HERBERT SMITH FREEHILLS

POLICYHOLDER INSURANCE HIGHLIGHTS 2020

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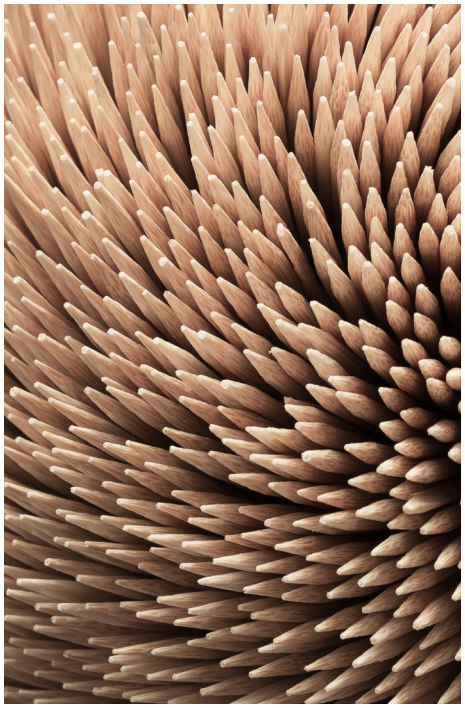

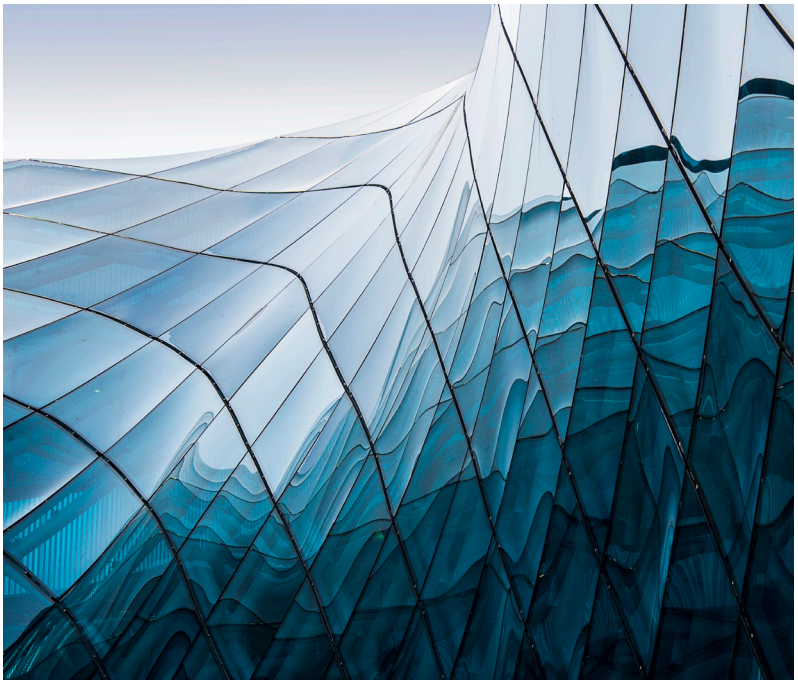

Introduction

Welcome to the sixth 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 previous editions of **Policyholder Insurance Highlights**, the key messages this year are:

1. **COVID-19 has meant insurance has been front page news and top of mind for corporate Australia:** interruption to Australian (and global) businesses as a result of COVID-19 has been widespread. Perhaps unsurprisingly, there has been a significant focus amongst policyholders, insurers and brokers on the response of various 'non-damage' coverage extensions in business interruption insurance policies, as well as associated exclusions. This has resulted in a series of cases in Australia and the UK – each dealing with a different range of issues. Some of these cases have been fast-tracked and decided at first instance, but appeals are ongoing. Policyholders should not expect quick resolutions – disputes will continue through 2021 as appeal rights are exhausted. However, there have so far been a number of successes for policyholders. As such, policyholders should be seeking advice as to (a) whether their policies potentially provide coverage; (b) whether existing cases on foot will resolve issues relevant to their coverage; and (c) what steps they should be taking now to preserve or enforce their rights.
2. **Further pressure on the Directors' & Officers' insurance market:** the proliferation of shareholder class actions means 'Side C' D&O insurance which covers companies for such claims is becoming increasingly difficult to obtain or prohibitively expensive. The same applies for similar, specific insurance cover for companies conducting capital raisings. Corporates are now giving serious consideration as to the value which is being obtained from this form of risk transfer and what alternatives there may be going forward. Significant ongoing D&O losses borne by insurers, together with increased claims in other areas (including COVID-19 business interruption) and reduced investment returns for insurers, have resulted in the insurance market continuing to harden across all major lines of business – the availability and scope of insurance coverage is generally reducing, and premiums are generally increasing.
3. **Delays and disputes continue to affect major insurance claims:** as expected as the insurance market hardens and insurers' profit margins come under increased pressure, and consistent with the trends we have observed in recent years, coverage disputes for major claims are on the rise. Our view remains that policyholders should 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 – it is clear that insurers are doing the same. This is even more important given the hardening market reduces policyholders' ability to push for (or even preserve) broader coverage at renewals.

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.

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Business interruption insurance for COVID-19 related losses

The hot-topic in the current insurance market is whether, and to what extent, business interruption caused by COVID-19 is covered by insurance policies. We have been releasing regular updates, available on our website, in relation to the various ongoing test cases on these matters:

- in relation to the recently finalised appeal in the UK FCA test case – in which Herbert Smith Freehills represented the FCA in successfully advocating the policyholder's positions (our most recent update available here);
- in relation to the various Australian test cases (here); and
- in relation to the Australian ICA test case (here).

What are the key issues?

Business interruption insurance (as part of an ISR policy) covers the loss of profit and increased costs that a policyholder suffers as a result of insured events. Typically that event or "trigger" for coverage is physical damage to the insured's business premises. COVID-19 is not physical damage, so a typical policy will not cover COVID-19 related losses.

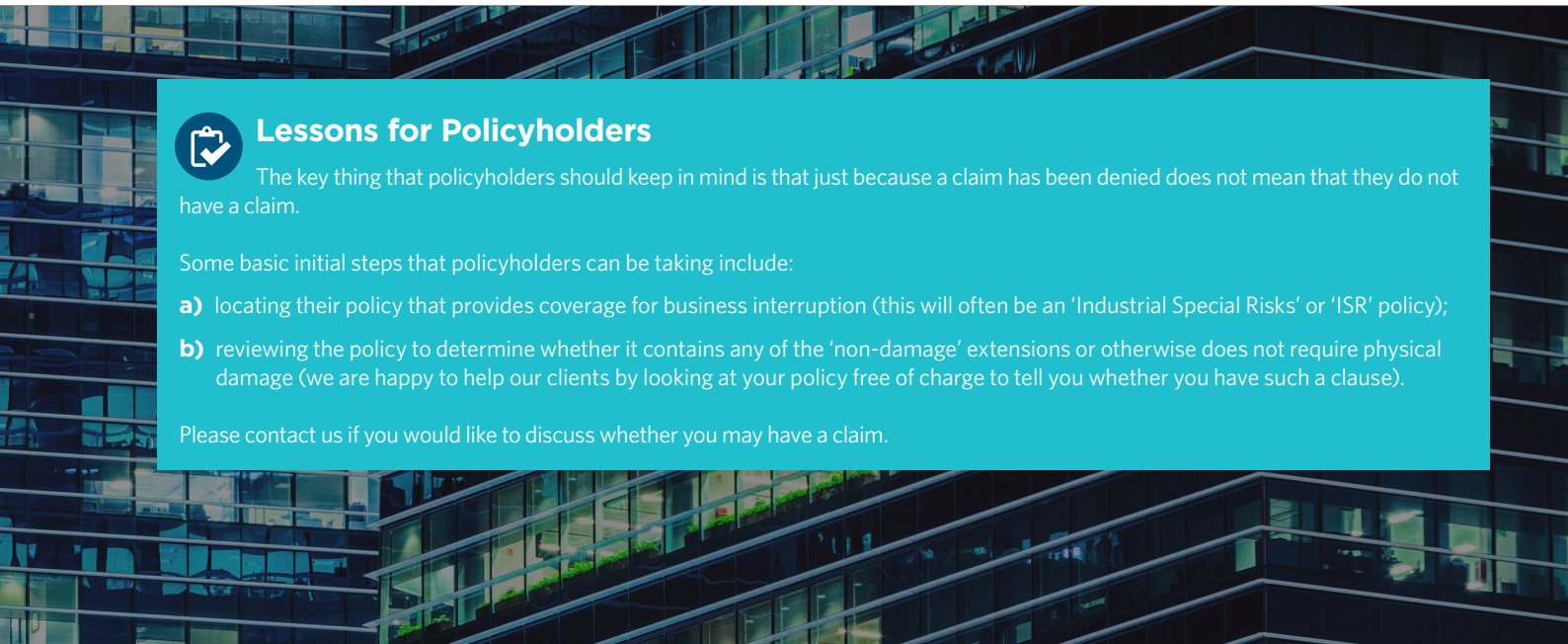
However, many policies contain a variety of 'non-damage' extension clauses which may open up the possibility for a claim. A list of examples which might apply appears below. While every policy will turn on its own wording, there are generally three main issues relevant to seeking coverage under a 'non-damage' extension:

TRIGGER ISSUE	**Have the specific requirements of the relevant 'non-damage' extension been met?** Some guidance may be obtained from the various test cases being conducted, however not all extensions are part of the test cases already decided. Further guidance is expected from the Star City Casino case (which was closed by the actions of authorities) which is due to be heard in late April 2021.
EXCLUSION ISSUE	**Are there any applicable exclusions?** The disease extension is often subject to an exclusion for diseases declared under the *Biosecurity Act* and the standard ISR policy contains a general exclusion for physical damage caused by disease (both of which we consider irrelevant to claims under other non-damage extensions but this is to be decided in the Star City Casino case). Some policies still refer to the now repealed *Quarantine Act* (which the NSW Court of Appeal has held is not effective as an exclusion, although this decision is being appealed to the High Court).
CAUSATION ISSUE	**Did the trigger cause the loss and what 'other circumstances' may be taken into account** in demonstrating the 'Standard' turnover which the business would have achieved absent the insured trigger? This issue has been resolved in favour of the policyholders by the UK appeal decision, assuming it is followed by insurers in Australia – which it should be given that they were happy to follow the now overruled UK decision in the *Orient Express Hotels case*.

What are the kinds of extensions being relied on?

There are a number of extensions being relied upon. Some examples of the main types of wordings policyholders should be looking for are:

CATEGORY OF EXTENSION	EXAMPLE WORDING
Disease	... will cover you for interruption to or interference with your business due to... (b) an outbreak of an infectious or contagious human disease occurring within a 20 kilometre radius of the Premises...
Prevention of Access	... will cover you for loss in consequence of access to or use of the premises being prevented or hindered by... any action of government due to an emergency which could endanger human life or neighbouring property...
Hybrid	...will cover loss arising from closure or evacuation of the whole or part of the premises by order of a competent government, public or statutory authority as a result of ... the outbreak of a notifiable human infectious or contagious disease occurring within a twenty (20) kilometre radius of the premises.
Civil Authorities	The word "Damage" under Section 2 of this Policy is extended to include loss resulting from or caused by any lawfully constituted authority in connection with or for the purpose of retarding any conflagration or other catastrophe.
Loss of Attraction	Loss as insured by the Policy resulting from interruption of or interference with the Business:... (b) by the action of any lawfully constituted Authority attempting to avoid or diminish risk to life or property in the vicinity of such premises, which shall prevent or hinder the use thereof or access thereto, or which causes a fall in the number of potential customers attracted to the vicinity of the Premises, whether the premises or property therein shall be damaged or not, shall be deemed to be loss resulting from Damage to property used by the Insured at the Premises.



Lessons for Policyholders

The key thing that policyholders should keep in mind is that just because a claim has been denied does not mean that they do not have a claim.

Some basic initial steps that policyholders can be taking include:

a) locating their policy that provides coverage for business interruption (this will often be an 'Industrial Special Risks' or 'ISR' policy);

b) reviewing the policy to determine whether it contains any of the 'non-damage' extensions or otherwise does not require physical damage (we are happy to help our clients by looking at your policy free of charge to tell you whether you have such a clause).

Please contact us if you would like to discuss whether you may have a claim.

What cases are ongoing?

There are a number of different test cases ongoing around the world. The main ones of note for the Australian market are:

CASE	ISSUES CONSIDERED	STATUS
UK FCA Test Case	Trigger Issue: Application of various extensions used in the UK. Causation Issue.	On 15 January 2021, the UK Supreme Court (highest court of appeal in the UK) decided 5-0 in favour of policyholders. The Court held that the extensions provided cover and the loss covered by the peril was not to be reduced by reference to what effect the broader pandemic would have had anyway. Judgment available (here).
ICA Test Case (First)	Exclusion Issue: whether exclusions referring to '*quarantinable diseases under the Quarantine Act 1908 (Cth) and subsequent amendments*' excludes COVID-19 given that the *Quarantine Act* was replaced by the *Biosecurity Act 2015*.	The NSW Court of Appeal decided 5-0 in favour of policyholders (available here). On 16 December 2020, insurers applied for Special Leave to Appeal to the High Court (here). A decision on whether they will be granted special leave could occur within or shortly after Q1 of 2021.
ICA Test Case (Second)	Issues are not yet finalised, but are said to include proximity (Causation Issue) and prevention of access (Trigger issue).	Not yet filed, but the ICA was reported after losing the First test case to be in negotiations to bring a further test case. Our view is that this should not be necessary in light of the 5-0 decision on these issues in the UK FCA appeal.
Star Casino Case	Trigger Issue: tests a Civil Authority clause. Exclusion Issue: tests general perils exclusion for physical damaged occasioned by diseases and whether a *Biosecurity Act* exclusion in a separate extension affects coverage under the Civil Authority clause.	Scheduled to be heard on 29 – 30 April 2021. Judgment predicted perhaps mid-2021. This will be an important case for policyholders in Australia to watch as many Australian businesses were less affected by COVID19 at or within a vicinity of their premises but more so affected by the actions taken by authorities to respond to the pandemic.
Melbourne Café Claim	Exclusion Issue: tests whether an exclusion for losses caused by '*biosecurity emergencies*' declared under the *Biosecurity Act 2015* (Cth) applies to losses caused by the action taken by authorities under the *Health Act* (Vic) in response to the emergency The policyholder argued that its loss was not caused by the declaration itself but only by the actions of the Victorian Government in response.	Judgment delivered on 18 December 2020 (available here). Although there were issues with how the separate question was framed, the Court considered that the exclusion referred to the state of affairs underpinning the making of the declaration and therefore did exclude loss caused by the response to the underlying emergency.

How many deductibles is that?

Rawson Homes Pty Ltd v Allianz Australia Insurance Ltd [2020] NSWSC 1654

Last year's update included news of the policyholder's successful appeal on the aggregation of deductibles for a class action which might have comprised numerous 'Claims' under a D&O liability policy[1].

The issue of multiple or aggregated deductibles has been considered again this year, this time in the context of hailstorm damage to multiple properties under construction by the policyholder (a building company).

Facts

On 18 February 2017, a severe hailstorm west of Sydney caused damage to 122 partially constructed houses in a development at Kellyville and Rouse Hill. The builder, Kelly Homes, sought indemnity under an annual construction insurance policy issued by Allianz.

The insuring clause and definition of 'Indemnifiable Event' each referred to individual 'Insured Contracts' for individual properties under construction. However, 'Deductible' was stated in the Schedule to be '*$10,000 Any One Event*' and defined by reference to each 'event or occurrence', as follows:

> 'Deductible' means the amount of money specified in the Schedule for each applicable Section or type of loss as specified, that the Insured must contribute as the first payment for all claims arising out of one event or occurrence.

Under the basis of settlement, a clause entitled 'Application of Deductible' also provided:

> The amount of the Deductible will be subtracted from the amount payable by Us for each event giving rise to a claim under this Section. If a claim arises from a single event and the Insured can obtain cover under more than one benefit in this Section, the Insured will only be required to pay the highest single Deductible applicable regardless of the number of Deductibles applying to this Section.

The insurer argued that, reading the policy as a 'coherent and harmonious whole', the builder was making 122 claims under the policy, as the insuring clause related to each building contract, and therefore 122 separate deductibles were payable.

The builder argued that only one deductible was payable on the basis that all claims arose out of the hailstorm which was "one event or occurrence".

Decision

The NSW Supreme Court agreed with the builder that only one deductible was payable. The starting point was the provisions dealing with the deductible which contemplated multiple claims arising out of one event. The 'Application of Deductible' clause referred to 'each event giving rise to a claim', and the deductible was specified for 'Any One Event'.

Although 'event' was not defined, the Court found that as a matter of common sense and ordinary meaning, the hailstorm could only be considered one event. This conflicted with the definition of 'Indemnifiable Event', which related to each building contract, however that could be explained by the deliberate use of different terms: 'event' vs 'Indemnifiable Event'.

To the extent Allianz asserted that there was ambiguity in the overall interpretation of the policy, as it was a standard form insurance contract authored by the insurer, any ambiguity had to be resolved in favour of the insured.

Lessons for Policyholders

The calculation of deductibles can have a significant effect on the value of claims. When preparing a claim, it is important to carefully consider the policy wording when approaching characterisation of the event, the loss and the claim.

This case also provides a reminder that the maxim of *contra proferentem* (ambiguities will be interpreted contrary to the party which prepared the document) may still have a role to play in the interpretation of insurer issued standard policy wordings.

1. *Bank of Queensland Ltd v AIG Australia Limited* [2019] NSWCA 190

Risk may 'attach' prior to the policy period (even when a helicopter is not attached!)

Swashplate Pty Ltd v Liberty Mutual Insurance Co (2020) 381 ALR 648

Facts

The policyholder purchased a helicopter located in Picayune, Mississippi, and in May 2018 arranged to ship the helicopter to Sunshine Coast Airport in Queensland. Under a facility master policy arranged by its broker and issued by Liberty Mutual, the policyholder obtained a placement slip insuring the transit of the helicopter on the terms of the master policy. The helicopter was found to be damaged on arrival because it was not sufficiently and suitably packed and the bracings tying it down in its container had broken in transit.

The terms of the master policy excluded liability for defective packing '*prior to the attachment of this insurance*'. The insurer relied on this exclusion to deny indemnity on the basis that the helicopter was packed prior to the insurance 'attaching'. So the key issue became when did the insurance "attach"?

The master policy required Liberty to accept placement slips for 'risks attaching' during a one-year period that covered the transit period. The helicopter was packed on 18 May 2018 in Mississippi, although in Australian time (where the placement slip was arranged) it was 19 May 2018 and the placement slip stated a 'Period of Insurance' from 19 May 2018 until the arrival of the helicopter at Sunshine Coast Airport (without stipulating when the insurance 'attached').

Importantly, the master policy incorporated the terms of the Institute Cargo Clauses (A) 2009 (**ICC(A)**), which provided that risk 'attaches' when the cargo is first moved for the purpose of immediate loading for transit, but also contained in extension which provided that:

> *Coverage is extended to include Static Cover for up to 5 days prior to loading.*

The insurer argued that the risk 'attached' on the start of the Period of Insurance specified in the placement slip (19 May) and that the relevant packing time was the local time in Mississippi (18 May), so the helicopter was packed before the insurance 'attached' and therefore the damage was excluded. The trial judge accepted the insurer's argument and the policyholder appealed.

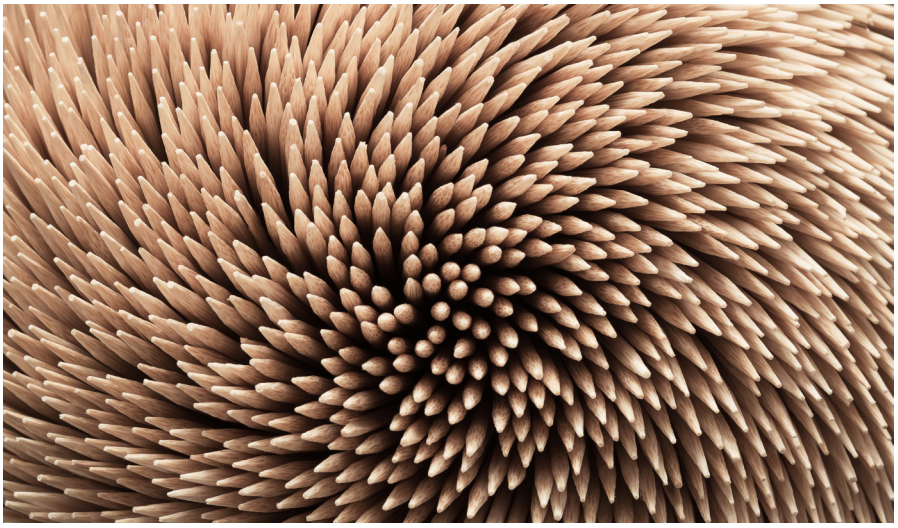
Decision

The Full Federal Court unanimously overturned the trial judge's decision, finding that the policy attached 5 days prior to loading because of the Static Cover extension.

While the placement slip specified a 'Period of Insurance' commencing on 19 May 2018, this did not use the language of 'attaching', so did not prevent the terms of the master policy being applied to provide an earlier attachment date based on when the helicopter was loaded and extended for 5 days of 'Static Cover' beforehand.

In reaching its decision, the Full Court found that the commercial purpose of stating a date in the placement slip was simply so that the insurer could determine whether it fell within the one year period of the master policy facility, and attaching cover only on the date stated in the placement slip would be contrary to the express words of the master policy and deprive the insurance of its primary commercial character, being for risks during the whole of a voyage, rather than merely part of it.

Given the finding policy coverage began earlier than 18 May 2018, it was not necessary to determine which time zone applied, however the Court indicated that the local time where the event causing the damage (loading) occurred was likely to be the relevant time, as the policy provided worldwide coverage.



Lessons for Policyholders

This decision is a welcome and commercially sensible outcome, given the commercial purpose of such voyage policies is to insure the entire period of transit.

However, it is also an important reminder of the value of ensuring that insurance coverage is arranged early, and to be aware of the terms of master policies, so that if needed appropriate extensions are included to provide protection where coverage is needed for periods prior to policy issuance.

Voluntary redress payments binding on insurers

National Australia Bank Limited v Nautilus Insurance Pte Ltd (No 3) [2019] FCA 2139

Facts

A review by, what is now, the Financial Conduct Authority (UK) identified issues in the way Clydesdale Bank, a former subsidiary of NAB, had sold products to customers.

Following an internal review into the way products had been sold, NAB chose to make a series of redress payments to a number of its customers. These payments were made by way of settlement agreements entered into voluntarily by the bank in circumstances where no court process proved liability on its part.

The bank, represented by Herbert Smith Freehills, sought to claim for these payments and associated legal costs – totalling over £357 million – under its civil liability insurance. Insurers and reinsurers denied liability alleging that the voluntary payments were not covered as the policy required proof of an underlying legal liability, for which in this case there had been no finding or even proceedings commenced.

The dispute turned on the construction of a number of terms in the policy, but primarily in issue was the construction of 'Civil Liability' which was covered by the policy, the meaning of which included:

(a) a legally enforceable obligation to a third party for compensation, damages, legal costs or a Restitutionary Order in accordance with an award of a court or tribunal by whose jurisdiction the Assured is bound;

(b) a legally enforceable obligation to a third party for compensation, damages, legal costs, or a Restitutionary Order acknowledged (subject always to... General Condition 7...) by an agreement made between the Assured and a third party in settlement of a Claim;

General Condition 7 required the policyholder to obtain the insurer's consent prior to entering into any settlement. The term 'Claim' was defined to include any demands "*either for or which could reasonably result in the payment of compensation, damages, or a Restitutionary Order...*"

Decision

The Court noted that liability insurance compensates a policyholder for damage which the insured must pay to a third party. In other words, generally, for coverage under a liability policy to be triggered there must be proof of an underlying legal liability to the third party.

A settlement voluntarily entered into creates a liability to the third party, but does not prove that there would have been a liability had the settlement not been entered into. As such, proof of a settlement alone is, generally, not enough to trigger coverage under a liability policy, unless the insurer has breached or repudiated the policy prior to the settlement (in which case there is plenty of authority to establish that a reasonable settlement will establish the liability of the insurer in a claim for damages).

The critical question in this case was whether the particular definition of 'Civil Liability' in this policy required proof of an underlying liability, or allowed just proof of a settlement?

The Court held that the broad drafting of 'Civil Liability' and 'Claim' did not require proof of the underlying liability. This was supported by various textual considerations, but key to the Court's reasoning was that:

- while subsection (a) of the definition of 'Civil Liability' required a legally enforceable obligation awarded by a court or tribunal, subsection (b) expressly permitted a legally enforceable obligation acknowledged by an agreement; and
- the definition of a claim expressly referred to a demand '*which could reasonably result in the payment of compensation*'.

The Court expressly did not determine whether there had been a breach of General Condition 7 (or whether such a breach could be remedied by s54 of the *Insurance Contracts Act 1984* (Cth)). The Court simply noted that the requirement to obtain the insurers' consent prior to settlement did not change the Court's interpretation of 'Civil Liability'.

Lessons for Policyholders

The decision is a win for policyholders. However, it also demonstrates the complexity of the law in relation to when a settlement will or will not bind an insurer. A policyholder who is considering entering into a settlement without the consent of their insurer should be mindful of this complexity. It may even be that repudiation of the contract of insurance (and suing for damages for breach rather than indemnity under the policy) is the preferable course of action.

These issues are particularly relevant given the recent increase in class action claims and high profile litigation where it is often undesirable for policyholders to hand over conduct of their defence to insurers. It is vital for policyholders to know their insurer's position prior to entering into a settlement and, if the insurer's position is not favourable, what the effect of a settlement would be on any insurance claim. Prior to any settlement, policyholders should therefore seek legal advice on whether the settlement may prejudice their insurance claim and what steps they can be taking to avoid that consequence.

The insured "Situation" is not limited by the insured "Business"

Oceanview Developments Pty Ltd trading as Darwin River Tavern & Darwin River Supermarket v Allianz Australia Insurance Ltd trading as Territory Insurance Office [2020] FCA 852

Facts

The policyholder (Oceanview) owned two adjacent lots in Darwin. It conducted a number of businesses on one lot (Lot 2333) including a hotel, supermarket, post office and service station. The other (Lot 2445) was leased to a nursery business (not conducted by Oceanview).

A fire caused damage to infrastructure on both lots. Oceanview lodged a claim for property damage (to both lots) and business interruption to its business on Lot 2333 under an Industrial Special Risks (**ISR**) Policy issued by Allianz. Allianz agreed to cover the damage to Lot 2333 and the consequential BI loss, but not the property damage to the nursery on Lot 2445 (no claim was made for the BI loss of the nursery).

The policy schedule which defined the Insured, the Business, the Situation, and Declared Values relevantly defined the "Business" as those businesses operation by Oceanview (on Lot 2333) and the "Situation" as "Lot 2333 and Lot 2445".

The Policy contained the standard indemnity clause and definition of "Property Insured" as follows (emphasis added):

Clause 1.1 – Indemnity for material loss and damage:

In the event of any physical loss, destruction or damage ... not otherwise excluded happening during the Period of Insurance at the Situation to the Property Insured described in Section 1, the Insurer(s) will, subject to the provisions of this policy, including the limitation on the Insurer(s) liability, indemnify the Insured in accordance with the applicable Basis of Settlement.

Clause 1.2 – Definition of "Property Insured":

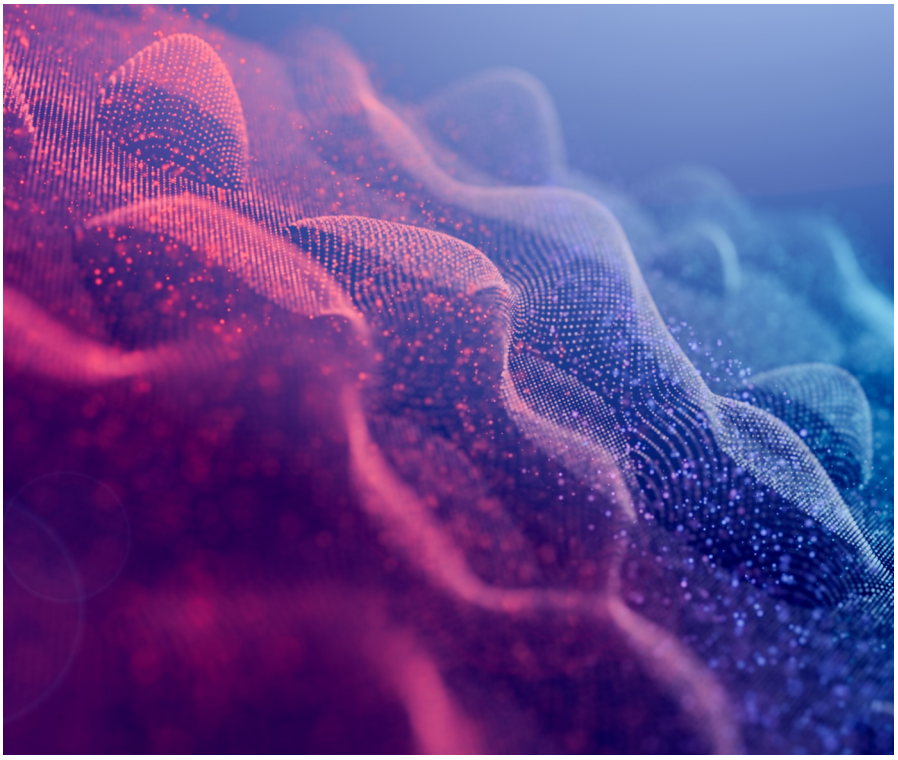
All real and personal property of every kind and description (except as hereinafter excluded) belonging to the Insured or for which the Insured is responsible, or has assumed responsibility to insure ...".

Allianz argued that the policy only covered damage to property which related to the "Business" of the policyholder and not the damage to the nursery. The policyholder submitted that the "Property Insured" under clause 1.1 of the policy was not confined or limited to the property related to the Business.

Decision

The Court found in favour of the policyholder, concluding that the material damage indemnity is not limited only to property relating to the Business conducted by Oceanview. It was held that the meaning of "Property Insured" under the indemnity, should be determined by construing clauses 1.1 and 1.2 in the context of the schedule and policy provisions as a whole in identifying the subject of the indemnity.

Allsop CJ ruled that the Policy provided indemnity for "*damage not otherwise excluded, happening at Lots 2333 and 2445 (the Situation) to (all) real and personal property of every kind and description, except as excluded, belong to [the insured], or for which it was responsible or had assumed responsibility to insure.*"



Lessons for Policyholders

The case illustrates the importance of clearly and accurately defining the "Situation" and "Business" and indeed all material aspects of the coverage to properly convey the parties' intentions. If this is done, and the insurer takes a view on the claim which, viewed objectively, sits outside these intentions, a Court should be supportive of the policyholder's position.

Insurer waives its rights goodbye

Delor Vue Apartments CTS 39788 v Allianz Australia Insurance Ltd (No 2) [2020] FCA 588

Facts

In 2014, Delor Vue Apartments, a body corporate for 62 Queensland apartments, became aware of a range of defects in the roof, which it attempted to address over subsequent years. In 2017, while the defects had still not been repaired, a new property damage and public liability was taken out with Allianz, although the roofing defects and repair works being conducted were not disclosed.

Five days after policy inception, Cyclone Debbie caused significant damage to the apartment complex including its roof.

The pre-existing defects quickly became apparent to Allianz in adjusting the claim, but nevertheless Allianz informed the policyholder by email that 'despite the non-disclosure issue' the policy would still be honoured. Specifically, the email stated:

> *Despite the non-disclosure issue which is present, [Allianz] is pleased to confirm that we will honour the claim and provide indemnity to the Body Corporate, in line with all other relevant policy terms, conditions and exclusions.*

Over the next year, the parties debated the measure of indemnity under the policy, with Allianz seeking to deduct the cost of repairing the pre-existing defects from the cost of repairing the cyclone damage. Agreement could not be reached, culminating in Allianz making a 'take-it-or-leave-it' settlement offer, in which Allianz threatened to decline the claim entirely if the offer was not accepted on the basis it would not have insured the building at all had the pre-existing defects been disclosed (exercising its remedy for non-disclosure under section 28(3) of the *Insurance Contracts Act*).

The policyholder rejected the offer and commenced proceedings seeking payment of its claim, arguing that Allianz had elected to waive its rights in relation to the non-disclosure and was estopped from reneging on its email, and further was in breach of its duty of the utmost good faith.

Decision

While the Court held that the policyholder has breached its duty of disclosure and that Allianz would have otherwise been entitled to reduce its liability to nil (as it was accepted that Allianz would not have insured the building), the policyholder's claim succeeded because Allianz had elected to waived this right when it expressly confirmed in the email that the insurance policy was to be honoured despite Allianz being aware of non-disclosure issues.

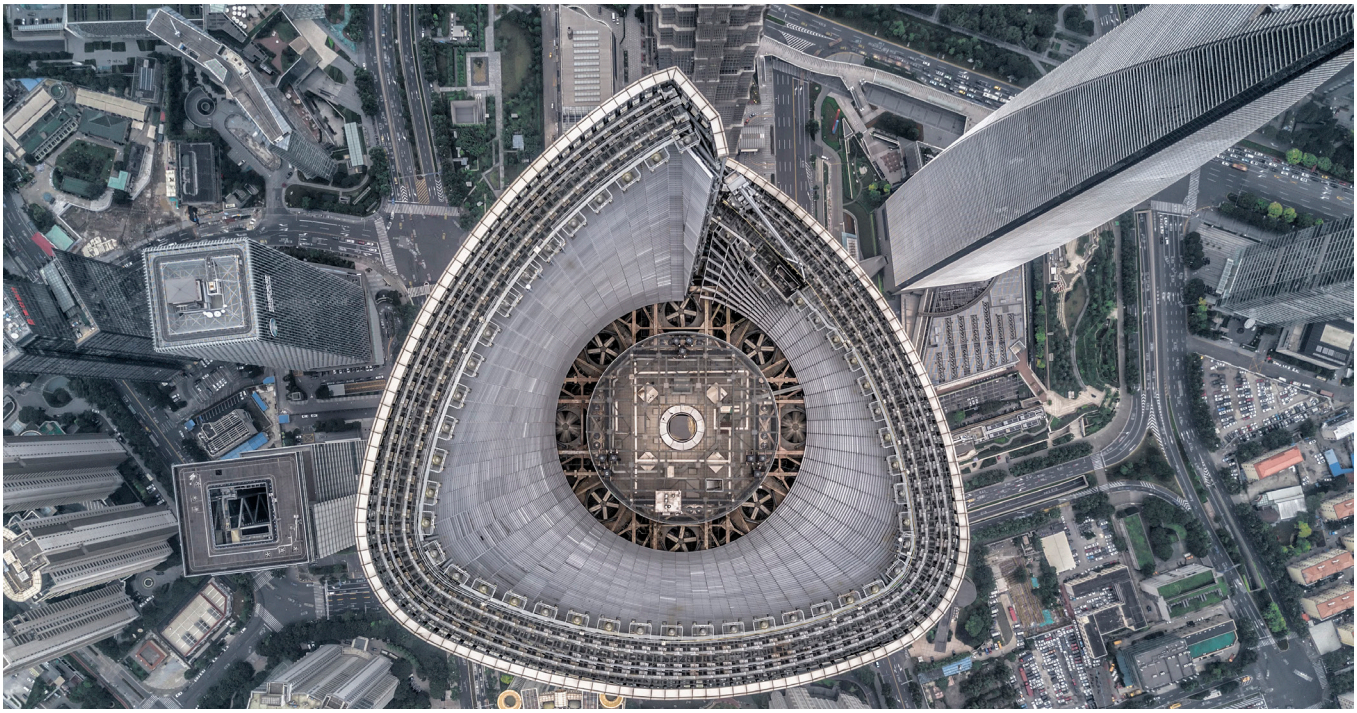
Furthermore, Allianz had breached its statutory duty to act with utmost good faith by making a 'take-it-or-leave-it' deal which was not commercially decent or fair in the circumstances.

Lessons for Policyholders

When considering the merits of pursuing an insurance claim, policyholders may also consider subsequent conduct of the insurer: if cover was unconditionally promised, then the policyholder may have a claim despite what its conduct might have entitled the insurer to do.

Construction cover is all it's cracked up to be

Icon Co (NSW) Pty Ltd v Liberty Mutual Insurance Company Australian Branch trading as Liberty Specialty Markets [2020] FCA 1493



Background

Icon is a construction company which built the Opal Tower at Sydney Olympic Park, with practical completion being achieved on 8 August 2018. A 12 month defect liability period then commenced.

A few months later (and within the defects liability period), major cracks were observed across three floors in certain wall panels and floor slabs and residents had to be evacuated. A class action was commenced by the residents against Sydney Olympic Park Authority which cross-claimed against Icon. Icon was liable for a total of $31m in rectification and alternative accommodation costs and legal fees.

Icon claimed indemnity for its liability from its insurers, Liberty and QBE. It ultimately succeeded against both, even though the claims did not at first glance appear to be covered by either policy.

Claim for an occurrence outside the insurance period

Liberty issued Icon with a series of successive and identical 12 month contracts of third party liability insurance, arranged via its broker, to insure against the risks of construction. The policy provided for Icon to notify the insurer of the time period of the project, from which the insurer would calculate the insurance premium.

Icon's contract with Sydney Olympic Park Authority required it to rectify all defects for a period of 12 months after the date of practical completion (defects liability period).

Icon's notification to its insurer merely referred to the estimated project period and did not mention the defects liability period.

The occurrence of the cracking which gave rise to the claim happened *after* the estimated project period, but during the defects liability period.

Icon had also argued that s 54 of the *Insurance Contracts Act* operated to forgive its omission to notify the insurer that it required coverage for the Defects Liability Period.

Decision

The Court held that s 54 did not apply to circumstances where cover did not exist in the first place – rather, s 54 only operates to remedy defects to trigger cover which already exists. However, the Court held that the Liberty policy should be rectified such that it included cover for the defects liability period. Despite this, the Court was prepared to accept evidence of the policy holder's representatives that they and the insurers representatives had always intended to cover the defects liability period under the contract.

The Court was persuaded that all four parties involved in the negotiation, Icon and Liberty, and also Icon's broker and Liberty's representative, had the relevant intention

and allowed the rectification claim. Specifically, Lee J held that:

- on the basis of agency principles, Icon's broker's intentions could be attributed to Icon and Liberty's representative's intentions could be attributed to Liberty.
- Liberty did not offer any evidence from its representative, so the judge held that he was entitled to draw the inference from this that the evidence from the insurer's representative would not have assisted Liberty's case.

Interpretation of terms in the context of the insurance – a "building" can be a product

Icon also lodged an alternative claim under its product liability policy with QBE, which was current when the cracks were identified. Under that policy, QBE was obliged to indemnify Icon for any legal liability incurred during the insurance period as a result of an occurrence in connection with one of Icon's products.

"Product" was defined as:

> ... any product or thing (including containers packaging or labelling) sold, supplied, erected, repaired, altered, treated, installed, processed, grown, manufactured, assembled, tested, serviced, hired out, stored, transported or distributed by the Insured including any container thereof (after such goods and/or products cease to be in the possession and/or under the control of the Insured) in the course of the Insured's Business in or from Territorial Limits, including liability arising out of the Competition and Consumer Act 2010 or similar legislation.

QBE denied that the building erected by Icon was a "product". It argued that the ordinary meaning of "product" did not include a building, and that Icon's products in this instance only related to carpets, stoves, cooktops, air conditioning units and the like installed in the building.

Decision

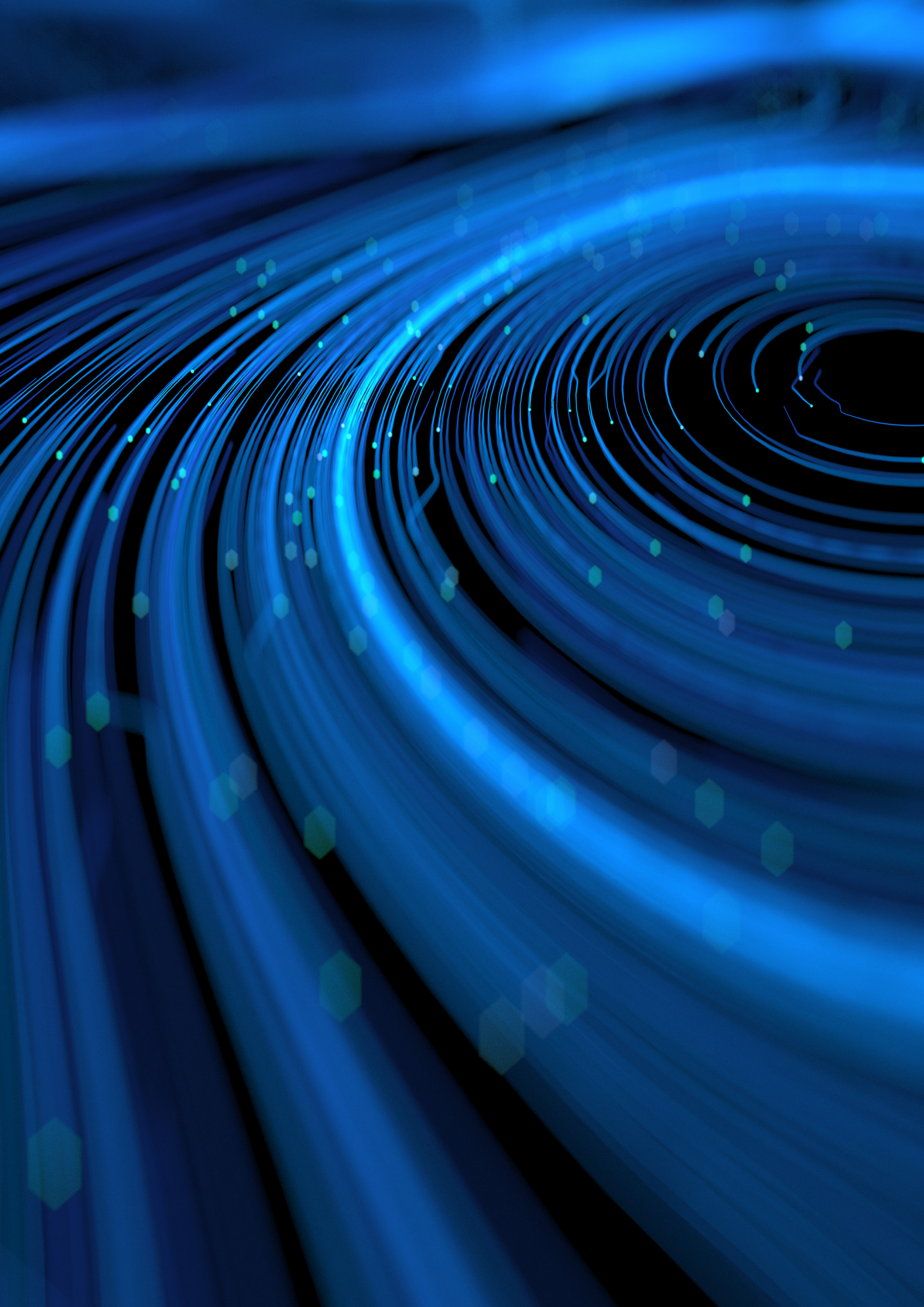
The Court rejected that argument. It held that the ordinary meaning of the term must depend on the subject matter in connection with which it is used and that:

> "[i]n the context of an insurance policy issued to a construction company which delivers large-scale building projects, it is hard to imagine what other product or thing, besides a building, would be erected such to fall within the meaning of the definition".

Lessons for Policyholders

Policyholders should question adverse decisions on coverage which do not accord with what they believe was intended by the policy. Even if on its face it appears that the policy may not respond, it pays to consider the issues in more detail. It is another example of the Court applying a common sense approach in favour of the commercial purpose of the party taking out insurance cover.

Please note that an appeal has been filed against this decision.



D&O insurance and class actions

Once again, D&O insurance (and related products such as Public Offering of Securities Insurance) have been front and centre in the context of the class action landscape during the course of last year.

Parliamentary Inquiry

Last year's Parliamentary Joint Committee Inquiry into Litigation Funding and the Regulation of the Class Action Industry included focus on the impact shareholder class actions in Australia have had on the D&O insurance market.

In a submission from Marsh, it expressed a view that the combination of securities class actions and litigation funders have created an unprecedented and unsustainable shift in the D&O insurance market based on its local and global experience and empirical data, with serious implications for corporate Australia and the Australian economy. The submission referred to average increases in premium for the ASX200 in 2019 of 118% with extreme cases at a staggering 600%, with no signs of these increases slowing. In addition, Marsh identified a number of major insurers withdrawing from the D&O market (including Allianz, Vero and various Lloyd's Syndicates) or reducing their exposure to the D&O market, putting increased pressure on capacity available for policyholders to transfer their D&O risk.

The report delivered by the Committee in December 2020 concludes that concerns that the current regulatory settings for class actions are not appropriate and are affecting fair and equitable outcomes for class members are "well-founded". In light of these concerns, the Committee sets out 31 recommendations directed at restoring the original intent of the regime: delivering reasonable, proportionate and fair access to justice in the best interests of group members. These include recommendations regarding the regulation of funders and plaintiff lawyers (including fees and commissions), competing class actions and the continuous disclosure regime itself.

Time will tell as to whether some or all of these measures will be adopted, and what impact they may have on class action risk and D&O insurance premiums.

Access to insurance policies

The importance of insurance in the context of class actions is reflected in two cases handed down this year regarding plaintiff access to a defendant's insurance policies.

Ardent shareholder class action[1]

In the shareholder class action against Ardent, after learning of Ardent's deteriorating economic position (exacerbated by the impact of COVID-19), the applicants sought an order under s 247A of the *Corporations Act* for inspection of Ardent's books (including insurance policies) by a member of the company. Inspection in this case was said to facilitate the efficient resolution of proceedings, including by facilitating proper mediation, and be necessary to meet concerns Ardent would be unable to meet a judgment. In addition, the litigation funding agreement was contingent on obtaining copies of Ardent's insurance policies, so inspection of the policies was necessary for the continuance of the class action.

Derrington J refused the inspection on a number of bases:

- the purpose for which inspection was sought was a claim connected with their rights and entitlements *as potential investors* in Ardent, not as Ardent shareholders/members (as required by the section). This is because a claim based on misleading or deceptive conduct or the breach of continuous disclosure obligations is concerned with the vindication of rights and entitlements that inhere in potential investors before they become members of the company;
- In any event, the power should not be exercised in favour of the applicants because:
  - Ardent was solvent and based on the financial statements provided, it was not possible to conclude that Ardent's net assets did not cover the extent of the claims;
  - even if Ardent's assets would not have covered the claims, it was too early to require access to insurance documents (that being a step perhaps more appropriately taken during settlement approval); and
  - effectively, the application was made for the benefit of all group members, which included parties that were no longer shareholders of Ardent. Ordering inspection would have therefore benefited non-members in a way that was not intended by s 247A.

Davantage vehicle warranty class action[2]

During the class action, the applicant learnt that Davantage had insufficient assets to meet the claim totalling $47 million, and sought an order from the Court to inspect Davantage's insurance documents under s 33ZF of the *Federal Court of Australia Act* 1976 (Cth) (**FCA**) for the purposes of:

- determining whether the class action was commercially viable;
- facilitating mediation and settlement, including by identifying criteria for a settlement approval under s 33V of the FCA; and

1. *Ingram as trustee for the Ingram Superannuation Fund v Ardent Leisure Limited* [2020] FCA 130.
2. *Evans v Davantage Group Pty Ltd (No 2)* [2020] FCA 473.

- assessing whether action should be taken against Davantage's insurers under the *Civil Liability (Third Party Claims Against Insurers) Act 2017* (NSW).

Beach J formed the view that the Court did have the power to make the inspection order under s 23 of the FCA (the Court's general power provision), but that he should not exercise his discretion to make that order. His key reasons were:

- the status quo is that insurance documents are not discoverable if they are not relevant to the determination of a fact in issue, save for specific exceptions with respect to actual insolvency, and that no provision of the FCA justified departure from this position.
- the High Court's approach to s 33ZF(1) in *Brewster* as to the scope of the s 33ZF(1) (as "supplementary" or "gap-filling") similarly did not permit a departure from the conventional position and the achieving of a "just outcome" in that section is not to be viewed solely from the perspective of the applicant and group members; the court must do justice having regard to the position of all parties.

Beach J also rejected the applicant's attempt to rely on a purported action under the *Civil Liability (Third Party Claims Against Insurers) Act 2017* (NSW) as the basis for an inspection order in this case. There was no suggestion that Davantage would not challenge its insurers' denial of liability and, in any event, the appropriate mechanism for uncovering the policies in an action by the applicant against the insurers was preliminary discovery in a separate case.

After the Event (ATE) insurance

The other form of insurance which commonly arises in class action litigation is 'after the event' insurance. ATE insurance typically provides cover for a plaintiff's exposure to adverse costs awards (and includes provisions for meeting orders for security for costs). The trend over recent years has been for ATE insurers to provide deeds of indemnity in satisfaction of requests for security for costs, and for this to be accepted by both defendants and the Courts as an acceptable form of security. The adoption of this practice followed the rejection by the Federal Court of the existence of an ATE policy as being, in and of itself, sufficient security for a defendant's costs.[3]

This practice may be re-visited in light of the Queensland Supreme Court's decision in *Equititrust Limited v Tucker*.[4]

While this did not involve a class action, the Court rejected a litigation funder's proposal to provide security by way of deed of indemnity with insurer AmTrust and instead required that security be by payment into court, or into a solicitors' trust account, or in the form of a bank guarantee.

Some of the key considerations regarding the adequacy of security are that:

- the plaintiff bears a 'practical onus' of establishing that the proposed security is adequate and does not impose an 'unacceptable disadvantage' on the defendant; and
- in order to be adequate, the proposed security must satisfy the protective object of a security for costs order, namely to provide a fund or asset against which a successful defendant can readily enforce an order for costs against the plaintiff.

In *Equitrust*, while Justice Bond accepted that there are examples of cases in which a Court has been satisfied that a deed of indemnity (provided by AmTrust) does provide adequate security, in this case the Judge was concerned that:

- the deed of indemnity was drafted in a way such that AmTrust's promise to pay was highly conditioned by reference to multiple clauses including with reference to particular steps required to establish the plaintiff's legal liability to pay costs in a particular amount – it was not in truth an unconditional undertaking to pay; and
- there remained a real potential to involve the defendants in further proceedings to establish AmTrust's liability and then to enforce a judgment against AmTrust. Considerations of delay and cost are relevant to evaluation of whether the proposed security would involve unacceptable disadvantage to the defendants and whether the proposed security is appropriate or sufficient.

The Court was also not persuaded by the funder's threat to decline to provide security in a different form and to terminate the funding agreement – "being unwilling is not the same as being unable".

3. *Petersen Superannuation Fund Pty Ltd v Bank of Queensland Limited* [2017] FCA 699.

4. [2020] QSC 269.

Cyber insurance update

Losses from cyber attacks continue to grow worldwide, highlighting the significant risks to policyholders in recovery, especially under general property damage or business interruption policies without specialist cyber insurance coverage.

Claims by Merck & Co and Mondelez against their insurers, arising from the NotPetya cyber attack originating in Ukraine in 2017, are ongoing, with insurers relying upon 'act of war' or 'hostile or warlike action' to exclude coverage for the malware which intelligence reports suggest was launched by the Russian government (or its actors) against the Ukraine.

Litigation over so-called 'silent cyber' coverage – which refers to potential coverage for cyber attacks under general policies that do not expressly insure against cyber risks but do not expressly exclude it either – has continued to grow around the world, although not so much in Australia at this stage. Here is a round-up of the important developments.

Ransomware: National Ink & Stitch

The United States District Court for Maryland recently granted summary judgment in favour of an insured embroidery and screen printing business, under its general businessowners' insurance policy, which provided that the insurer:

> will pay for direct physical loss of or damage to Covered Property at the premises

An endorsement defined 'Covered Property' to include:

a) Electronic data processing, recording or storage media such as films, tapes, discs, drums or cells;

b) Data stored on such media

The business was the victim of a ransomware attack, which locked up parts of its design and art data, resulted in significant slowdown of its systems once remediated, and left its systems vulnerable to re-infection by the malware.

The Court rejected the insurer's argument that there was no 'physical loss or damage to' the computer system because it could still be operated. It ruled that loss of efficiency and reliability of the system was sufficient to constitute insured damage, in addition to the lost data and software.

'Social engineering' email fraud

Email scams where fraudsters impersonate suppliers to direct legitimate invoice payments to compromised bank accounts continue to present risk to business. Careful review of policy wordings is required to determine whether these losses are covered as a cyber attack or excluded because they are simply the result of employees being duped and voluntarily transferring fund without the fraudsters hacking into the system.

Two recent North American cases highlight the need for specific coverage to deal with this risk. In both *Mississippi Silicon Holdings LLC v AXIS Insurance Co* 440 F.Supp.3d 575 (N.D.Miss. 2020) and *Future Electronics Inc (Distribution) Pte Ltd v Chubb Insurance Co of Canada* [2020] QCCS 3042, insureds were unable to recover under 'Computer Transfer Fraud' or 'Funds Transfer Fraud' coverage for similar schemes whereby legitimate invoice payments were misdirected when unwitting employees were duped by unknown fraudsters masquerading as suppliers.

In each case, coverage was available under a specific 'Social Engineering Fraud' clause, however this was restricted by an insufficiently high sublimit.

In *Mississippi Silicon*, the Computer Transfer Fraud provision required the fraudulent entry of information into the insured's computer system to 'directly' cause the loss. However, as the fraudsters did not enter the information into the computer system (rather, unwitting employees did), coverage was not available. Similarly, the Funds Transfer Fraud provision required a payment direction to a bank issued without the insured's knowledge, but in this case like many others the insured did in fact know of the instruction because the employee was duped into issuing the incorrect payment instruction.

In *Future Electronics*, Funds Transfer Fraud coverage was denied for similar reasons. For Computer Transfer Fraud, this required the 'taking' of funds by the fraudster: but as the funds were transferred by the insured, albeit incorrectly, coverage was unavailable.

Cryptocurrency as property

In *AA v Persons unknown* [2020] 4 WLR 35, the High Court of England and Wales considered an application by an anonymised insurer against unknown ransomware fraudsters and the operators of a Bitcoin exchange. The insurer had, on behalf of an insured, paid a ransom in Bitcoin to secure reinstatement of the insured's systems after a ransomware attack, and then immediately sought injunctions requiring the operators of the Bitcoin exchange to freeze the accounts in which the Bitcoin was held, and to disclose the identity of the holders of the account. The injunctions were granted.

Although the legal issues in the case concerned whether Bitcoin could be characterised as legal 'property' for the purposes of granting the injunction, the case serves as a reminder of the potential benefits of specific and clear insurance coverage that enables timely acceptance of indemnity by an insurer and a speedier recovery from a cyber attack.

Lessons for Policyholders

The uncertainty around how insurance policies will respond to cyber attacks continues, leading insurers to continue to tighten up policy wording to remove 'silent cyber' risks from coverage under general policies.

The implications remain the same – it is important to obtain specific cover for ransomware, malware and cyber attacks if that is a risk a policyholder wishes to mitigate. Relying on general property insurance or fraud policies will not always be enough.

Clearly there is a need for advice from an expert in this field when ransomware demands are received, and businesses ought to have a crisis plan prepared and rehearsed in advance of such attacks occurring. A specialist cyber insurance policy may provide the necessary expertise, provided it is not undermined by standard exclusions (such as 'acts of war') which may result in difficult disputes caused by the active involvement of certain nations in state-sponsored cyber attacks.

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Market recognition – awards and accolades

Firm awards

INTERNATIONAL FIRM OF THE YEAR 2020
BENCHMARK LITIGATION ASIA PACIFIC AWARDS

DISPUTE RESOLUTION FIRM OF THE YEAR 2020
ASIA LEGAL AWARDS

MOST INNOVATIVE LAW FIRM ASIA-PACIFIC 2019 & 2020
FT INNOVATIVE LAWYERS ASIA PACIFIC AWARDS

Australia

TIER 1 INSURANCE, TIER 1 DISPUTE RESOLUTION & TIER 1 CLASS ACTIONS
LEGAL 500 ASIA PACIFIC, AUSTRALIA 2021

BAND 1 INSURANCE AND BAND 1 DISPUTE RESOLUTION (INCL CLASS ACTIONS)
CHAMBERS & PARTNERS ASIA PACIFIC, AUSTRALIA 2021

Mark Darwin

Leading Individual in Insurance –
LEGAL 500 ASIA-PACIFIC 2021

Band 2 in Insurance –
CHAMBERS ASIA-PACIFIC 2021

Guy Narburgh, Philip Hopley & Travis Gooding

Rising Stars –
LEGAL 500 ASIA-PACIFIC 2021

Mark Darwin is *"one of Australia's most impressive policyholder lawyers", "the best legal practitioner in Australia in the area of complex property and business interruption claims", and has "exceptional understanding of the nuances of this very bespoke area".*

Guy Narburgh's *"extensive understanding of the industry and market practice sets him apart from his peers". Clients "value his ability to deliver commercial, targeted advice in a timely manner and would highly recommend him".*

"ability to understand and strategically navigate through complex legal issues".

"pragmatic and very good to deal with".

Notes

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