (purchaser) was ultimately successful, the history of the claim demonstrates the importance of co-ordinating any underlying recovery action and the warranty and indemnity insurance claim from the outset.

Clarity on depreciation

Mobis Parts Australia Pty Ltd v XL Insurance Company SE [2018] NSWCA 342

Facts

The policyholder owned a warehouse, the roof of which collapsed in a storm, damaging stock, plant and equipment. The damage and consequential business interruption loss was claimed under a typical ISR policy, which insured "Gross Profit" in the following form:

> "The insurance under this chapter is limited to loss of Gross Profit due to (a) reduction in Turnover and (b) Increase in Costs of Working, and the amount payable as indemnity under this Policy shall be:
>
> (a) in respect of the reduction in Turnover: the sum produced by applying the Rate of Gross Profit to the amount by which the Turnover during the Indemnity Period shall in consequence of the Damage fall short of the Standard Turnover
>
> ...
>
> less any sum saved during the Indemnity Period in consequence of the Damage in respect of such of the charges and expenses of the Business payable out of Gross Profit."

The parties agreed that the policyholder would have ordinarily made provision in its accounts totalling $1.5m for depreciation of plant and equipment destroyed in the incident, but that it did not do so during the Indemnity Period (because of the Damage). The question was whether any amount should be deducted from the claim for the depreciation "saved" since it was not booked in the accounts due to the interruption.

At first instance, the trial judge had (without a detailed consideration of the issue) followed a single judge's decision of the UK's High Court in *Synergy Health v CGU* holding that depreciation which was no longer booked as an expense in the P&L was "saved" and therefore should be deducted from the insured Gross Profit payable to the policyholder.

Decision

The NSW Court of Appeal unanimously reversed the trial judge's decision, and expressly rejected the reasoning of the judge in *Synergy*. Meagher JA (with whom Beazley P and Leeming JA agreed) analysed the true nature and impact of depreciation on profit, noting depreciation to be the systematic allocation of an asset's cost as a series of expenses over its useful life, which appears in the P&L statement as an expense, and reduces the carrying value of the asset in the Balance Sheet, but which has no direct impact on cash flows.

In recognising that the ISR Policy's formula for the assessment of insured loss qualifies the principle of indemnity insofar as it might depart from perfect indemnification in some contingencies, the Court held that attention must be focussed on the language describing the method for ascertaining the loss as coloured by its immediate and commercial context.

In that regard, the Court noted that the calculation of loss of Gross Profit under the ISR Policy involved three integers:

- Reduction in Turnover, to be determined by a formula;
- Increased Costs of a particular description, also to be determined by a formula; and
- any sum **saved** ... in respect of such charges and expenses of the Business **payable out of** Gross Profit [emphasis added].

The Court held that the focus on what is "saved" and the use of the word "payable", rather than "deducted", suggested the **exclusion of charges and expenses that are not liable to be paid away**, such as depreciation. Noting that the Flaux J in *Synergy* had recognised this textual consideration but then ruled otherwise on the application of the indemnity principle, the NSW Court of Appeal held that the indemnity in the ISR Policy is not against "actual loss", rather it contains a formula and there was nothing in the context of the clause which required any departure from the language used.

Finally, the Court held that any debate on whether this would result in the policyholder being over or under indemnified is an enquiry of the kind that the formula in the policy would be expected to foreclose (ie that it is irrelevant – just apply the formula).

Lessons for Policyholders

Whether a reduction in non-cash costs such as depreciation following insured damage amounts to a "saving" to the policyholder which is to be deducted from insured Gross Profit in calculating business interruption losses is an issue which has been debated by claims professionals for many years. This decision resolves that debate, and policyholders should pay close attention to this issue in the context of a claim. More generally, issues such as this highlight the potential overlap between legal and accounting disciplines in the context of a major claim – it is important that legal advisers and claims preparers work together closely to maximise the outcome for the policyholder client.

Identity crisis – the specifics of the schedule override the general standard terms

Tokio Marine & Nichido Fire Insurance Co Ltd v Hans Bo Kristian Holgersson trading as Holgersson Complete Home Service [2019] WASCA 114

Facts

The policyholder (a builder) held an annual projects and legal liability policy which covered both physical damage and legal liability in relation to projects. Relevantly:

- The standard terms provided that 'We agree… to pay You… all amounts You shall become legally liable to pay as compensation…' and 'You' was defined to mean 'the Person(s) or legal entity named in the Schedule'.
- The Schedule named the 'Insured' to be '[the policyholder] and all Principals, Contractors, and Sub-Contractors' (those terms, despite capitalisation, were not defined in either the Schedule or the standard terms).
- 'Named Insured' was defined in the standard terms to include 'all contractors and sub-contractors… not being You but being a legal entity with whom You have entered into a Contract and provided their interests are required to be insured jointly by You and then only to the extent required by the terms of the Contract '. [emphasis added]

In October 2015, the policyholder was engaged to renovate a home and engaged a sub-contractor, Holdersson, to paint the interior of the house. The sub-contract did not require the policyholder to insure the sub-contractor.

During the paint works, the house burned down – allegedly due to combustion of oil soaked rags left in a bin room by the subcontractor. The insurer covered the policyholder's liability and sought to bring a subrogated claim against the sub-contractor to recover the amount paid on the claim due to the sub-contractor's negligence.

The sub-contractor successfully argued at trial that they were a relevant 'You' named in the Schedule and were therefore entitled to be indemnified by the insurer so the subrogation claim was not available. The insurer appealed on the basis of a variety of technical contractual interpretation arguments including:

- a person is only 'named' in the Schedule if they are named by proper noun;
- the standard terms limited the coverage available to sub-contractors to entities with whom the 'Named Insured' "have entered into a Contract [which] provided their interests are required to be insured by You' (which qualification would exclude the subcontractor); and
- the original proposal for insurance form completed by the policyholder only referred to the policyholder (and not its subcontractors).

Decision

In a joint judgment, the Court of Appeal dismissed the appeal and upheld coverage for the subcontractor.

In essence, the Court of Appeal concluded that effect should be given to the definition of 'You' in the Schedule prepared specifically for this policy over the general standard terms. In reaching this conclusion, the Court engaged in a detailed discussion of the principles to be applied in interpreting a policy. Some of the key reasons included that:

- in ordinary usage, the term 'named' does not require identification by a proper noun;
- the insurer's interpretation would mean that the definition in the Schedule would mere surplusage;
- the policy was a standard form document, whereas the Schedule was a document created specifically for this insurance contract (and therefore, generally, should not be read down to give effect to a contrary definition in the policy);
- it is commercially sensible to have one umbrella policy covering all parties involved in a construction project instead of requiring each party to obtain separate coverage; and
- what was said in the proposal was only of limited relevance as contractual interpretation involves ascertaining the meaning of what is said in the policy – not a search for what parties may have meant to say.

Lessons for Policyholders

The result in this case reinforces the likelihood that courts will take a sensible and commercial approach to interpreting the policy and will look more closely at the specific terms drafted for a particular policy over what is said in the general standard terms where inconsistencies arise.

In particular, this case can be expected to have general relevance to construction companies seeking cover for their projects – in that it confirms that a policy can cover multiple unnamed parties (e.g. 'subcontractors') including where they are not engaged at the time of entering the policy – provided the policy schedule says so.

The judgment also contains a useful detailed discussion on contractual interpretation and the relevance of extrinsic evidence such as proposal forms and other documents created in arranging cover when interpreting the meaning of the policy ultimately issued.

Cyber insurance

Recent international experience has highlighted both the potential magnitude of losses that can arise from cyber attacks and the diversity of challenges that a policyholder may face in recovering that loss – particularly where it does not have a specialist cyber insurance policy.

In 2017, hundreds of companies globally were crippled by the deployment of the NotPetya malware, which the US government and international law enforcement agencies linked to the dispute between Russia and Ukraine.

Merck & Co, an American multinational pharmaceutical company, and Mondelez, an American food and beverage company, each suffered loss as a result of the NotPetya attacks. Both companies subsequently sought to recover their losses under their insurance policies, and both had some or all of their claims rejected.

Merck & Co

NotPetya was introduced into Merck & Co through software running in the company's Ukraine office. The malware crippled thousands of company computers and servers, paralysing its sales, manufacture and research. The company's losses as a result of the incident were estimated at more than US$1 billion.

Merck & Co made claims under a number of its insurance policies, and recovered some of its loss through policies which included specific cover for cyber damage. However, the majority of its claims, which were made under its property policies, were rejected by the insurers on the basis that the NotPetya attacks were acts of war or terrorism and thus excluded from cover.

Merck & Co commenced action in New Jersey against its insurers. It has settled its case with a couple of insurers, but the dispute with the remaining defendants is ongoing. We'll keep you posted.

Mondelez International, Inc.

Mondelez was similarly impacted by the NotPetya malware, paralysing its servers and logistics software, impacting the distribution of its products, with losses estimated at more than US$100 million.

Mondelez sought to recover its losses under a property insurance policy it held with Zurich, which covered "physical loss or damage to electronic data, programs, software caused by the malicious introduction of a machine code or instructions" as well as "nonphysical losses and expenses caused by the failure of 'electronic data processing equipment or media to operate' due to malicious cyber damage".

Zurich also relied on the exclusion for "hostile or warlike action" by any government or sovereign power (or its agents), based on the intelligence reports that NotPetya was launched by the Russian government (or its actors) in its attempts to destabilize the Ukraine.

In 2018, Mondelez commenced action in Illinois against Zurich for breach of contract. That litigation is also ongoing.

Lessons for Policyholders

Although the number of incidents of catastrophic loss caused by cyber attacks continues to increase, there is still a lot of uncertainty around how insurance policies will (and should) respond. These cases – and any Court decision that results – will inevitably shape how insurers will treat claims for loss caused by cyber attacks which might have political or other motivations.

The key lesson reinforced by these cases – and others concerning cyber damage – is the importance of including specific cover for losses arising out of ransomware, malware and other cyber attacks, if that is the intended risk the policyholder is seeking to mitigate. Relying on the cover afforded under any property insurance policies or general crime policies may not be enough, particularly as insurers tighten the wording to ensure such loss is not inadvertently covered.

In some instances it might be appropriate to obtain separate specialist cyber insurance policy. Irrespective of whether the cover is afforded under a general or specialist policy, policyholders should make sure to review closely the boilerplate exclusions – such as acts of war – to ensure they will not undermine the cover being sought.

Contacts – who can help?

Insurance team

Australia

Mark Darwin
Partner
T +61 7 3258 6632
mark.darwin@hsf.com

Peter Holloway
Partner
T +61 3 9288 1693
peter.holloway@hsf.com

Ruth Overington
Partner
T +61 3 9288 1946
ruth.overington@hsf.com

Guy Narburgh
Special Counsel
T +61 2 9322 4473
guy.narburgh@hsf.com

Philip Hopley
Special Counsel
T +61 2 9225 5988
philip.hopley@hsf.com

Andrew Ryan
Executive Counsel
T +61 8 9211 7965
andrew.ryan@hsf.com

Amelia Edwards
Senior Associate
T +61 3 9288 1626
amelia.edwards@hsf.com

Asia

Gareth Thomas
Partner
T +852 2101 4025
gareth.thomas@hsf.com

United Kingdom

Paul Lewis
Partner
T +44 20 7466 2138
paul.lewis@hsf.com

Europe/Latin America

Paulino Fajardo
Partner
T +34 91 423 4110
paulino.fajardo@hsf.com

Additional contributors

Travis Gooding, Nicholas Darwen

Market recognition – awards and accolades

AUSTRALIAN FIRM OF THE YEAR 2019
ASIALAW ASIA PACIFIC DISPUTE RESOLUTION AWARDS

LAW FIRM OF THE YEAR 2019
REGULATION ASIA AWARDS FOR EXCELLENCE

TIER 1 INSURANCE 2020 AND TIER 1 DISPUTE RESOLUTION
LEGAL500 2020

BAND 1
DISPUTE RESOLUTION – AUSTRALIAN
CHAMBERS ASIA-PACIFIC 2016 - 2020

BAND 2
INSURANCE – AUSTRALIAN
CHAMBERS ASIA-PACIFIC 2016 - 2020

BAND 1
DISPUTE RESOLUTION
GLOBAL WIDE
CHAMBERS GLOBAL 2020

Mark Darwin
Leading individual in Insurance,
LEGAL 500 ASIA-PACIFIC 2020

Notable Practitioner,
CHAMBERS ASIA-PACIFIC 2020

Guy Narburgh, Philip Hopley
Next Generation Partners,
LEGAL 500 ASIA-PACIFIC 2020

Travis Gooding
Rising Star,
LEGAL 500 ASIA-PACIFIC 2020

" The ability to understand and navigate strategically through complex insurance dispute matters"

" Their organisational ability is phenomenal and they're very good technically as well - particularly in complex litigation ... The team have been extremely helpful and very clear in communicating issues and the strategy to overcome the issues that we've faced"

" Very approachable, and have the great ability to simplify complex insurance issues for clients without any knowledge of insurance"

" The team is very commercially focused and remains concentrated on the substance of the matters rather than getting distracted by matters of minor form"

For a full list of our global offices visit **HERBERTSMITHFREEHILLS.COM**