Striving for Equilibrium: A Critical Analysis of Section 54 of The Australian Insurance Contracts Act

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Introduction: The art of balancing interests in insurance law

'Balance is no place
is a becoming,
a lovely tension
between holding on
and letting go
risk and safety
up and down.
Edward D. Depew III [1]

Insurance in society

1. Insurance is an 'ambiguous phenomenon.'[2] When compared to our grocery or water bills where money is paid in return for something tangible, insurance is intangible. 'What is purchased is neither goods nor services, but a set of promises by the insurer which the insured hopes never to have to enforce.'[3]

2. Historically, insurance was a means of guarding against basic and individual risks, such as the loss of a ship or the outbreak of a fire.[4] Over time, it has grown into a set of intricate arrangements, facilitating business dealings and 'harmonious social existence.'[5]

3. Insurance is a commercial transaction[6] which involves sharing risks with others.[7] The insured pays the insurer a

premium as consideration for the insurer accepting the risk. The insurer, in return, agrees to pay the insured for any loss suffered if the risk eventuates.[8] Insurers will group various prospective insureds into risk categories which attract progressively higher premiums as the categories move from low risk to high risk.[9]

4. The insured's premiums are often invested in stocks, bonds, mortgages, government securities and other income-producing enterprises. The insurer uses the collected premiums and income earned from investing the premiums to compensate the insureds who suffer losses.[10]

5. Insurers play a pivotal role in the financial system as a whole.[11] They contribute to a country's economic stability by compensating individuals and businesses for financial losses and liabilities that might otherwise ruin them.[12] Insurance companies also help to increase the production of goods and services by allowing entrepreneurs to reduce the risks of starting a new business or acquiring a property.[13] There are obvious benefits from having a healthy insurance sector and therefore it is vital that the legislative environment is conducive to insurers. However it is also important that insureds have access to insurance policies that provide effective cover in the event of a claim, with limited and clearly delineated circumstances where an insurer may deny indemnity.

Insurers and insureds under the microscope

6. The insurer and the insured are the two principal parties to an insurance contract. An insurer has interests to protect before the contract is entered into, during the period of cover and after a loss has occurred.[14] In the pre-contractual stage, the insurer has an interest in ensuring that all relevant facts are disclosed.[15] Once the contract is on foot, the insurer seeks to prevent the risk which they have assessed and accepted from increasing.[16] When a loss occurs, insurers want to be certain that they can properly investigate and assess a claim.[17] They achieve these objectives by drafting specific clauses and incorporating them into the insurance contract. These include clauses requiring disclosure, terms imposing certain obligations on the insured and terms which exclude claims that arise or are caused by a particular risk.[18]

7. With a constant demand for insurance cover in today's society,[19] it can be argued that the insurers and the insureds do not possess equal bargaining power.[20] The insureds, similar to the tenant in a landlord-tenant scenario, are vulnerable to any potential rise in premiums or an insurer's refusal to accept cover. The insurer may, through the medium of an insurance contract, often impose terms which are unfair to the insured.[21] By paying insurance premiums, the insureds expect to be compensated financially for losses which they may incur as a result of a future uncertain event. The traditional legal environment did not, however, function properly in protecting those expectations. Insurers could, for example, refuse to pay under the policy, even where the breach by the insured had not caused or contributed to the loss.

Legislative intervention: section 54

8. Compared to other common law countries, Australia is unique in that it has a comprehensive legislative regime covering non-marine general insurance.[22] The Insurance Contracts Act 1984 (Cth) ('the ICA') is a remedial statute which was designed to reform the pre-existing law of insurance.[23] It radically altered the law of insurance in many ways.[24] According to the Australian Law Reform Commission (the 'ALRC'), a central problem of the pre-existing law was that insurers were allowed to avoid a contract whenever the insured had failed to disclose a material fact during the policy period.[25] It was suggested that;

   > '[there was a] 'disproportion' between the loss to the insured where the insurance contract was avoided...and the prejudice to the insurer occasioned by the non-disclosure.'[26]

9. As a result of the ALRC's report on insurance contracts, section 54 was drafted to address that disproportion.[27] It has broken new ground in traditional insurance law by limiting the insurer's ability to avoid the contract where there has been a breach of or non-compliance with a term. The section imposes upon an insurer a prima facie liability to indemnify an insured under every policy to which the Act applies.[28] It alters the operation of provisions of an insurance contract, reducing the circumstances in which the insurer can deny a claim because of the insured's conduct after the contract is entered into. Whilst this could be seen as a major swing in favour of the insured, the second limb of section 54 ('the prejudice limb') has sought to limit this effect. The prejudice limb allows the insurer to reduce its liability when the insured's action or omission has adversely affected the insurer's interests. Although section 54 is

'reformatory,' it does not intend to favour a particular party at the expense of the other.[29]

10. The operation of section 54, however, has had a controversial history. Compared to other countries, such as the United Kingdom, Australian courts have appeared to be more judicially active and creative in their role in administering the law to the facts.[30] Whilst judicial activism has its advantages in allowing the law to adapt to the ever-changing society, recent decisions concerning section 54 have raised concerns. Examples to be considered in this paper are the court's decisions regarding the applicability of section 54 in cases where the insurance policy requires the insured to give notice of a claim or an occurrence[31] and the insurer's ability to reduce the insured's claim to nil in offsetting the prejudice suffered.[32] As will be discussed below, some of the decisions regarding section 54 have tended to thwart the aim of the ALRC in reforming the insurance legal environment.[33]

11. Since the ICA has been in operation for over a decade, a review of section 54 in light of recent case law is timely.[34] This paper will investigate the mechanics of what is arguably the Act's most controversial and difficult section. It will provide an insight into the treatment of the interests of the insurer, insured and 'other parties' where there has been a breach of or non-compliance with a term of an insurance policy. It will examine the strengths and weaknesses of the section, especially regarding the issues of 'claims' policies and the notion of prejudice.[35] Other countries such as the United States and New Zealand will also be considered to illustrate how they deal with these issues. Reference will also be made to recent marine insurance reforms which have considered using the words of section 54 in amending the Marine Insurance Act 1909 (Cth). This paper will conclude by making suggestions for improving the overall operation of section 54 in balancing the competing interests of the insurer and the insured.

The basic features of an insurance contract

12. An insurance policy contains the details of the contractual arrangement between the relevant parties. It records the nature and extent of the cover, the exclusions from cover and the obligations which are imposed on both the insurer and the insured during the term of the contract.[36] A brief examination of terms that define and limit the insurer's liability to the insured under the policy is necessary to understand the motivation behind section 54.

Armour for the insurer

13. There are two periods which are crucial to the insurer in an insurance arrangement. Prior to entering into the contract, the insurer has an interest in ensuring that the insured has disclosed and properly represented all material facts.[37] During the policy period, the great significance to the insurer is in making sure that their risk remains static.[38] It is the latter period which is pertinent to the operation of section 54. Thus, sections of the ICA that deal with the issue of pre-contractual nondisclosure are outside the scope of this paper.[39]

14. Insurers employ various drafting techniques to protect themselves against a change in risk during the policy period. They may include:

    - an ambit of cover clause;
    - an exclusion clause; or
    - a term which imposes an obligation on the insured.

    A comprehensive motor vehicle insurance policy[40] will be used as a hypothetical example in explaining these clauses.

Ambit of cover clauses

15. An ambit of cover clause is a term commonly used in an insurance contract.[41] The insurer often uses such a clause to outline their obligation to indemnify the insured where there is a loss.[42] They specifically describe the risk that the insurer will agree to underwrite. An example of such a term may be,

    > This policy will indemnify an insured for loss arising from the insured's use of the vehicle on a public road.[43]

16. The clause covers an insured for using the vehicle on a public road. The insured is not therefore covered for any damage sustained where the vehicle was used on a rally racetrack or on private property such as the insured's own driveway.[44] The damage must also arise out of using 'the vehicle' specified under the policy, not, for instance, some other vehicle the insured may have been driving at the time.

17. Ideally, insurers want to limit the likelihood of a claim arising during the policy period. Nevertheless, events may occur that alter the risk originally agreed upon between the parties. Some events may have no effect on the cover or other events may be foreseeable as incidental to the risk.[45] For instance, the fitting of wider wheels to a motor vehicle is an act which may have caused minor alterations to the risk, but are nevertheless insufficient to take the risk outside the policy cover.[46] In the context of life insurance, the fact that the insured's health will inevitably deteriorate is a foreseeable risk factor which the insurer would consider when issuing the policy.[47]

18. In some cases, however, the risk may be altered in a way that affects the cover or may not be foreseeable as incidental to the risk. An example is a marine policy which covers the risks associated with a particular voyage. Where there has been a change of voyage, the risks are likely to be different. In that case, as a matter of law, the insurer will not be liable.[48]

Exclusion clauses

19. Whilst an ambit of cover clause is used to describe the risk and broadly establish liability, it is common for insurers to incorporate specific exclusion clauses in their contracts to restrict the boundary of cover.[49] Many such exclusions are aimed at avoiding liability for loss caused by an alteration in the risk during the period of cover.[50] It could be worded as a causal exclusion clause which excludes liability resulting from specific causes.[51]

    > This policy excludes cover for loss caused by using the vehicle in 'either practising for or taking part in any race, time trial, rally, sprint or drag race, or similar motor sport event, demonstration, or test.'[52]

    The policy excludes cover for loss resulting from the use of the car in, for example, a drag race. Alternatively, the insurer could reword the same exclusion clause as;

    > This policy excludes cover for loss occurring whilst the vehicle is 'either practising for or taking part in any race, time trial, rally, sprint or drag race, or similar motor sport event, demonstration, or test.'[53]

20. This is an example of a temporal exclusion clause which will not cover a loss where a particular set of circumstances exists. It excludes cover for loss whenever the insured uses the car in a drag race, even where the use of the car in that manner did not cause the loss. For example, consider a racetrack surrounded by gum nut trees. If by pure chance, a gum nut drops, hits and cracks the insured's windscreen, the insurer could argue that insured will not be able to claim from its insurance policy, since it was using the car in a race.

21. Compared to a causal exclusion, therefore, a temporal exclusion clause has wider and harsher implications for an insured. On the other hand, it provides better protection for an insurer against an increase in risk. It excludes liability for a loss caused whilst the relevant circumstances exist, whether or not those circumstances are the cause of a particular loss.[54]

Terms imposing obligations

22. To further protect itself, the insurer may also incorporate a term which imposes an obligation on the insured or creates a condition precedent to liability. Warranties are terms which an insurer may use to protect itself against an increase in the risk during the period of cover.[55] A warranty, in the insurance context, is a term of the insurance contract which, if breached, entitles the insurer to repudiate the contract.[56] In this clause, for example;

    > The insured warrants that '...the vehicle...has not been and will not be specially modified...'[57]

    Where the insured modifies the vehicle without the insurer's consent before an accident occurs, the insurer would be entitled to terminate the contract.[58]

23. Clauses aimed at preventing an increase in risk can also be expressed as imposing an obligation on the insured, as opposed to a warranty. The remedy for breach of such an obligation is the same as for breach of a warranty.[59] Here is an example from a motor vehicle policy;

    > '...the insured shall take reasonable precautions for the safety and protection of the vehicle.'[60]

    If, instead of parking the vehicle under the roof of a garage, the insured had chosen to park it on the side of a main road, the insurer may well terminate the contract for failure to take reasonable care of the vehicle. These terms are especially effective, since they require the insured to take positive steps in preventing an increase in risk for the insurer.

Summary

24. The main source of the rights and obligations of the parties to an insurance contract is to be found in the contract itself.[61] Insurers often incorporate terms which define the limits of their liabilities. These boundaries are further restricted by temporal and causal exclusion clauses. Another common feature of an insurance policy is a term which imposes an obligation on the insured to act or refrain from acting in a certain way before the insurer becomes liable to pay a claim. All of these terms are usual features of an insurance contract which are focused on giving the insurer grounds to deny cover if the risk turns out to be different from that which it intended to originally take on. Without statutory intervention, they provide one-sided protection for the insurer. The consequences can be extremely harsh on the insured. As will be discussed,[62] insurers were heavily favoured under the previous legal environment as they could rely on a technical breach of the contract to reject the insured's claim.[63] The ALRC strongly asserted that the law must be amended to better protect the interests of the insureds where their conduct which had caused little or no prejudice to the insurer.[64]

25. Having examined the basic features of an insurance contract, the next section will focus on the development of insurance law in Australia. It will consider the reforms that were initially proposed by the ALRC and subsequently adopted in section 54 of the ICA. The basic mechanics of section 54 will also be discussed.

Outline of Australian insurance law

The Australian insurance industry

26. The Australian insurance industry as a whole has undergone massive changes in the last decade. It has had to adapt to pressures generated by globalisation and the dominance of information technology.[65] Over 170 Australian and multinational companies actively compete for domestic and international business within the insurance market.[66]

27. With more than two hundred years of experience, Australia has been able to develop a mature, diversified and highly competitive insurance industry.[67] Australia already has the eleventh largest insurance market in the world and the eighth highest per capita spending on general insurance.[68]

Law prior to the Insurance Contracts Act 1984 (the 'ICA')

28. Prior to the enactment of the ICA, the law governing insurance contracts was confusing.[69] English law governed the new-founded country when the British 'colonised' Australia in 1788.[70] Australian law is therefore, 'not only the historical successor of, but is an organic development from, the law of England.'[71] Principles and rules developed by judges on a case-by-case basis were subjected to the statutes of the Imperial, State and Commonwealth parliaments. The Imperial Acts, part of the legal 'baggage' shipped to Australia, were often expressed in a code-like manner, rather than in plain English.[72] State intervention was minimal, with legislative provisions limited to particular types of transactions.[73] Commonwealth legislation dealing with insurance contracts was restricted to the area of life insurance.[74] Both State and Commonwealth legislation possessed problems which demanded the attention of legislators.[75]

Common law and the freedom of contract

29. Predominantly common law principles governed insurance contracts before the commencement of the ICA.[76] Any breach of a warranty would entitle the insurer to avoid the contract or to reject the claim. Insurer's liabilities were effectively limited by the various exclusion clauses incorporated in the insurance contracts. The position reflected the nineteenth century laissez-faire philosophy.[77] Parties were free to enter into any contracts they desired and could agree on such terms as suited their particular needs.[78] The insurer's legal rights were ultimately determined by the form in which the contract was drafted, rather than by reference to the harm caused.[79]

30. In a few instances, various statutory laws have served to limit the effect of the contract. For example, section 18 of the Insurance Act 1902 (NSW) provides that a court can excuse a breach of a term or condition which does not prejudice the insurer.[80] The legislation was designed to 'prevent advantage being taken of a mere technicality.'[81] The section does not apply where the insured has breached a common law duty.[82] At the federal level, an insured could be excused from complying with a warranty of a marine insurance policy where compliance would be unlawful or where circumstances had changed.[83] Similarly, any warranty or exclusion in an insurance contract would be ineffective to relieve an insurer's liability to indemnify a carrier against personal injuries.[84]

31. The courts were also willing to construe a temporal exclusion clause in such a way as to allow recovery where the relevant circumstances could not have caused or contributed to the loss.[85] In Bashtannyk v New India Assurance Co Ltd[86] the insured's vehicle was travelling at a moderate speed when it was struck, through no fault of its own, by another car. The insurer relied on an exclusion 'while the motor vehicle ... is being used in an unsafe condition' to deny liability to the insured. The insurer alleged that because the tyres were bald, the vehicle was unsafe when the accident happened. The Supreme Court of Victoria held that the clause only excluded liability if the vehicle was being used in an unsafe condition at the time of the loss.[87] Chief Justice Winneke used the example of a car's lighting system and stressed that where the system had failed, its safety condition may vary depending on whether the person was using the car 'in daylight or in darkness.'[88] In this case, despite the baldness of the tyres, the court was not satisfied that the tyres were unsafe and the insured was entitled to recover for the loss.

A call for reform

32. The common law proved sadly deficient in most of the relevant areas of an insured's needs. In a situation where an insurer could avoid a claim on the basis of a warranty, condition or exclusion, the result was harsh and unjust.[89] An insured might, for example, have suffered a loss within the scope of the policy, but failed to give notice of the loss within the time warranted. The common law allowed the insurer to terminate the contract even where it had suffered no prejudice.[90] Although an insurer had a legitimate interest to ensure that the risk it had agreed to cover would not increase during the policy period, in some instances, the common law remedies available depended on matters of form rather than substance.[91] Statutory law prior to the ICA had made no real impact on the common law position of the insured. It was piecemeal, confusing and was more concerned with improving the legal process than reforming the law.[92]

33. An example in the marine insurance context (which represented the general law at that time) was Azevedeo v Australian and International Insurances Ltd[93] where the insured brought an action under a marine policy after his fishing vessel had been destroyed by fire. The insurer denied liability on several grounds. One was that the insured was in breach of warranty. In the proposal form, the insured had stated that the vessel would not be 'let out on hire or charter or used for the carriage of paying passengers.'[94] The proposal form was stipulated to be the basis of the contract. When the loss occurred, the vessel was being used by the insured. The insured had, however, informally hired it on earlier occasions to a friend.[95] The court held that the insured was in breach of warranty and that the insurer was entitled to avoid the contract from the time of the original breach. Consequently, it was not liable for the insured's loss.[96]

34. Following the Attorney General's reference in 1976 which required an assessment of the law governing insurance contracts, the ALRC suggested that a national Insurance Contracts Act was required to correct the faults in the existing law.[97] An Act was also needed to provide a uniform and fair set of rules for the industry nation-wide.[98] In 1982, the ALRC's report on insurance contracts included a draft Bill which was enacted with few changes in 1984.[99] The ICA applies to insurance contracts entered into on or after 1 January 1986. Some types of insurance are excluded from its operation.[100]

Important ALRC recommendations: substance over form and the principle of proportionality

35. The ALRC had made several important suggestions in regard to reforming the law of insurance.[101] One of the more significant proposals relevant to this paper is the issue of 'substance over form.' The ALRC noted that the problem with the previous legal environment was that the precise remedy available to an insurer in the event of a breach depended on matters of form, rather than of substance.[102] The wording of the particular clause was crucial.[103] As was discussed in section 2, insurers could use different drafting techniques to accommodate their desired level of protection.[104] The ALRC found that the difference in effect between, for example, a causal and a temporal exclusion clause, 'is not justified.'[105] It commented that;

> 'The rights of the parties should depend on matters of substance, not on subtle differences in form.'[106]

36. Another problem, as identified by the ALRC, concerned the legal effect of the insured's conduct.[107] The fact that the insurer could terminate the contract for a breach of term was found to be a 'far harsher remedy in the context of insurance [when compared] to other contracts.'[108] The ALRC noted that it could 'impose heavy loss upon the insured [although] the insurer [had] suffered little or no prejudice [from] the insured's breach.'[109]

37. In promoting the spirit of 'substance over form,' the ALRC recommended that all breaches be treated the same.[110] Whether it be a breach of a causal or temporal exclusion, the insurer would be liable to indemnify the insured if the insured had not caused or contributed to the loss.[111] In adopting this approach, the ALRC commented that the result was most 'satisfactory' where the tests of causation and proportionality were combined.[112] Where the insured's conduct might, in principle, have caused or contributed to a loss, a causal connection approach should be adopted. The insurer may refuse to pay the claim where the insured's act or omission had caused or contributed to the whole loss.[113] Where the insured's conduct could not, in principle, have caused or contributed to the loss, the insurer is limited to a right of damages if it had been prejudiced by the insured's act or omission.[114] An example is where the insured had modified its vehicle without the insurer's consent. The ALRC proposed that the amount of damages should be assessed via ordinary contractual principles and the application of the principle of proportionality.[115]

38. According to the principle, the insurer would only be responsible for its proportion of the total risk. Where the additional risk was insurable, but that the insurer would have charged a higher premium had it known the insured's act or omission, an objective assessment of the appropriate premium would be made and the principle of proportionality would be applied.[116] Where the additional risk was not insurable at all, the insured would be unable to recover any part of its claim from the insurer.[117]

39. Given the importance of these recommendations in reforming the previous legal environment, it was essential that they be accurately implemented and reflected in the wording of the legislation. As was aptly put by President Mason, the identification of particular problems was only a 'prelude to legislative drafting,'[118] as the court must still struggle through issues of construction and application of the words adopted by legislators.[119] The next section will briefly examine the overall mechanics of section 54.

The inherent balance in section 54: a brief overview of the section

40. Although limited in its scope, the Act has made substantial changes to almost all areas of insurance law.[120] Amongst other sections of the Act[121] section 54 has contributed much to balance the interests of both the insurer and the insured without 'cutting a jagged swathe through [their] respective rights.'[122]

41. Section 54 provides that:

> (1) Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred **after** the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.
>
> (2) Subject to the succeeding provisions of this section, where the act could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract, the insurer may refuse to pay the claim.

(3) Where the insured proves that no part of the loss that gave rise to the claim was caused by the act, the insurer may not refuse to pay the claim by reason only of the act.

(4) Where the insured proves that some part of the loss that gave rise to the claim was not caused by the act, the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act.

(5) Where:

(a) the act was necessary to protect the safety of a person or to preserve property; or

(b) it was not reasonably possible for the insured or other person not to do the act;

the insurer may not refuse to pay the claim by reason only of the act.

(6) A reference in this section to an act includes a reference to:

(a) an omission; and

(b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.

(emphasis added.)

The first limb of section 54

42. There are two limbs to section 54. The first limb distinguishes between two kinds of acts during the policy period.[123] These are acts which 'could reasonably be regarded as being capable of causing or contributing to a loss'[124] and acts which were incapable of achieving such an effect. In the former case, the insurer may refuse to pay the claim. The act is presumed to have caused the loss and the insurer is relieved from liability where the act has possibly caused the loss.[125] The insured must then rebut that presumption and prove that the act is not wholly or even partly responsible for the relevant loss.[126] The insurer only needs to show a fairly tenuous link between the act and the loss for the presumption to apply.[127]

43. Where an act is not capable of causing the loss, the insurer may not refuse to pay the claim. Section 54 imposes on the insurer a prima facie liability to pay under the policy by 'sterilising the operation of the change-of-risk clause.'[128] In Australian Associated Motor Insurers Ltd v Ellis, for example, a term of the contract prohibited the insured from modifying the insured vehicle without the insurer's consent. The vehicle was modified without obtaining consent and an accident occurred whilst it was being driven by the insured's 23-year-old daughter. In this case, since the daughter was not at fault and the modification did not cause the loss, the insurer could not refuse to pay the claim.[129]

44. Although this first limb goes some way to eliminate the inequality of bargaining power as often existed previously between the parties, it could not operate fairly on its own. Equality requires the law to protect the interests of all parties. A law which entirely favours the insured is equally disastrous. In FAI General Insurance Ltd. v Jarvis, an insured was injured after falling on a slippery shop floor. The insurance policy required the insured to give written notice to the insurer of 'the happening of any event likely to produce a claim under any section of this policy.'[130] This included any injury that the insured had sustained. The insurer was only notified of proceedings one month before the hearing and therefore had no time to investigate the cause of the accident.[131]

45. Clearly, it would be unfair for the insured to succeed against the insurer who had lost the opportunity to gather information in establishing a viable defence.[132] It is submitted that had the law been so, an insurer would most likely charge a much higher premium to protect against the increased risk of indemnifying an insured. As a consequence, many low-income earners and small businesses would struggle to obtain an appropriate cover for their situation, since the cost would tend to outweigh the benefit of being insured under a policy.[133]

The second limb of section 54

46. Although the insurer is prohibited from refusing to pay a claim where the insured has not contributed to the loss, the second limb of section 54(1) allows the insurer to reduce its liability by the amount of prejudice suffered in the circumstances.[134] The second limb is important in helping to establish equilibrium between the insurer and the insured. In the Ellis example, the insurer legitimately argued under the second limb of section 54 that, had it known of the modification, it would have still continued the current policy, but excluded liability for persons driving under 25 years of age. The South Australian Supreme Court allowed the insured's claim to be reduced by the amount that 'fairly represented the extent to which the insurer's interests were prejudiced as a result of' the modification.[135] This was held to represent the full amount of the claim.[136]

47. As will be discussed,[137] the High Court has broadly interpreted the words 'act' or 'omission' in section 54(1).[138] By doing so, the High Court has evinced an intention to allow an insured more readily to take the benefit of section 54(1) in appropriate circumstances.[139] More importantly, the court has adopted the view that an insurer will be provided with adequate protection of its interests via the operation of the prejudice test within the second limb of section 54(1).[140]

48. This view could be compared with the equitable jurisdiction of a court. In equity, a plaintiff must come to the court with clean hands.[141] Section 54(1) limits the insured's prima facie ability to claim where the insurer's interest was prejudiced by the insured's conduct. The prejudice limb is required to prevent unfair outcomes for the insurer and to prevent the insured from recovering more than what it is entitled to in the circumstances. The problem for the courts is to decide how to interpret the wording of section 54 so as to balance the interests of the insurer and the insured.

The position in New Zealand: a brief insight

49. Australia is unique in that other common law countries do not have a provision similar to section 54. New Zealand is the only jurisdiction which has legislated a remedial provision comparable to the section.

50. Under section 9 of the Insurance Law Reform Act 1977 (NZ) ('the NZ Act'), a term which requires an insured to promptly notify a claim will bind the insured only if it would otherwise prejudice the insurers' interests.[142] The section effectively 'excuses' an insured from the consequences of giving late notice of a claim where the late notice has not prejudiced the insurer.[143] In Sinclair Horder O'Malley & Co v National Insurance Co of New Zealand Ltd, the NZ Court of Appeal held that section 9 applied to a 'claims made and occurrence notified' policy which required the insured to give immediate notice of an occurrence.[144] Although section 9 specifically referred to the notification of a 'claim,' Justice McKay held that the section was broad enough to cover the notification of an 'occurrence.'[145] His Honour found that the distinction between the two was one which could be made, but lacked substance.[146]

51. Section 11 of the NZ Act also alters the insurer's remedies where the insured has breached a term of the contract.[147] It changes the operation of provisions which limit the insurer's liability by reference to the happening of certain events or the existence of certain circumstances.[148] The effect of the section is that an insured is only entitled to indemnity if they can establish that the circumstances falling within the provision did not cause or contribute to the loss. If they did, then the insurer is entitled to decline indemnity.[149]

52. The section makes less radical changes than those made by section 54 of the ICA.[150] Although the section mainly serves to modify the effect of temporal exclusions, its wording seems to suggest a wider application.[151] The section has been held to apply where the limitation on the insurer's liability is expressed as an exclusion[152] or in the form of a warranty.[153]

53. In State Insurance Ltd v Electronic Navigation Ltd, for example, a motor vehicle policy excluded loss while an unlicensed driver was driving the vehicle.[154] One of the insured's employees had been disqualified from holding a driver's licence for six months following a conviction for a drink driving offence.[155] The insured believed that the disqualification period had ended, when it in fact had a further two weeks to run and permitted the employee to drive the insured vehicle.[156] The vehicle was involved in an accident while being driven by the employee. The insurer denied liability and argued that since the driver was unlicensed, his driving had caused or contributed to the accident, hence, excluding the operation of section 11.[157] The High Court of New Zealand held for the insured, that section 11 would apply, since the absence of the licence did not cause or contribute to the loss.[158]

Summary

54. Although 'words are only pictures of ideas on paper,'[159] in law they may determine the substance of the legislative response to a problem, 'sometimes intentionally sometimes unintentionally.'[160] The wording of section 54 generally indicates the drafters' attempt to incorporate the spirit of the reform into the section. It provides that the insurer is liable to indemnify the insured where the insured's act or omission has not caused or contributed to the loss. This liability may be reduced by the amount of prejudice suffered by the insurer in the circumstances. However, as will be discussed in the balance of this paper, the wording of section 54 has raised problems which legislators had not envisaged. Furthermore, although the recommendations of 'substance over form' and 'proportionality' are sound theoretically, in reality, they are harder to apply.[161]

55. New Zealand is the only other common law nation that has legislation akin to section 54. Its provisions are, however, overly simplistic and are not as well developed as its Australian counterpart, as will be demonstrated below.

56. Having established the background, purpose and features of section 54, the next two sections will examine the mechanics of the section in detailed. Recommendations will be made to improve its overall effectiveness in attempting to achieve a balance between the interests of the insured and the insurer.

Section 54 and 'claims' policies

57. The insured's failure to comply with the notification provision of a 'claims made and notified' or 'claims made and occurrence notified' policy has contributed much to judicial and academic controversies regarding the construction of section 54(1).[162] This section will examine the various cases concerning these policies and expose the courts' vacillation in construing the term 'omission' under section 54(1). A critical discussion regarding judicial activism in this area will follow.

58. An understanding of the nature of 'claims made and notified' and 'claims made and occurrence notified' policies is essential to appreciate the issue at hand. The next section will focus on explaining the general aspects of these policies.

The evolution of 'claims made and notified' policies

59. The law regarding 'claims made and notified' policies is complex. It involves specialised versions of the clauses that were discussed in section 2. It is useful, therefore, to draw a distinction between the different types of policies that have emerged in this area.

'Occurrence based' policies

60. Historically, policies were written to cover loss caused by events during the policy period. An 'occurrence based' policy covers the insured for liability regarding defined events occurring within the policy period. Even if the claim is reported to the insurer after the policy has expired or been cancelled, the policy will cover the insured for any incident that occurred while the policy was in force.[163] The trigger is the loss that occurs during the specified policy period. An example being;

> 'We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies....
>
> This insurance applies to "bodily injury" and "property damage" only if: (1) The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory"; and (2) The "bodily injury" or "property damage" occurs during the policy period.'[164]

61. This type of policy is well suited to the needs of insureds such as motor vehicle owners.[165] Where a mechanic, for example, is negligent and accidentally scratches the insured's vehicle, the nature of the negligent act and the resultant damage are often known upon the happening of the negligent act.[166]

62. The 'long tail' nature of the risk under an 'occurrence' based policy has, however, presented a problem for insurers when providing cover for the insured.[167] When insuring professionals such as doctors or lawyers for losses caused

by their negligence,[168] damages can eventuate many years after a negligent act is committed.[169] This is also the case for manufacturers who can cause damages by producing hazardous products or toxic waste.[170] Recent asbestosis claims[171] are examples: it takes at least 20 to 30 years for a person to develop mesothelioma, an asbestos-related cancer, after being exposed to the asbestos.[172] Insurers, in these cases, face the risk of having to pay out an unknown number of claims that may be made many years after the particular policy has expired.[173] This is referred to as 'long tail' business.[174]

63. The 'long-tail' nature of 'occurrence' policies has also caused problems where the insured had taken out insurance covers from different insurers over the years.[175] Disputes might arise between insurers regarding the actual period in which the relevant 'occurrence' happened and which the insurer must indemnify the insured for the loss.[176] These disputes have created unnecessary expense for the insurance industry.[177] They have also produced uncertainty for the insurer in calculating their actuarial risk and setting aside adequate reserves for future claims.[178]

'Claims made' policies

64. Insurance contracts drafted as 'claims made' policies have helped to curtail the 'long-tail' problems associated with 'occurrence' policies.[179] 'Claims made' policies cover the insured for liability only where a claim is made against the insured by the third party during the policy period.[180] They have evolved 'from difficulties within the insurance industry flowing from claims being made under [insurance policies] for a year long past.'[181] Here is an example of a 'claims made' clause under a 'claims made' policy;

> 'GIO will pay on behalf of the insured all sums for which the insured shall become legally liable to pay by way of compensation ... in respect of: ...
>
> > (c) Professional Liability
> > A claim or claims made against the insured during the Period of Insurance arising out of any negligent act, error or omission committed or alleged to have been committed, by the insured in the conduct of the insured's business as specified in the Schedule.[182]

65. It became clear that the problem with 'claims made' policies, however, is that they do not specify notification to the insurer as a requirement for an indemnity. Notification is important for the insurer to estimate possible future liabilities so that 'appropriate provision' can be made to meet its commitments.[183] It can also allow the insurer to investigate events within a reasonable time of their happening and possibly settle the matter 'in a financial climate [not] materially different from that in which the risk had been undertaken and the premium for that risk assessed and agreed.'[184] As a result, 'claims made and notified' policies have evolved to provide a more effective protection for the insurer.[185]

'Claims made and notified' policies

66. In contrast with 'claims made' policies, which do not insist on notification as a basis for indemnity, 'claims made and notified' policies provide coverage only for claims which are both made and notified to the insurer within the policy period.[186] These policies have evolved to answer the particular demands of third party liability type cover, particularly professional indemnity cover. They cover the insured against a third party's claim made for the first time during the currency of the policy, provided the existence of the claim was notified to the insurer during that period. Notification is required to activate the cover under the policy.[187] Professional indemnity policies and legal expenses policies are common examples where the insured must seek the insurer's consent before commencing any litigation.[188]

67. An example of a 'claims made and notified' clause under a 'claims made and notified' policy is as follows;

> 'On the terms and conditions herein contained the Insurers shall Indemnify the Assured up to an amount not exceeding the Sum Insured and Related Costs against all loss to the Assured (including claimants' costs) whensoever occurring arising from any claim or claims first made against the Assured during the Period of Insurance and reported to the Insurers during such period, in respect of any description of civil liability whatsoever incurred in connection with the Practice...'[189]

68. Apart from the benefit of requiring the insured to notify the insurer,[190] 'claims made and notified' policies also limit the 'long-tail' problems of an occurrence policy.[191] The date at which a claim was made is easier to ascertain than

the date at which an 'occurrence' happened.[192] Compared to 'claims made' policies, 'claims made and notified' policies also better equip insurers in forecasting the likely level of claims that will be payable under liability insurance policies.[193]

The evolution of 'claims made and occurrence notified' policies

69. Apart from 'claims made and notified' policies where the insured is required to notify an actual claim made against the insured during the policy period, 'claims made and occurrence notified' policies have evolved to impose a greater onus on the insured to disclose material facts. Under a 'claims made and occurrence notified' policy, potential claims against the insured are covered under the policy provided notice of these was given during the policy period.[194] Where the insured has notified the insurer during the policy period of any circumstances that may subsequently give rise to a claim against them, any third party claims which are later made outside the policy period are deemed to have been made during the policy period.[195]

70. In reality, the courts make no clear distinction between a 'claims made and notified' policy and a 'claims made and occurrence notified' policy. Facts in case law suggest that insurers tend to include 'occurrence notified' provisions as extension clauses in expanding the scope of a 'claims made and notified' policy.[196] To avoid confusion, however, this paper will maintain the distinction between these two different types of insurance.

71. When compared to a pure 'claims made and notified' policy, a 'claims made and occurrence notified' policy helps to ensure that claims which are not made until a later policy period will be covered under the existing policy.[197] If the insured does not notify the insurer of the occurrence under the existing policy, then the insured must disclose the existence of circumstances that may lead to a future claim before entering into any subsequent insurance policy.[198] This enables the insurer to decide whether to, either expressly or via a general exclusion clause, exclude the possible claim from the cover under the terms of the new policy.[199] An example of an 'occurrence notified' clause is as follows;

    > 'If during the [policy period,] the insured shall become aware of any occurrence which may subsequently give rise to a claim against him or them for breach of professional duty by reason of any negligence, whether by way of act, error or omission and shall during the [policy period,] give written notice to the insurer of such occurrence, then any such claim which may subsequently be made against the insured arising out of such negligence shall for the purposes of this Policy be deemed to have been made during the [policy period].'[200]

    This policy excludes cover for 'loss arising out of any circumstance or occurrence [which] has been notified under any other insurance attaching prior to the inception of this Certificate of Insurance, or of which the Assured was aware at the commencement of the Period of Insurance. ......'[201]

72. It is the notification of 'awareness' that has caused problems for the courts. The extent of awareness required under a 'claims made and occurrence notified' policy refers to the insured's awareness of the prospect of a claim against it, rather than to knowledge of the occurrence itself.[202] The insured must appreciate that the circumstances will subsequently give rise to a claim. It is not enough merely to have knowledge of the circumstances,[203] as otherwise, the insured would be ineligible to be indemnified merely by being aware of the occurrence which resulted in a claim, but without having any reason to anticipate that claim.[204] The insured does not, however, have to be aware of why a possible claim might be made or whether such a claim is justified or might be expected to be successful.[205] The insured merely has to be aware of the possibility, however remote, of a claim being made in the future.[206]

A brief sketch of case law development regarding 'claims' policies

73. Although it is important for the insureds to notify the insurer of claims and circumstances that may give rise to a claim, there are instances where they do not notify the insurer when they receive a claim from a third party or become aware of an occurrence.[207] The insured may simply have forgotten to notify, notified the wrong insurer or not realised that a claim has been received.[208] The insured might have regarded the possibility of a future claim as being remote.[209] In other cases, the insured may be gambling on the fact that a claim will not be made against it and choose not to notify the insurer of an occurrence to avoid the risk of a higher premium for future cover.[210]

74. Section 54(1) provides that an insurer may not use the insured's act or omission as a reason for refusing to pay a claim where that act or omission occurs during the policy period and could not have contributed to the loss.[211] Although the following is not an exhaustive list, a policy may provide that the insured is obliged to notify the insurer:

    - of a claim made against them by a third party;
    - of facts that are likely to give rise to a claim; or
    - to obtain prior consent before taking actions.

    The issue arises as to whether a non-compliance with these terms can be excused as an 'omission' under section 54(1).

75. From the insurer's standpoint, it is important that section 54 does not operate at all in this context, since the section imposes a prima facie liability on the insurer to pay. Insurers have therefore argued that the insured's failure to comply with the notification term of the policy is not an 'omission' under section 54. On the other hand, from the insured's perspective, it is essential that section 54(1) is operative, so that the insurer is barred from refusing their claim for a failure to give notification. As will be discussed later, an insured may, for various reasons, be without cover after the original insurance policy has expired, since later policies may not always respond to the insured's claim.[212] In these instances, it is imperative that the earlier insurance policy will apply in their favour. As the wording of section 54 does not provide guidance regarding the matter, the courts have been left with the unenviable task of resolving the battle of interests between the insurer and the insured regarding the operation of section 54 in this context.

East End - A controversial beginning for insurers and the insureds

76. East End Real Estate P/L v CE Heath Casualty & General Insurance Co Ltd[213] is the first major case to deal with the issue of whether the insured's failure to notify a claim under a 'claims made and notified' policy could be classified as an omission under section 54(1).[214] The policy contained an 'ambit of cover clause,' which required the insured to notify the insurer during the policy period of any claims made against them for breach of professional duty within the period of cover.[215] In this case, a third party made a claim against the insured during the policy period. The insured had, however, failed to notify the insurer of this. The insurer argued that section 54 was not concerned with acts or omissions which formed part of the definition of the risk insured.[216] Section 54 dealt with matters such as warranties, conditions and exclusions, but not matters concerning the ambit of insurance cover. The insurer argued, referring to Justice Handley in Ferrcom, that the intention behind section 54 was not to widen the cover in an insurance policy.[217]

77. The NSW Court of Appeal held that the insured's failure to give notification could be excused as an omission under section 54. The court found that the section was designed to remedy the 'mischief' under the previous legal environment where the insurer could rely on particular drafting techniques and virtually decide the outcome in the case of litigation.[218] It was enacted so that substance would triumph over form.[219] In this case, 'the effect' of the policy allowed the insurer to refuse to pay the claim where there had been a lack of notification 'by the insured or some other person.'[220] The court held that section 54 used general words to show clearly that the section would operate whether the insurance policy had used an ambit of cover clause, an exclusion clause or a condition in the body of the policy to deny cover for certain act or omission.[221] The High Court refused an application for special leave to appeal from the Court of Appeal's decision.[222]

78. The High Court has also subsequently endorsed the East End decision.[223] The case must therefore, be taken as representing the law.[224] There have, however, been attempts to limit the ramifications of the decision.

Perry - A disagreement over East End; 'omission/inaction' dichotomy

79. The NSW Court of Appeal in FAI General Insurance Co Ltd v Perry ('Perry') had another opportunity to examine the issues raised in East End.[225] In Perry, a 'claims made and notified' policy contained an 'occurrence reported' extension clause where the insured could exercise the option to notify the insurer of circumstances that might subsequently give rise to a claim and expand the cover accordingly.[226] The insured, an accountant, discovered irregularities regarding his client's statement of financial position. He became aware that the errors had existed for the time that he was engaged as an auditor for his client and that he had been negligent in not discovering the irregularities earlier.[227] The insured decided not to advise the insurer of this discovery during the policy period. A claim was made against the insured after the policy had expired and the insured sought cover under the policy. The insurer

refused to pay the claim because the insured had failed to notify it of the relevant circumstances during the policy period. The insured relied on East End to argue that the failure to notify was an omission under section 54(1).[228]

80. The majority of the Court of Appeal[229] refused to apply section 54 in favour of the insured.[230] The court held that the insured's failure to notify under an optional provision did not constitute an omission under section 54. Rather, it was an 'inaction' to which section 54 did not apply.[231] Chief Justice Gleeson held that where the insured had an option to notify the insurer of an occurrence, a failure to notify was an 'inaction' rather than an 'omission' under section 54.[232] Where the insured was obliged to notify the insurer of an occurrence, a failure to notify would be an 'omission' under section 54(1).[233] 'The words inaction and omission are not synonyms.'[234] Judges and academics have referred to this as the 'omission/inaction' dichotomy.

81. According to Chief Justice Gleeson, where an insured had exercised the optional right to notify the insurer of an occurrence, the original contract would be changed so as to create a 'new contract.'[235] If, as in Perry, the insured had chosen not to notify, his Honour held that section 54 could not be allowed to operate to cure that omission so as to create a 'new contract' by altering the original nature of the contract.[236] If, as in East End, the insured had failed to discharge the mandatory obligation to notify the insurer of a claim, his Honour believed it would be appropriate to allow section 54 to 'cure' that omission as it would not alter the original nature of the contract.[237] It would affect the entitlement to claim, but not the extent of the cover.[238]

82. As will be discussed, Perry has been criticised by judges and academics for devising an artificial distinction between an omission and inaction.[239] To classify an optional right to notify as an inaction and a mandatory obligation to notify as an 'omission,' the decision would leave the way open for insurers to draft notification clauses as optional, so as to deny the insured the benefit of section 54. Such a result is contrary to the ALRC's spirit in achieving 'substance over form' in the law.[240]

Antico - Judgement day for Perry?

83. Despite the various criticisms,[241] the Perry decision was nevertheless followed by the NSW Supreme Court and the Full Court of the WA Supreme Court.[242] The High Court reviewed the law regarding 'claims made and notified' and 'claims made and occurrence notified' policies in Antico v Heath Fielding Australia P/L ('Antico')[243] In this case, the insured failed to seek the insurer's consent before proceeding to defend claims made against him. The insured argued that the failure to obtain the necessary consent was an omission under section 54. The argument was successful before the High Court.

84. The majority of the High Court stressed that section 54 is 'clearly remedial legislation.'[244] The section must therefore be,

> 'beneficially construed so as to provide the most complete remedy of the situation with which they are intended to deal [but consistent with] the actual language employed."[245]

85. In adopting that construction, the majority found that the term 'omission' under section 54 was not limited to the insured's failure to discharge an obligation.[246] The section was broad enough to cover cases where the insured had failed to exercise the 'right, choice or liberty' to take certain actions as allowed under the contract.[247] This means that whether the insured failed to notify a claim under a 'claims made and notified' policy or failed to exercise the right to notify the insured of an occurrence under an optional 'occurrence notified' extension clause, both are construed as 'omissions' under section 54.[248]

86. Although the High Court had not expressly overruled Perry, many commentators believed a rejection of the 'omission-inaction' dichotomy meant that Perry was as good as dead.[249] Subsequent decisions, however, have held that Perry was still good law.[250]

Greentree and Permanent Trustee - The 'omission-non-event' dichotomy

87. In Greentree v FAI General Insurance Co Ltd ('Greentree'), the insured, an engineer, was negligent in designing a building. Although the negligent act occurred during the policy period, it was only later discovered by the third party plaintiff owner well after the policy had expired.[251] When the plaintiff owner was unable to recover its losses from

the insured,[252] the owner sought to recover against the insurer.[253] The insurer denied liability by arguing that the plaintiff did not make a claim within the policy period. The plaintiff relied on section 54 and argued that his failure to make a claim on the insured during the policy period was an omission to act by 'some other person' under section 54.[254] The NSW Court of Appeal held that such a failure was not the sort of omission to which section 54 applied. The absence of a claim in the policy year meant that there was nothing to activate the policy. The High Court refused leave to appeal.[255]

88. Chief Justice Spigelman held that there was a distinction between a 'non-event' and an 'omission' under section 54.[256] A 'non-event' is an event 'wholly external to the policy.'[257] It is where the act or omission was an event which preceded any consideration of whether the effect of the contract was that the insurer might refuse to pay a claim made by the insured. In such situation, section 54 would not apply because the issue of whether the insurer might refuse to pay the insured's claim arises only after a third party has made a claim against the insured during the policy period.[258]

89. Chief Justice Hodgson used a simpler approach in Permanent Trustee Australia Ltd v FAI General Insurance Co Ltd ('Permanent Trustee').[259] The case was similar to Greentree where the third party did not make a claim against the insured during the policy period. The difference between the two cases was that in Permanent Trustee, it was the insured, rather than the third party, that was making a claim against the insurer.[260]

90. In analysing the distinction between an 'omission' and a 'non-event,' Chief Justice Hodgson found that where a claim was not made within the policy period, the crux of the reason why the insurer had refused to indemnify was not that someone omitted to do something, but that something did not happen.[261] His Honour used 'a plainly absurd' example to explain his argument.[262] An insured may have taken out insurance cover against fire damage for 1995. Suppose that an arsonist set fire to the insured's house which causes seriously damages in 1996. The insured seeks cover under the 1995, arguing that section 54 prohibits the insurer from refusing to pay claim due to the arsonist's omission to burn down the house in 1995. Chief Justice Hodgson argued that it was clear in this example that the insurer's refusal to pay was that there was no fire in 1995. It would be 'bizarre' to argue that the insurer's refusal was due to the arsonist's omission to destroy the house earlier.[263]

91. The approach adopted by Chief Justices Spigelman and Hodgson in distinguishing between an 'omission' and a 'non-event' in the sense of conduct 'wholly external to the policy' has met various criticisms. The approach was problematic in that one could never determine 'the effect of a contract of insurance' without considering the external facts and circumstances.[264] In many cases, the fundamental reason why something does not happen is because someone does not do something.[265] Judges have described the approach as 'elusive'[266] and 'a little difficult to understand.'[267] The High Court in FAI General Insurance Company Ltd v Australian Hospital Care P/L ('Australian Hospital Care') [268] finally clarified the matter.

Australian Hospital Care - Curing 'claims made and occurrence notified' policies

92. The factual scenario in Australian Hospital Care[269] stretched the minds of the justices of the Queensland Court of Appeal regarding the issue of whether an insured should be allowed to invoke section 54 where they had failed to notify an occurrence.[270] The court refused to follow the lead given in Greentree and held that the High Court had overruled Perry in Antico.[271] The Full Federal Court of Australia's decision in HIH Casualty & General Insurance Aust P/L v DellaVedova[272] was cited in supporting this point.[273]

93. Australian Hospital Care involved circumstances substantially similar to Perry in that both involved a 'claims made and notified' policy with an 'occurrence notified' extension clause. Essentially, the clause provided that where the insured had chosen to notify the insurer of an occurrence that may subsequently give rise to a claim during the policy period, any relevant subsequent claims would be deemed to have been made within that policy period.[274] During the policy period, the insured became aware that a patient had contracted septicaemia whilst in hospital. The patient's solicitor had made enquiries with the insured regarding the matter as a preliminary step to taking possible legal action against the insured. Following the investigation and the insured's own study into the matter, it was found that there was no ground for complaint. The patient was satisfied with this outcome.[275] The insured therefore did not advise the insurer of this occurrence as it was 'not expected...that a claim would be made.'[276] The patient had, however, later made a claim against the insured after the policy had expired. The insurer refused to indemnify the insured on the ground that it had failed to notify the occurrence during the policy period. The insured argued that this was an

omission that section 54(1) could cure.[277]

94. Justice Derrington rejected Chief Justice Gleeson's approach in Perry that a 'new contract' would come into place where an insured had chosen to notify the insurer of an occurrence under an 'occurrence notified' clause and hence, expand the level of cover.[278] His Honour commented that the 'claims made and notified' and 'occurrence notified' components of the policy were 'interlocked' together to form an 'integrated whole.'[279] The policy in this case was not merely a 'claims made and notified' cover during the policy period, it embraced claims made after that period as well.[280] The latter formed part of the insurer's total promise and was equally important to the insured in arranging their affairs.[281] When insurers calculated their premium, both aspects of the promised indemnity would have been incorporated into their calculations.

95. The court noted that the High Court in Antico had already disapproved the approach in Perry.[282] It concluded that the insured's failure to notify an occurrence in this case was an 'omission' under section 54(1). Before this Queensland Court of Appeal's decision could be appealed to the High Court, another case which involved facts that were virtually indistinguishable from Perry arose for consideration in the NSW Supreme Court.[283]

Einfield - A decision on the fate of Perry

96. The case of Einfeld v HIH Casualty & General Insurance ('Einfeld')[284] involved a 'claims made and notified' policy with an 'occurrence notified' extension clause. During the policy period, the insured became aware of circumstances that may have subsequently given rise to a claim. The insured obtained legal advice and chose not to take advantage of the 'occurrence notified' extension clause by advising the insurer of these circumstances. The basis of the insured's decision was to avoid the possibility of having to pay a higher premium for later policies as a result of the notification. A claim was subsequently made against the insured. The insured sought cover under the original policy and relied on section 54(1) to 'excuse' his failure to notify when the insurer declined to indemnify the insured against the claim.[285]

97. The NSW Supreme Court was therefore faced with the task of deciding whether Perry was valid, given the decisions of Antico, Greentree, Della Vedova, and Australian Hospital Care. After examining the High Court's decision in Antico, Justice Rolfe found that the reasoning in Perry had been rejected and therefore the case could no longer stand.[286] His Honour held that in light of the decisions in Della Vedova and Australian Hospital Care, the plaintiff's failure to notify the occurrence was an omission under section 54.[287]

98. Justice Rolfe concurred with Justice Chesterman's view in Australian Hospital Care that it was unfortunate that section 54(1) had been held to 'excuse' the insured's failure to notify the insurer of relevant circumstances. Justice Rolfe had also expressed concern regarding the different judicial opinions on this area of law. His Honour stressed that as matters stood, different results could be expected depending on the jurisdiction in which the litigation was brought.[288] Perry, for example, is not binding in all States. Courts could therefore hand down inconsistent decisions.[289]

Australian Hospital Care again - The final outcome for 'claims' policies

99. The insurer's decision to appeal against the findings of the Queensland Court of Appeal provided the High Court with an opportunity resolve a matter that has 'agitated courts and commentators for several years,' once and for all.[290] With a majority of four to one, the High Court found in favour of the insured.[291] The court reaffirmed the Court of Appeal's finding that section 54 would prevent an insurer from denying a claim on the basis that an insured had failed to give notice of circumstances during the policy period even where the claim was made after that policy period had expired.[292]

100. Justices McHugh, Gummow and Hayne criticised the reasoning in Greentree and Permanent Trustee although their Honours agreed with the actual decision in each case.[293] In devising a better approach, their Honours commented that section 54(1) would not apply to relieve the insured of certain 'restrictions or limitations that were inherent in a claim.'[294] In other words, where a failure concerned an element that was inherently essential to a claim as a matter of law, as opposed to matters that were merely ancillary or procedural, section 54 would not apply to 'cure' that failure.[295] Under an 'occurrence' policy, for example, the 'occurrence' of an event is the essential element. Section 54(1) will not operate to cure a failure of the event to occur which has subsequently given rise to liability under the policy.[296] The essential element under a 'claims made' or 'claims made and notified' policy is a third party's 'demand' made within the policy period. The third party's failure to make the demand would not be classified as an 'omission'

under section 54(1).[297] Under a 'claims made and occurrence notified' policy, the essential element is the insured becoming aware of facts which may subsequently give rise to claims. Section 54(1) will not apply to 'excuse' a failure to become aware of certain facts.[298]

101. The inherent limitation test was recently considered and applied by the District Court of Queensland in Stapleton & Anor v NTI Limited.[299] Justice McGill found the test difficult when determining how to distinguish between restrictions inherent in a claim, which could not be overcome under section 54(1), and other restrictions to which the section would apply.[300] His Honour held that the manner in which the test will operate in a particular case 'may well be largely a matter of impression,' but concluded that in this case, the causal relationship required under section 54(1) was not satisfied.[301]

102. On the question of the term 'omission,' Justice Kirby, the other justice in the majority, described previous distinctions as simply artificial.[302] These included Justice Handley's approach of the 'failure to act for the insured's benefit' and Chief Justice Spigelmans' 'omission-non-event' dichotomy in Greentree.[303] Chief Justice Hodgson's distinction between 'someone's omission to do something' and a relevant event that 'did not happen' was also criticised.[304] Similar to President Mason's approach in Greentree,[305] Justice Kirby had instead argued for the approach of causation in determining whether the insurer's 'real reason' for refusing to pay was because of the failure of the insured or of some other person or because the claim did not fall within the policy. If the former was the insurer's 'real reason' for refusing to pay, then section 54 would apply and vice versa.[306] In Greentree, for example, the 'real reason' for the insurer's refusal was not some act or omission of the insured or some other person. Instead, it was because the policy did not extend cover to a claim that was made outside the policy period.[307]

103. The dissenting judge was Chief Justice Gleeson. His Honour also applied the causal connection test and found that the insurer's reason for refusing to pay in this case was due to the third party patient not making a claim on the insured during the policy period. The refusal was not due to the insured's failure to notify the insurer of the occurrence under the optional notification provision.[308] The problem with his Honour's approach is, however, that it would depend very much on how the notification provision was drafted in the first place. If, rather than being optional, the notification provision were included in the policy's scope of cover itself, Chief Justice Gleeson's approach might lead to a different result. The insurer's real reason for refusing to pay in the latter case would be the insured's failure to discharge their obligation to notify. The approach is therefore problematic and undesirable, in that its result would depend on matters of form rather than substance,[309] contrary to the ALRC's original recommendations.[310]

General overview of the case law

104. In general, where the insured had failed to notify a claim under a 'claims made and notified' policy, section 54 would apply to 'cure' that failure.[311] Similarly, where the insured had failed to notify an occurrence under a 'claims made and occurrence notified' policy, whether the notification was optional or mandatory, section 54 would apply to 'excuse' that failure. It was irrelevant whether the failure would be intentional or otherwise.[312] Where the case concerns facts which are the same as or similar to Permanent Trustee or Greentree, the relevant failure would not be an omission pursuant to the omission/non-event dichotomy.[313]

105. It took the courts at least a decade to come to these conclusions. The controversy began with the NSW Court of Appeal in East End giving a liberal interpretation to the expression 'the effect of the contract' in section 54(1).[314] The same court then attempted to change its direction by devising a distinction between an 'omission' and an 'inaction' in Perry.[315] That attempt failed to gain support of the courts in Antico, Australian Hospital Care, Della Vedova and Einfeld. The cases unanimously supported the original direction taken by East End.

106. These decisions have produced an insurance policy different to the one originally agreed upon by the parties.[316] A 'claims made and notified' policy is effectively transformed into a 'claims made' policy.[317] Provided the claim is made during the policy period and the insured notifies the insurer of that claim at some stage, perhaps years later, the insurer may not refuse to pay the claim under section 54.[318] The parties' freedom to contract has also 'gone largely by the board,' because they cannot set the extent of the exposure.[319]

107. The same could be said in regard to a 'claims made and occurrence notified' policy, where the High Court in Australian Hospital Care effectively changed it into an 'occurrence based' policy.[320] As a result, an insured who becomes aware of an occurrence during the policy period may notify the insurer of that occurrence at a much later stage.

108. There is much to criticise in the end result of these decisions. From the insurer's perspective, the decisions have therefore nullified the intended purpose of the notification provisions of a 'claims made and notified' policy and a 'claims made and occurrence notified' policy. They have revived the 'long tail' problem with claims being made many years later and the conflict as to exactly when an insured became aware of facts and therefore, which policy applied.[321] Contrary to the original aim of 'claims made' policies, insurers must set aside reserves to cover future claims under expired policies in order to satisfy any 'long tail' claims that these policies sought to avoid.[322] Increased exposure may lead to an increase in reinsurance[323] and other costs which will ultimately be passed onto the insured as increased premium costs.[324] Overseas and Australian insurers and reinsurers may also not continue to write business in and for the Australian market,[325] as it may also cause a degree of uncertainty for the insurer in determining its financial position.[326]

109. As Justice Cole commented in Breville Appliances P/L v Ducrou, this leaves Australia in a 'unique position throughout the world.' Australian insurers could no longer offer an effective 'claims made and notified' policy or 'claims made and occurrence notified' policy as opposed to a 'claims made' policy.[327] The ultimate outcome would be a decline in the demand for and the supply of insurance cover, a deterioration in the economy's productive capacity and overall standard of living.[328]

110. As can be seen from the recent public liability crisis, insureds have found it almost impossible to obtain cover. Those who are offered cover have been faced with grossly inflated premiums.[329] Ironically, the consequences may be even harsher for the insured than if the High Court had ruled the first limb in the insurer's favour.

Finding a middle ground for section 54 for 'claims' policies

111. Section 54 was enacted to remedy the previous legal environment where insurers were heavily favoured.[330] However, a law which entirely favours the insured is equally disastrous. Given that section 54(1) applies to both a failure to notify a claim and a failure to notify an occurrence, it is important that its effect be shackled to a certain extent to achieve a balance between the interests of the insurer and the insured. As Justice Pincus commented in Australian Hospital Care, to allow section 54 to operate in such a way that unfairly favoured the insureds would create 'so extreme an outcome that [the legislators] could hardly have intended it.'[331] It would impose on the insurer a risk 'much more uncertain in scope' and 'quite different in character' than that which it had originally agreed to undertake.[332]

The benchmarks for reform and methods for 'shackling' the effect of section 54

112. The following discussion covers the controversial situations where the insured has failed to notify a claim or an occurrence and is seeking to raise section 54(1) to 'excuse' that failure so as to be indemnified under the original insurance policy. It will not deal with the Greentree-type situations where the insured had no knowledge of an occurrence during the policy period and a claim did not arise until some time after the original policy had expired. It is submitted that the High Court in Australian Hospital Care had adequately resolved such 'non-event' situations by treating such claims as falling within the period in correspondence with when the claim is first made against the insured, or when the insured first becomes aware of an occurrence, rather than the original policy period.[333]

113. The crux of the problem is whether the insureds should be protected from a failure to notify certain facts that are important to the insurers in determining their positions under the contract. Where the failure to notify a claim or an occurrence is deliberate, it would be contrary to the legislator's intention to allow section 54 to 'cure' that omission in favour of the insured. On the other hand, to exclude section 54 from coming into operation every time the insured had omitted to notify a fact would favour the insurer so much as to defeat the original purpose of the legislation. Hypothetically, an insured may become aware of an occurrence at 4pm on the last day of the policy period and decide to notify the insurer of that occurrence. By the time the insured is able to notify the insurer, the last insurance officer leaves for the day. To allow the insurer to deny the claim in such a circumstance would be harsh indeed.[334]

114. Any reform to the law must therefore make section 54 fair for both parties who are vulnerable to the abuse of the other. The insured is vulnerable to the insurer who relies on technicalities to deny liability. The insurer, on the other hand, is vulnerable to the insured who does not inform it of certain facts that are important to it in assessing its risks. It follows that there are several factors which form the benchmarks for reforming the first limb of section 54. As was discussed

earlier, the ALRC's recommendation of 'substance over form' is an important consideration. The solution must be practical and capable of being easily and fairly implemented so as to avoid lengthy litigation. The solution must also create certainty for both the insurer and the insured. This could be in the form of legislative or contractual certainty. Resolving the 'long-tail' problems faced by insurers under 'claims made and notified' and 'claims made and occurrence notified' policies is a priority. An aim to achieve certainty should not, however, affect the parties' right to a certain degree of contractual freedom.

115. Judges and academics have proposed various methods that might be used in balancing the interests of the insurer and the insured whilst achieving the above benchmarks and also the broad aims of the legislation. The alternative proposals are:

- restoring the 'omission/inaction' dichotomy so that where the insured has exercised the decision not to notify an occurrence under an 'occurrence notified' extension clause, that is an 'inaction' which falls outside the protection of section 54;
- accepting the current legal position in Australian Hospital Care and rely primarily on the prejudice limb to 'filter out' potentially unjust outcomes;
- omitting 'occurrence notified' clauses from insurance policies so as to force the insureds to rely on the provisions of section 40 for protection;
- amending section 54(1) so that it does not operate in relation to 'claims made and notified' clauses and 'occurrence notified' extension clauses in professional indemnity policies; or
- incorporating statutory time limits on when the insured must notify the insurer of a claim or an occurrence after the original insurance policy has expired.

The next sections will critically examine each of these methods in turn. An additional alternative will then be proposed for consideration.

Reviving the 'omission/inaction' dichotomy

116. The 'omission/inaction' dichotomy is immensely unpopular amongst judges and academics because it creates an artificial distinction between the effects of a failure to notify a claim and an occurrence under a mandatory and optional notification provision respectively.[335] As Sutton argues, the whole point of notification is to enable the insurer to set aside appropriate reserves to meet future claims and to properly investigate a matter.[336] There is no difference between a mandatory obligation to notify and an optional provision to notify.[337] They produce the same result in that notification will affect the entitlement to claim in both the 'primary' insurance and the expanded cover.[338] 'Consistency would demand' that if a failure to notify a claim were 'excused' under section 54, a failure to notify an occurrence should also be similarly 'excused.'[339]

117. Apart from these criticisms, the dichotomy is problematic in situations where the insureds have legitimate reasons for failing to notify an occurrence. The insured might honestly believe that the occurrence would not later give rise to a claim after, for example, having obtained appropriate legal advice.[340] There is no reason why the insured's failure to notify should be treated as an 'inaction' rather than an 'omission' in these instances.

118. Despite these arguments, the 'omission/inaction' dichotomy still holds some attraction as it recognises the 'opt-in' nature of an optional notification clause. If the insured was aware of and had chosen not to notify an occurrence, it would lack common sense to later allow that decision to be 'excused' as an omission. As the Insurance and Superannuation Commission ('ISC') argues, there are practical reasons for having an option to notify facts, as distinct from an option to notify claims.[341] Amongst other things, the insured may feel that the possibility that the occurrence may actually turn into a claim is so remote that notification is not warranted. This is given the fact that notification may lead to an increase in premium or that the insurer may refuse to provide cover in a subsequent year.[342] There is also the expectation that any claim will fall into a later policy period.[343] Where the insured has made the commercial decision to not notify an occurrence, it is at least only fair to both parties that section 54 does not apply.[344]

119. The 'long-tail' problems of 'claims made and notified' and 'claims made and occurrence notified' policies are sought to be resolved by drawing a distinction between an omission and an inaction. The recent medical indemnity crisis is an example where insurers face difficulties in indemnifying doctors for claims that arise many years later.[345] Insurance premiums have skyrocketed due to rising payouts and increasing litigation.[346] The problem was so serious that the

government has recently proposed a package where it will subsidise insurance premiums for 'obstetricians, neurosurgeons and GP proceduralists.'[347] It will also pay half the cost of payouts over $2 million from January 2003. The package is likely to cost the government between $45 and $50 million a year.[348] The fact that the government has intervened and is willing to spend money to resolve the issue shows that the 'long tail' problem is significant to other issues that currently exist in the insurance sector.[349]

120. There is, however, no such thing as an Utopian legislation. The hard edges of the law are liable to produce unfortunate results in certain cases. As Shakespeare aptly said, 'the web of our life is of a mingled yarn, good and ill together.'[350] Although insureds might have legitimate reasons for not notifying an occurrence, ideally they should always err on the side of caution and notify the insurer to ensure that they are covered should a claim later arise.[351]

121. To allow a degree of fairness and flexibility, where the insured honestly believes in good faith that an occurrence will not later give rise to a claim,[352] the failure to notify should be treated as an omission rather than an inaction. An example is where the insured has honestly believed that a claim would not later arise after having obtained legal advice.[353] The classification would not disturb the balance of interests between the insurer and the insured, since, as is the case with the insureds, the hard edge of the law should equally apply to the insurer. The 'omission/inaction' dichotomy is therefore a two-edged sword.

122. Despite the various criticisms that may be made against the 'omission/inaction' dichotomy, the method helps to generate certainty for the insurer by providing a differential treatment to an omission and an inaction. It is a tool that is capable of being used in limiting the effect of the wording of section 54.

123. In terms of its overall effectiveness, however, the method does not meet some of the more important criteria for reform; namely reducing litigation and promoting substance over form. A distinction between an omission and an inaction will inevitably give rise to disputes concerning whether the insured was aware of an occurrence during the relevant policy period. To prove that the person was aware of something is notoriously difficult. The issue is even more complicated in the corporate context where the controlling mind must also be considered. Another dispute that may arise is whether the chance that the occurrence may later transform into a claim is so remote that it does not warrant notification in the circumstances.[354] These are issues which will require judges to solve problems that will only generate lengthy litigation.

124. The dichotomy also promotes 'form over substance,' as the application of section 54 is dependent upon whether notification was an option or a contractual obligation. Since a failure to notify under an optional clause is considered an inaction, insurers would draft notification clauses as imposing on the insured an optional obligation to notify so as to avoid the application of section 54.[355] As was mentioned in section 3,[356] the use of such 'drafting devices' is contrary to the spirit of the ICA in encouraging 'substance over form.'[357]

Prejudice - the 'Catcher in the Rye'

125. Another possible method of resolving this issue is to examine the original intention of the ALRC in devising the legislation. Section 54 was enacted as a remedial legislation designed to prevent the problems associated with the previous legal environment where insurers could refuse to pay a claim upon a breach of term.[358] The result was often harsh, as the insured's act or omission which led to the breach might not have caused the loss. It was therefore important for section 54 to intervene and limit the insurer's ability to refuse to pay a claim in those situations.[359]

126. The outcomes in Antico and Australian Hospital Care are in line with that spirit. Whether the case involves a choice or a mandatory obligation to notify, section 54 should cure the insured's failure to notify. The fact that this would allow section 54 to alter the original scope of the policy is irrelevant.

127. Allowing section 54 to 'cure' the insured's omission may, however, unfairly prejudice the insurer's interests. An insured may, for example, have deliberately delayed the notification of facts until new and non-punitive policy terms have been agreed with a replacing insurer.[360] In these instances, the second limb of section 54 (prejudice limb) should apply to help alleviate that deficiency by reducing the amount that the insurer must pay in indemnifying the insured for the loss. The amount that is reduced is determined by the extent to which the insurer's interests were prejudiced as a result of the act or omission.[361] The second limb of section 54, which will be discussed in the next section, acts as the 'Catcher in the Rye' in helping to 'catch' any unfair application of section 54 in the first limb.[362] At least one judge has commented that the appropriate use of the concept of prejudice can control the operation of section

54(1).[363]

128. In general, by treating a failure to notify a claim and a failure to notify an occurrence as equal, this approach is a lot simpler and more efficient than the current approach adopted by the courts. It does not require the courts to trudge through a 'legal jungle' just to find an answer to whether the failure to act was an 'omission' under section 54. A question remains, however, as to whether the courts could rely on the prejudice limb to produce an equitable outcome. Judges and academics have expressed the view that it can.[364] If the insurer cannot establish that they have suffered any prejudice as a result of the insured's omission, section 54 will apply in ensuring fairness between the parties.[365] Sutton has nevertheless admitted that proof of prejudice is not always easy to establish. It may involve a disclosure of commercially sensitive material which an insurer is unwilling to divulge.[366] As will be discussed in the next section, the prejudice limb has generated its own criticisms: particularly regarding the way in which the courts quantify the total amount of prejudice.[367] Relying on prejudice suffered to reduce liability may therefore turn out to be an uncertain safeguard, generating more litigation.

Omitting 'occurrence notified' clauses from 'claims made' insurance policies

129. Justice Chesterman in Australian Hospital Care suggested a different approach for limiting the effect of section 54(1). His Honour recommended that the insurers should avoid drafting 'occurrence notified' clauses in their policies. They should instead advise the insureds to rely solely on the protection proffered under section 40(3).[368]

Section 40 provides that;

> (1) This section applies in relation to a contract of liability insurance the effect of which is that the insurer's liability is excluded or limited by reason that notice of a claim against the insured in respect of a loss suffered by some other person is not given to the insurer before the expiration of the period of the insurance cover provided by the contract.
>
> (2) The insurer shall, before the contract is entered into:
>
> > (a) clearly inform the insured in writing of the effect of subsection (3); and
> >
> > (b) if the contract does not provide insurance cover in relation to events that occurred before the contract was entered into, clearly inform the insured in writing that the contract does not provide such cover.
>
> (3) Where the insured gave notice in writing to the insurer of facts that might give rise to a claim against the insured as soon as was reasonably practicable after the insured became aware of those facts but before the insurance cover provided by the contract expired, the insurer is not relieved of liability under the contract in respect of the claim, when made, by reason only that it was made after the expiration of the period of the insurance cover provided by the contract.

130. Section 40(3) has created much controversy by effectively inserting a statutory 'occurrence notified' clause in liability insurance policies.[369] These include 'claims made and notified' and 'claims made' policies.[370] Where the case involves a 'claims made' or a 'claims made and notified' policy as opposed to a 'claims made and occurrence notified' policy,[371] the insurer will remain liable to indemnify the insured where the insured has notified the insurer in writing of an occurrence giving rise to a subsequent claim.[372] That notice must, however, be sent as soon as 'reasonably practicable' during the policy period after the insured has become aware of the occurrence.[373]

131. Under section 40(3) therefore, the insured must notify the insurer of an occurrence only during the policy period. On its face, this contradicts the operation of section 54(1), since the courts have allowed the section to 'cure' the insured's failure to notify the insurer of an occurrence during the policy period.[374] Section 54 may therefore apply to retrospectively convert a 'claims made and notified' policy into an 'occurrence based' policy.[375] The problem has led to much judicial 'head scratching.'[376]

132. The purpose of section 40 was to make available to all purchasers of 'claims made and notified' policies an opportunity to extend cover by notifying facts during the policy period. This was a benefit that was previously offered by only some insurers.[377] Where the insured has failed to notify an occurrence,[378] it would be contrary to the legislature's

intention to allow section 54(1) to apply and 'excuse' the insured's failure to notify. To allow otherwise would defeat the purpose of section 40(3) and disturb the balance between the interests of insurers and insureds under section 40.[379]

133. The courts have, however, been reluctant to perceive any inconsistency between section 40(3) and section 54(1).[380] It was found that the sections were concerned with 'conceptually different problems.'[381] Section 40 dealt with the situation where facts had been notified. It did not deal expressly with the situation where facts had not been notified. Section 54, on the other hand, expressly dealt with omissions. The two provisions were therefore held not to be in conflict with each other.[382]

134. Sutton argued that it was not obvious that section 54(1) would affect the operation of section 40(3).[383] The 'effect' of the insurance contract which came within the scope of section 40(1) was not to enable the insurer to refuse to pay the claim due to the insured's failure to notify an occurrence.[384] Instead, the insurer's refusal to pay is based on the insured's failure to observe the statutory requirements of section 40(3). This is something which is quite outside the terms of the insurance contract. Section 54(1) cannot operate to extend the ambit of section 40(3).[385]

135. The problem with this approach is that it contradicts the fact that section 54 employs 'words of generality.' The term 'omission' should be wide enough to cover the insured's failure to comply with a statutory provision such as that of section 40(3).[386] The apparent distinction between a failure to notify an occurrence where section 40 does not apply and a failure to notify where section 40 applies is rather artificial.

136. The controversy may have been partially resolved with the recent NSW Court of Appeal decision in Gosford City Council v GIO General Ltd ('Gosford City').[387] In this case, the insured failed to notify the insurer of an occurrence under a 'claims made and notified' policy which had later led to a claim. This case is distinguishable from Australian Hospital Care and Einfeld, in that both cases are concerned with 'claims made and occurrence notified' policies.[388] The insured defended the proceedings and sought to recover the legal costs from the insurer. The insurer denied liability and argued that the insured had not notified it in writing of an occurrence pursuant to the requirements of section 40(3). It further contended that section 54 could not operate to 'excuse' the insured's failure to notify in bringing the claim within the policy.[389]

137. Justice Bergin referred to the Queensland Supreme Court's decision in MEC McInally Nominees P/L v HTW Valuers (Brisbane) P/L ('McInally')[390] where the facts were identical to that of Gosford City. Her Honour supported the comments made by Justice Chesterman in McInally that;

> 'If it were parliament's intention that section 54 should modify the operation of section 40(3) one would expect to find some indication of the intention in the provision. There is nothing in section 40(3) which make the requirement that notice be given during the currency of the policy 'subject to section 54'.'[391]

Here, Justice Bergin rejected the insured's attempt to exploit section 40(3) in implying an 'occurrence notified' clause into the policy and then rely on section 54(1) to 'excuse' compliance with the requirements of section 40(3).[392] Her Honour held that the approach would be contrary to the intention of the section 40. Interestingly, Justice Bergin found that the insured might be able to utilise sections 40(3) and 54 together where the insured had given some sort of notice to the insurer during the policy period.[393] Where the insured has, for example, given verbal notification of an occurrence, Justice Bergin suggested that the insured could rely on the two sections to overcome the failure to provide written notice as required under section 40(3).[394] Finn criticises this approach and argues that there is hardly any difference between a complete failure to notify and a failure to notify in writing to justify a different approach for each case.[395]

138. Gosford City and McInally therefore support the view that section 54 cannot complement section 40(3) in overcoming an insured's failure to notify occurrences during the policy period where the policy does not contain an 'occurrence notified' clause.[396] Justice Bergin's decision in Gosford City was recently reaffirmed by the Full Court of NSW.[397] The result is not, however, definitive. It remains to be seen whether the High Court will accept this approach.

139. In general, this method may, to a certain degree, help to resolve the friction between section 40 and section 54. It is, however, rather impractical in limiting the effect of the first limb of section 54(1). By excluding 'occurrence notified' clauses from insurance policies, insureds may well find such policies to be unattractive or unsuitable for their

circumstances. As was mentioned earlier, occurrence notified policies were brought in to deal with the problems of pure 'claims made and notified' policies.[398] Although Finn observes that a number of insurers have already removed 'occurrence notified' clauses from their policies[399] a perceived adverse reaction in the market may nevertheless serve as a principal reason for other insurers being reluctant to omit these clauses.[400]

Amendment to section 54

140. Sutton suggests that another approach is to amend section 54 so that it would not apply to 'claims made and notified' clauses and 'occurrence notified' extension clauses that are included in professional indemnity policies.[401] He limits both exclusions to professional indemnity policies, because he recognised that the major problems of construction regarding section 54 had revolved mainly around these types of policies.[402] Particularly with 'claims made and notified' policies, Sutton argues that the change would effectively abrogate East End and restore 'claims made and notified' policies to their 'rightful place in the insurance industry's armoury.'[403] As reflected in section 40(3), he believes that there would be no unfairness for an insured, who is a professional, to give written notice of a claim or potential claim.[404]

141. The amendment would involve amending the definition of an 'act' under section 54(6) which provides that;

> A reference in this section to an act includes a reference to:
>
> (a) an omission; and
>
> (b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.

142. Since Sutton has not proposed a possible way of drafting the amendment, it is suggested that it may take the form of;

> (6) A reference in this section to an act includes a reference to:
>
>> (a) an omission [other than that which occurs under a 'claims made and notified' clause or an 'occurrence notified' extension clause that is included in a professional indemnity insurance policy]; and
>>
>> (b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.

143. Sutton's suggestion received backing from President Kirby[405] in Perry. His Honour suggested an exception to the operation of section 54 be limited to a failure to notify an occurrence under a 'claims made and notified' policy with an 'occurrence notified' extension clause.[406] President Kirby claimed that the exception would address the problems associated with these 'peculiar' types of insurance policies where cover is defined via some form of notification by the insured within the policy period.[407] Provided an appropriate definition of the type of policy to be excluded can be devised, Sutton suggested that the amendment would leave other types of cover to be governed by section 54. An employers' liability policy which requires a prompt notice of injury is an example.[408]

144. In September 1995, the ISC reviewed the situation and rejected the need to amend section 54 in response to the problems that are posed by the section.[409] Amongst other arguments, the ISC argued that although the application of section 54 has introduced a degree of uncertainty for the insurer, this is something that an insurer must deal with as an underwriter. They are paid to exercise their expertise in this area.[410] Even with recent developments and the High Court's decision in Australian Hospital Care, the Australian Prudential Regulation Authority ('APRA')[411] and the Australian Securities and Investments Commission ('ASIC') have yet to consider any proposal to amend section 54.[412] The Treasury have similarly considered the implications of the Australian Hospital Care decision, but have stated that no decision has been made on whether 'amendment of section 54 of the Insurance Contracts Act is warranted.'[413]

145. Meanwhile, the Insurance Council of Australia, a non-profit organization representing the interests of the general insurance industry, has been especially enthusiastic about amending section 54.[414] It suggests that the 'omission/inaction' dichotomy be revived via statute.[415] The approach will be discussed in detail below.

146. On the one hand, amending section 54 to exclude 'claims made and notified' policies and 'claims made and occurrence notified' policies from its operation will help to create contractual certainty for both the insurer and the insured. The approach may assist in eliminating the 'long tail' problem and other issues that are otherwise unfavourable to the insurer following the High Court's decision in Australian Hospital Care.

147. On the other hand, the method is nevertheless unsatisfactory, as it would defeat the overall purpose of the legislation. With occurrences, professionals must comply with section 40 and give written notice of an occurrence during the policy period to be able to claim against the insurer. With claims, on the other hand, professionals must comply with the terms of the contract and notify the claim within the policy period to claim against the insurer. In both cases, a failure to notify will result in the insurer being able to deny the claim. The problems faced by insureds that are professionals under the previous legal environment would therefore return with a vengeance. The approach effectively restores the pre-ICA situation, where any breach of a term will allow the insurer to avoid liability. Although the proposed amendment is limited to professionals, to reform the law in favour of one group of insureds and biased against another would be contrary to the original spirit of the legislation.

Limitation period

148. Another approach, which has been previously considered by the ISC, is to introduce a statutory period imposing a time limit after the expiry of policies requiring notification.[416] Due to the operation of section 55 of the ICA, any proposed limitation periods must be incorporated into Division 3 of the ICA. The section provides that;

> The provisions of this Division with respect to an act or omission are exclusive of any right that the insurer has otherwise than under this Act in respect of the act or omission.

149. The question is what would be an appropriate time frame to allow an insured to make a claim after the policy has expired? With claims, the existence of a claim means that there is no issue of when it is going to be brought. It is a relatively cut and dry situation. With occurrences, however, it is a lot less clear-cut, since a claim has not yet been made. The time frame is therefore much more uncertain.

150. With regard to claims, some insurers have suggested that a period of one year after the policy has expired is reasonable, since it would be unusual for an insured who is faced with a third party's claim to not notify the insurer within that period.[417] Other insurers suggested that an even shorter time frame of twenty-one days is fair and reasonable.[418]

151. With regard to occurrences, Sutton suggests that there should be a time limit of 2 years after the original policy had expired within which to bring an action where the insured has relied on section 54(1) to excuse a failure to notify an occurrence.[419]

152. Section 38 of the Limitation Act 1935 (WA) is a good starting point in deciding any proposal for introducing limitation periods. Section 38A(6) applies to situations where the symptoms of an asbestos-related disease manifest many years later. It provides that the limitation period starts from when the person 'has knowledge of the relevant facts.'[420] By analogy, with the notification of occurrences, there are situations where the insured honestly believe in good faith that a claim would not arise from the occurrence. The limitation period could start from when the claim eventuates to protect the interests of the insureds in these situations. This would, however, present a 'long-tail' problem for the insurer in meeting claims made many years later. To solve this problem, a statutory cap could be placed on the maximum amount that the insured could claim from the insurer. There are precedents for the use of caps. A statutory cap of $120,000 is, for example, imposed for claims under section 38A(3) of the Limitation Act.[421] A cap is also being considered for negligence claims as a result of the public liability insurance crisis. A recent report has recommended capping damages payouts to $250,000.[422] A cap should help insurers to better manage their budget for future losses.

153. As will be discussed, the advantages of imposing a limitation period and liability cap is that it introduces certainty in the contractual arrangement and it also helps to limit the 'long-tail' problems faced by insurers.[423] The ISC had earlier rejected a proposal for imposing a statutory limitation period for fear that if section 54 were to rigidly define time limits for notification, it could lead to unfair results for insureds. The ISC noted that although the 'prejudice test' can sometimes result in lengthy and expensive litigation and introduce an element of uncertainty, it is better to base the

insurer's liability on the flexible concept of prejudice, than to base it on compliance with rigid statutory time limits.[424] A problem with Sutton's suggestion regarding occurrences is that the insured must depend on the third party making a claim against them within 2 years. If the claim is made after this time, hardship could result for the insured if later insurance policies do not respond in their favour.[425]

154. In considering the proposals, the ISC had referred to the model used in California. The 'notice-prejudice' rule is a US common law rule that late notice will not preclude a claim, unless the insurer can demonstrate substantial prejudice.[426] Following twenty years of judicial debate, Californian courts had concluded that the rule should only apply to a 'claims made and occurrence notified' policy.[427] It should not apply to 'claims made and notified' policies where the reporting requirements under each policy were 'reasonable.'[428] Insurers were therefore not required to prove that the insured's failure to notify a claim had caused them prejudice.[429] It would be up to the insureds to prove that they have complied with the policy provision and that timely notice was given.[430]

155. In the case of Burns v. International Insurance Co., it was held that where a 'claims made and notified' policy had offered the insured an extended period to report a claim, there were public interest reasons for favouring the enforcement of these policies.[431] Some companies in California have adopted automatic 'grace periods' to allow the insureds to report a claim where it was made close to the policy's expiry date. Thirty to sixty days are commonly used time frames.[432] In other US jurisdictions, insurance regulations require a brief automatic reporting period[433] or a mandatory 'extended reporting period' of up to one to two years in exchange for a statutorily calculated premium.[434]

156. The ISC was less than enthusiastic with the Californian model and its 'reasonableness' test for periods in which claims might be notified. It stressed that the test would generate uncertainty, inconsistency and litigation on what is 'reasonable.' The insurers could be made worse off as a result of the loss of the prejudice test. The ISC did state, however, that insurers could nevertheless formulate their own views as to what were reasonable late notification periods, given the nature of the particular risks involved. These views might help the court in assessing prejudice under the second limb of section 54(1).

Alternatives for reforming section 54 and 'claims' policies

157. In general, the above sections show that there are three main scenarios which must be considered for 'claims' policies under section 54. Where a claim was made against the insured and the insured failed to notify it to the insurer during the policy period, section 54 would apply to 'excuse' that as an omission.

158. Where no claim was made against the insured during the policy period, but the insured had become aware of an occurrence that may or may not later give rise to a claim and failed to notify it to the insurer, there are two separate scenarios for consideration.

    - If the policy does not contain an 'occurrence notified' clause, it appears that section 54 would not apply to 'excuse' the insured's failure to give written notice of that occurrence as required under section 40.[435] The insured may have to wait until a claim later emerges and hope that it would fall within a policy operative at that time given that it must disclose all relevant facts and circumstances before entering into a new policy; or
    - If the policy contains an 'occurrence notified' clause, the failure is treated as an 'omission' that may be 'excused' under section 54. That is, the section effectively allows the original policy under 'period A' to respond, should a claim arise at a later 'period B.'[436] If the insured had taken out an insurance policy with a different insurer after the original policy 'period A' had expired, a claim which arises in 'period B' may therefore be covered under both the original policy with the previous insurer in 'period A' and the new policy with another insurer in 'period B.'[437]

159. In practice, most cases involve a situation where policy A is the insured's only hope, as the later policy often expressly excludes cover for events that are covered by an earlier policy. Another instance is where the insured may not have taken out an insurance policy for that later period. In these cases, the Australian Hospital Care decision provides relief for the insured by treating a failure to notify an occurrence as an 'omission' under section 54 so that the original policy would respond to a claim made many years later.

160. Where the insured was not aware of an occurrence during the original policy period, the insured would not be required

to notify, since it simply does not have knowledge of the occurrence. The cases show that there are two separate scenarios to be considered:

- Where a claim arises after the original policy had expired and the insured's business is still operating and is covered by insurance,[438] that claim would be dealt with by a later policy that covers the period when the claim first arises; or
- Where a claim arises after the original policy had expired and the insured is not covered by insurance that;
  - the insured might want to activate; or
  - the third party might wish to claim against the original insurer who may have a 'deeper pocket' than the insured,

In either case, as was with the engineer in Greentree, the third party would not be able to instigate section 54 in these so-called 'non-event' cases.[439] According to the High Court in Australian Hospital Care, a third party's 'demand' within the policy period is an essential element under a 'claims' policy. The third party's failure to make the demand would not be classified as an 'omission' under section 54(1).[440]

161. The previous section has critically examined the various approaches that may be adopted in resolving the friction between section 54 and 'claims' policies in those controversial situations where the insured has become aware of a claim or an occurrence, but has failed to notify it to the insurer during the original policy period and under a policy which contains an 'occurrence notified' clause. The 'omission/inaction' dichotomy makes practical sense by distinguishing between situations where the insured has made the business decision not to notify an occurrence or a claim and where the insured has legitimate reasons for not notifying. The method will, however, generate complex disputes resulting in lengthy and costly litigation for the insurer and the insured.[441]

162. Although the prejudice limb of section 54 helps to 'catch' any unfair applications of the first limb, as will be discussed in the next section, the notion of prejudice has generated its own criticisms and will similarly lead to extensive court battles. To ask insurers to omit 'occurrence notified' clauses in their policies and demand insureds to rely solely on the protection under section 40(3) is impractical, since the market may react adversely to that approach. It also assumes that High Court will accept the decisions in Gosford City and McInally that section 54 will not apply to 'excuse' the insured's failure to notify an occurrence under section 40(3).[442]

163. Amending section 54(1) to exclude 'claims made and notified' clauses and 'occurrence notified' extension clauses in professional indemnity policies from its operation will only defeat the overall purpose of the legislation in reforming the previous legal environment. Whilst the incorporation of a statutory limitation period will help to resolve the 'long-tail' problems faced by insurers, the rigid nature of the approach may curtail the contractual freedom of the parties.

164. Following an examination of all the possible methods, it appears there are three major alternatives which could be considered. One such method is for insurers to introduce commercially attractive insurance packages which would encourage insureds to notify a claim or an occurrence early: the 'commercial solution.' Another method is to enshrine the High Court's approach in Australian Hospital Care[443] and limit its effect along the lines of limitation periods and a liability cap for claims. Yet another alternative to that is to take the 360-degree radical step of yet again, reviving the much criticised 'omission/inaction' dichotomy.

Alternative A: Commercial solution

165. Given both a failure to notify a claim and an occurrence are 'omissions' under section 54, the insurers could help reduce the 'long-tail' problem of 'claims' policies by making it more commercially attractive for insureds to notify early. They could allow a discount on any increase in premium, or offer a reduced excess or even guarantee a renewal whenever the insured has chosen to notify a claim or an occurrence whether or not it may turn into a claim. Although this method is simple, its practicality would depend very much on the extent to which insurers are willing to introduce such incentives.

Alternative B: Limitation period and liability cap

166. Legislation could be incorporated into the ICA requiring insurance policies to include a period within which the insured must claim against the insurer and the extent to which the insurer shall be liable to the insured in certain

situations.

167. One approach is to allow the parties to freely agree on such terms. The problem is, however, that insurers may draft unreasonably short periods or adopt an unreasonably low cap. A better approach, which could also help to inject a certain degree of legislative certainty, is to specify a period within which the insured must claim against the insurer in both situations of 'claims made and not notified' and 'occurrence aware and not notified' in the provision itself. Below is a possible model that could be used in achieving this purpose.

s.54(7) Limitation period and insurer�s extent of liability

Notwithstanding the preceding provisions of this section;

(a)(i). in any insurance policy which requires the insured to notify a *claim* made against them during the policy period, where a claim was made against the insured during the original policy period, the insured must notify the insurer of that claim within 3 months from the expiry of the original policy; or

(a)(ii)(A). in any insurance policy which requires or allows the insured to notify an *occurrence* that they become aware of during the policy period, where:

(1). the insured has become aware of an occurrence during the original policy period that, in their opinion, may or may not later give rise to a claim; and

(2). the claim eventuates after the original policy has expired,

the insured may seek to be indemnified under the original insurance policy provided the insured *notifies the insurer of the claim* within 3 months from when it is first made against the insured. The insurer shall only be liable to indemnify to the extent of 30 percent of the claim made against the insured when this subsection applies; or

(a)(ii)(B). where:

(1). the insured has become aware of an occurrence during the original policy period that, in their opinion, may or may not later give rise to a claim; and

(2). the claim eventuates after the original policy has expired,

the insured may seek to be indemnified under the original insurance policy provided the insured *notifies the insurer of that occurrence* within 3 months from the expiry of the original policy;

(b)(i). In regard to policies to which subsections (7)(a)(i) and (7)(a)(ii)(A) apply, the court shall have the discretion to extend the period within which the insured may notify the insurer of a claim or an occurrence and seek to be indemnified under the original insurance policy where it thinks it is just to do so; and/or

(b)(ii). In regard to policies to which subsection (7)(a)(ii)(A) apply, the court shall have the discretion to reassess the extent of the insurer�s liability in accordance with the court�s assessment of the extent to which the insurer�s interests were prejudiced in the circumstances where it thinks it is just to do so.

168. The proposed legislation has been carefully drafted using specially chosen words to adequately express the intention of the proposed legislation. Each proposed subsection will now be explained below with the corresponding words of the legislation highlighted in bold.[444]

s.54(7) Limitation period and insurer's extent of liability

169. The proposed provision would fit more naturally as a separate subsection under section 54 of the ICA, since the section expressly deals with omissions. The other option is to include the provision as a separate subsection under section 40. This section, however, deals with situations where facts have been notified. It does not deal expressly with

the situation where facts have not been notified.[445]

Notwithstanding the preceding provisions of this section;

170. These words ensure that the insured's failure to notify a claim or an occurrence within the limitation period would not be 'excused' as an omission under the first limb of section 54(1). This is especially important following the Australian Hospital Care decision. If necessary, an additional subsection may be required to remove any doubt. The wording also precludes the operation of the prejudice limb under the second limb of section 54(1). As will be discussed later, the proposed legislation has already crystallised the notion of prejudice as part of its overall mechanism in balancing the interests of the insured and the insurer. The wording avoids an overlap between the notion of prejudice under section 54(1) and the proposed section 54(7).

(a)(i). in any insurance policy which requires the insured to notify a claim made against them during the policy period, where a claim was made against the insured during the original policy period, the insured must notify the insurer of that claim within 3 months from the expiry of the original policy; or

171. This provision effectively limits an insured's ability to claim against the insurer where they have become aware of a claim made against them during the policy period, but failed to notify it to the insurer before that period expires. It deals specifically with claims so as to avoid confusion with occurrences.

(a)(ii)(A). in any insurance policy which requires or allows the insured to notify an occurrence that they become aware of during the policy period, where:

(1). the insured has become aware of an occurrence during the original policy period that, in their opinion, may or may not later give rise to a claim; and

(2). the claim eventuates after the original policy has expired,

the insured may seek to be indemnified under the original insurance policy provided the insured notifies the insurer of the claim within 3 months from when it is first made against the insured. The insurer shall only be liable to indemnify to the extent of 30 percent of the claim made against the insured when this subsection applies; or

172. This provision covers those situations where a claim is not made against the insured during the policy period, but the insured has nevertheless become aware of an occurrence that has later given rise to a claim. The words 'requires or allows' are used to catch optional, as well as mandatory 'occurrence notified' clauses, despite the fact that optional extension 'occurrence notified' clauses are more common. Subsection (7)(a)(ii)(A)(1) includes reference to situations where the insured has become aware of an occurrence that, in their opinion, may not later give rise to a claim. This would take into account situations similar to Australian Hospital Care where the insured had made an error of judgment by being satisfied, either through its own investigation or other means, that the occurrence would not later turn into a claim. The subsection deems the insured's subjective analysis of whether a claim would later arise irrelevant, given that a claim has in fact, eventuated after the original policy has expired. This approach could reduce costly and lengthy litigation of whether the insured should have concluded that an occurrence would later give rise to a claim.[446]

173. The problem with subsection (7)(a)(ii)(A) alone is that, apart from imposing a time limit within which the insured must notify when they first receive a claim made against them, it does not really solve the 'long-tail' problem faced by insurers. The effect of the provision is that the insurer would remain liable for claims that arise thirty years later. To mitigate the extent of this problem, it is suggested that words similar to those in the later part of subsection (7)(a)(ii)(A) be included so that the insurer's liability is capped to a certain maximum amount. For simplicity, the cap should be expressed as a percentage of the insured's total claim. That is, the provision will fix a percentage to which the insurer is liable to indemnify the insured in the event of a claim being made against the insured. The figure should reflect the prejudice suffered by the insurer from having to carry the potential liability over an extended period. It is, of course, within the insured's power to avoid that outcome by notifying the occurrence earlier.

(a)(ii)(B). where:

(1). the insured has become aware of an occurrence during the original policy period that, in their opinion, may or may not later give rise to a claim; and

(2). the claim eventuates after the original policy has expired,

the insured may seek to be indemnified under the original insurance policy provided the insured notifies the insurer of that occurrence within 3 months from the expiry of the original policy;

174. Subsection (7)(a)(ii)(B) and the liability cap in subsection (7)(a)(ii)(A) must be read in totality. An important aspect of the proposed cap is that it only applies to subsection (7)(a)(ii)(A) where the insured has chosen not notify the insurer of an occurrence before the original policy expires. With occurrences, it is suggested that a provision such as subsection (7)(a)(ii)(B) be incorporated to encourage the insured to notify earlier. This provision allows the insured to avoid the liability cap by notifying the insurer whenever they become aware of an occurrence. It effectively gives the insured an option to decide whether to:

    - notify early, so as to be covered for the whole claim, but at the risk of a higher premium, or
    - notify only when a claim eventuates, so as to avoid the risk of a higher premium, but to allow the insurer forfeit part of their cover.

175. The proposed legislation is primarily designed to reduce the 'long-tail' problems faced by insurers. The legislation has proposed a period of three months and a liability of thirty percent as rough estimates. Its effectiveness would depend heavily upon incorporating figures which are reasonable for both the insurer and the insured. It is therefore suggested that a survey be conducted amongst the various parties including insurers, insureds and other outside parties to gain a consensus on feasible limitation periods and liability cap.

(b)(i). In regard to policies to which subsections (7)(a)(i) and (7)(a)(ii)(A) apply, the court shall have the discretion to extend the period within which the insured may notify the insurer of a claim or an occurrence and seek to be indemnified under the original insurance policy where it thinks it is just to do so; and/or

(b)(ii). In regard to policies to which subsection (7)(a)(ii)(A) apply, the court shall have the discretion to reassess the extent of the insurer's liability in accordance with the court's assessment of the extent to which the insurer's interests were prejudiced in the circumstances where it thinks it is just to do so.

176. The problem with fixing a limitation period and a liability cap is that they may not be applicable in every situation given the variety of insurance policies that exist. It is therefore suggested that a provision similar to subsection (7)(b) be drafted to allow the courts to extend or relax the limitation period and liability cap where it is equitable in the circumstances. With the liability cap in particular, it is recommended that the court could assess whether the cap is appropriate by examining the extent to which the insurer was prejudiced in the circumstances, using similar principles to those in the second limb of section 54(1). It is believed that the court's assessment of prejudice[447] should reflect whether the statutory imposed cap is appropriate in the circumstances and also enable the provision to become more flexible in adapting to different circumstances and to operate more fairly. As was discussed earlier, however, the prejudice limb under section 54(1) does not apply where the proposed section 54(7) applies. The proposed subsection (7)(b)(ii) essentially crystallises the notion of prejudice used under the second limb of section 54(1) and excludes the operation of the second limb to avoid the possibility of overlapping. This eliminates the insurer's ability to raise the prejudice issue again under the second limb of section 54(1) as an alternative to or after having failed to satisfy the court with the prejudice argument under the proposed subsection (7)(b)(ii).

177. To achieve the purpose of this proposed legislation, namely encouraging the insureds to notify as soon as possible and limiting the 'long-tail' problems faced by insurers, it is proposed that the limitation period and liability cap be set at the lowest level possible that is fair for both the insurer and the insured. This is necessary to allow some room for the court to extend the period and relax the cap where appropriate.

178. The phrases 'the extent to which the insurer's interests were prejudiced' and 'where it thinks it is just to do so' are adapted from the prejudice limb of section 54(1) of the ICA and section 47A(3)(b) of the WA Limitation Act 1935 respectively. It is hoped that the use of those words, having previously been interpreted and applied by judges, will assist the courts in exercising its discretion in whether to extend the limitation period or reassess the liability cap.

179. As was mentioned earlier, since this approach follows the High Court's reasoning in Australian Hospital Care where a failure to notify a claim or an occurrence are both treated as 'omissions' that may be 'excused' under section 54, it follows that certain improvements could also be made to section 54(1) itself. As was mentioned earlier, section 54(6) defined an act as;

s.54(6) A reference in this section to an act includes a reference to:

(a) an omission; and

(b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.

180. To introduce legislative certainty and to settle the disputes regarding the meaning of 'omission' once and for all, it is proposed that the word 'omission' be further defined under section 11, the interpretation section of the ICA;

11 Interpretation

s.11(1) omission means the failure to:

(a) perform an act, obligation, or requirement; or

(b) elect to exercise a right, choice, or liberty to take certain actions.

as provided under the contract of insurance.

181. This definition of 'omission' should prevent the insurers from denying liability where the insured has merely chosen not to perform a certain act, such as the failure to notify an occurrence. This is consistent with the current decision in Australian Hospital Care. The words 'right, choice or liberty' are adapted from Antico, since they were used, interpreted and applied by the High Court.

182. In general, one disadvantage of this proposed legislation is that it could be perceived as adding to the complexity of section 54. Case law may well be needed to establish, in particular, the circumstances in which the court is prepared to reassess the limitation period or the liability cap.

183. Despite that, the 'beauty' of this proposed legislation is that it effectively removes all of the disputes concerning the first limb of section 54(1) by introducing a period within which insureds must claim against the insurer. For example, where an insured has failed to notify a claim within 3 months of the expiry of the original policy period, the issue of whether the failure is an 'omission' under section 54 is irrelevant. As was mentioned earlier, the insured's failure to notify within the statutory limitation period could not be 'excused' as an 'omission' under section 54(1).

184. Litigation concerning the issue of prejudice, the second limb of section 54(1), would also be reduced, since the insured must first establish that it had notified the claim within 3 months from when it first arises.[448] For the prejudice issue to arise, the insured must then persuade the court under section 54(7)(b)(ii) that it would be 'just' in the circumstances for the court to reassess the fixed liability cap as espoused under section 54(7)(a)(ii)(A). The insured must overcome these hurdles before the notion of prejudice is considered a relevant issue.

Alternative C: Statutory revival of the 'omission/inaction' dichotomy

185. An alternative to imposing a statutory limitation period and liability cap is to revive the 'omission/inaction' dichotomy via statute. Given the numerous decisions that have supported the rejection of the dichotomy, however, this would be a controversial step.

186. As was discussed earlier, the 'omission/inaction' dichotomy concerns situations where an insurance contract contains an 'occurrence notified' extension clause allowing the insured the choice of whether to notify the insurer of an occurrence that may later give rise to a claim and hence, expand the level of cover. The major problem with the 'omission/inaction' dichotomy is that it would generate litigation where the insured seeks to argue that the failure to notify was an 'omission' rather than an 'inaction.' The dichotomy also encourages substance over form in that the application of section 54 is dependent upon whether notification was an option or a contractual obligation.[449]

187. Despite these criticisms, the fundamental attraction of the dichotomy is that where the insured has elected to exercise the business decision not to notify, there is no logical reason why the insurer should be liable for a claim made against the insured many years later.[450] It is submitted that the 'omission/inaction' dichotomy is the best viable option out of all the other alternative methods that were mentioned in section 4.4.1. in resolving the 'long-tail' problems faced by insurers.[451] Although the approach may effectively defeat the ALRC's original recommendation of promoting substance over form, as Chief Justice Gleeson aptly stated;

> 'When one is dealing with a commercial contract, there is a limit to the extent to which a preference for substance over form can justify disregarding the agreement of the parties.'[452]

188. In taking this approach, it is suggested that the following be drafted under the interpretation section of the ICA;[453]

11 Interpretation

s.11(1) omission means the failure to perform an act, obligation, or requirement, but does not include an election not to exercise a right, choice, or liberty to take certain actions as provided under the contract of insurance.

189. This definition of 'omission' should prevent the insureds from arguing that their failure to choose not to notify an occurrence was an 'omission' which may be 'excused' under section 54.

190. Applying the scenarios that were mentioned above in section 4.4.2., under the 'omission/inaction' dichotomy, where the situation concerns a 'claims made and occurrence notified policy'; - if a claim was made against the insured and the insured had failed to notify it to the insurer before the expiry of the original policy period, this is an 'omission' which would be 'excused' under section 54(1); or - if no claim was made against the insured during the policy period, but the insured had become aware of an occurrence that may or may not later give rise to a claim and failed to notify it to the insurer before the expiry of the original policy period, this is an election not to exercise the 'right, choice or liberty' to notify and is therefore, not an 'omission' under section 54(1).[454]

Summary

191. 'Claims made and notified' policies and 'claims made and occurrence notified' policies are carefully constructed to allow insurers to provide insurance protection in potentially difficult areas of risk at a realistic and affordable price.[455] The 'occurrence notified' component of this type of a policy was important in repairing the serious deficiency in the 'claims made and notified' component of the policy.[456] Under the 'claims made and notified' component, the insured would be left in a most 'unhappy position' if it became aware of a possible claim that might not be made during the policy period.[457] Since the claim would not be made within the current policy period, it would be excluded from cover under the current insurance contract. If the insured had changed insurer, the new policy would require the insured to disclose the known possible claim. The new policy would usually expressly exclude that claim from the cover.[458] As Justice Cole commented, neither policies were unfair to the insureds by requiring them to notify a claim or certain facts before the policy would operate.[459] Insureds would be covered if they became aware of a claim or relevant occurrence and then notified the insurer.[460] If the insured did not notify, then pursuant to the 'four corners' of the agreement, the insured would not be covered.[461]

192. By treating the failure to notify a claim or an occurrence as an 'omission' under section 54, the High Court in Australian Hospital Care has appeared to 'place a premium' on the insured's negligence or a deliberate disregard of its contractual obligations.[462] The decision has also helped to restore the 'long tail' problem posed by 'occurrence based' policies, as insureds are permitted to wait until a claim is made before notifying under the policy.[463]

193. It is interesting that the ALRC has recently decided against using the words of section 54 in amending the Marine Insurance Act 1909 (Cth) (the 'MIA') to address the 'harsh and disproportionate impact' of a breach of term.[464] The ALRC concluded that, amongst other things, section 54 'was broader than necessary to address the deficiencies of the present law of marine insurance.'[465]

194. The effect of the first limb of section 54 must be restrained to a certain extent to maintain an equitable balance between the interests of the insurer and the insured. The recent medical indemnity and public liability crisis are examples why it

is important to sustain a healthy insurance sector, so as to keep insurance premiums at a reasonable level. In light of these problems, various methods aimed at shackling the effect of section 54(1) following the Australian Hospital Care decision have been suggested for consideration. Although none of these have comprehensively met the criteria forming the benchmarks for reform, an analysis of the different approaches has nevertheless resulted in three compelling alternatives for resolving the problems in this area.

195. One simple method is to rely on the insurers to reduce the 'long-tail' problems by introducing commercially attractive insurance policies which would allow, for example, a decreased premium for notifying a claim or an occurrence early. The extent to which the insurer is willing to 'encourage' insureds to notify early will measure this method's degree of success.

196. An alternative is to follow the High Court's approach and treat both a failure to notify a claim and an occurrence as 'omissions' under section 54. A statutory limitation period and liability cap should then be incorporated in limiting the period within which the insured must notify a claim or occurrence to the insurer and in 'capping' the insurer's liability where the insured does not notify the insurer of an occurrence. Especially in the case of occurrences, the approach presents the insured with the option of whether to notify early. Should they choose to wait until a claim arise, the insured will only receive part of the claim from the insurer under the liability cap. Should they choose to notify early, the insured will avoid the cap, but face the risk of a higher premium from advising the insurer of an occurrence.

197. Another option is to reject the reasoning in Australian Hospital Care and revive the 'omission/inaction' dichotomy. Although this approach has been criticised heavily, it appears to be an alternative to introducing a limitation period and liability cap. In taking this path, it is suggested that section 11 of the interpretation section of the ICA be amended to define 'omission' as excluding the failure to elect to exercise a 'right, choice or liberty' to taken certain actions.

198. The proposed legislative amendments will also not meet all benchmarks for reform mentioned in section 4.4.1. Although they both may introduce greater legislative certainty into the area of 'claims' policies, litigation will inevitably arise on certain points. It is nevertheless hoped that either option will contribute in achieving a better balance for the first limb of section 54(1).

199. It is our view that the limitation period and liability cap approach appears to be the most effective out of the three proposed alternatives. Whilst the method introduces certainty into the parties' contractual arrangement, it is flexible, to a certain degree, in that the court could the discretion to extend the period or reassess the cap where it is 'just' in the circumstances. Compared to the 'omission/inaction' dichotomy, limitation periods and liability caps are much less controversial and are tools which have been used in other areas of law. The proposed legislation limits the extent of the 'long-tail' problem by encouraging the insured to notify early so as to avoid the cap. It is suggested that the method be combined with the 'commercial solution' alternative to further reduce the negative impact of the Australian Hospital Care decision.

Prejudice to the insurer

200. Similar to the first limb, the second limb of section 54 has generated much criticism from judges and academics. As was mentioned in Section 4, given the effect of the first limb in imposing a prima facie liability on the insurer to indemnify the insured, it is important that the second limb operates to strike a balance between the interests of the insured and the insurer. This section will examine the mechanics of the prejudice limb and its effectiveness in the overall scheme of section 54. It will also provide recommendations for improving its operation in light of the recent case law development.

The meaning of prejudice

201. The word 'prejudice' is employed widely in different areas of law. The term is especially popular under the ICA, with its use in several different sections, including its role under the controversial, yet important, prejudice limb of section 54(1). This section will briefly examine the notion of prejudice in the context of insurance and other areas of law. It will investigate the various arguments that the courts have accepted in applying the second limb.

Prejudice generally

202. 'Prejudice', in layman terms, is defined as a 'preconceived and biased opinion'[466] which is 'unfair and unreasonable'[467] In law, the term is used in different contexts and often refers to an act or event which tends to injure or harm the rights of others.[468] Courts often consider the question of prejudice in assessing the rights, interests and obligations of various parties to a dispute.[469] In civil litigation, for example, the court may extend the limitation period enabling a plaintiff to bring an action against a defendant where the defendant is not materially prejudiced in its defence.[470] In other contexts, an action may similarly be dismissed for want of prosecution, where the defendant was prejudiced by an 'inordinate or inexcusable' delay in the prosecution of an action.[471]

Prejudice in insurance law

203. Under the ICA, the concept of prejudice arises in different scenarios. Where the insured has failed to disclose certain facts or has made a misrepresentation to the insurer, the insurer's potential liability may be reduced by the extent to which the insurer has been prejudiced.[472] This section, however, only applies where the contract is still in existence.[473] Where an insurer has avoided an insurance contract for fraudulent non-disclosure or misrepresentation, the court may nevertheless disregard the insurer's avoidance and allow the insured to recover where it would otherwise be harsh and unfair.[474]

204. The notion of prejudice also applies from the perspective of an insured. Section 52(1) of the ICA limits the insurer's ability to exclude, restrict, or modify the operation of the ICA where it would prejudice the interests of the insured.[475] In Akai P/L v Peoples Insurance Co Ltd, for example, in considering whether Australia was clearly an inappropriate forum, the High Court held that the prejudice to the insured of the English system was that the remedial operation of section 54 of the ICA would not be available.[476]

205. Under section 54, the notion of prejudice arises where the insured breaches a condition or term of an insurance policy during the policy period and the issue is whether the insurer has been prejudiced as a result.[477] There has, however, been little judicial guidance as to what constitutes prejudice and how it is to be measured.[478]

206. Section 54 does not limit the arguments that insurers may raise when deciding to avoid a claim.[479] Prejudice could include an act or omission that may increase the risk that the event insured against will occur. Disregarding other factors, the insurer may have suffered prejudice in the form of foregone extra premiums or unnecessary costs incurred in examining and dealing with a claim.[480] Alternatively, and more significantly, the act or omission may operate to deprive the insurers of an opportunity to modify the terms of the policy, to investigate the claim fully and in good time, or to go 'off risk' altogether.[481] Whether section 54 will allow the insurer's liability to be reduced to nil has only been determined reasonably recently.[482]

207. As was discussed above, where an insured has failed to notify a claim or an occurrence under a 'claims made and notified' or 'claims made and occurrence notified' policy, that is an 'omission' which the first limb of section 54(1) may 'excuse.'[483] One of the preferred methods that may be used in limiting the effect of the section is to rely on the prejudice limb as the 'Catcher in the Rye' in preventing any outcome potentially unfair to the insurer.[484] The High Court in Australian Hospital Care supported this approach and noted that the prejudice limb of section 54(1) could remedy any issues of unjust departure from the contract agreed between the parties.[485] The Court held that the insurer did not need to show that it had suffered financial loss as a consequence of the failure to give notice to establish prejudice.[486] The insurer was only required to prove that it had been placed at a substantial disadvantage, since it was denied the opportunity to investigate the claim or take steps which might have reduced the ultimate loss.[487]

208. The courts do not, of course, accept every claim made by the insurers that prejudice has been suffered. In East End, for example, the insurer argued that costs incurred in the earlier unsuccessful litigation concerning the operation of section 54 amounted to prejudice within section 54(1).[488] Justice Rolfe rejected the argument and considered that the costs were as a result of the insurer's decision to litigate and the subsequent failure of that litigation. It was not as a result of any act or omission of the insured.[489] In Antico, the insurer contended that it had suffered prejudice as a result of the insured failing to obtain consent, as required under the policy, before incurring legal costs in defending a proceeding.[490] The High Court noted that the insurer's interests would be prejudiced where the insured had unreasonably paid out funds on the defence.[491] The case was remitted to the NSW Supreme Court where it was determined that the insurer had suffered no prejudice in the circumstances.[492] In quantifying prejudice, the approach adopted by the insured to legal services was compared with the insurer's legal fees.[493]

209. In Zollo v National Australia Bank, the SA Supreme Court found that an insurer might suffer prejudice if it was denied an opportunity to have a disability claimant medically examined.[494] In this case, however, the court found that there had been no prejudice, since early medical examinations would not have assisted the insurer's case and the insurer would not have arranged medical examinations anyway.[495] The insurer further argued that the operation of section 54 had prejudiced its interests by allowing the insured's failure to notify an occurrence to be 'excused' as an omission.[496] Justice Kirby rejected this argument and held that the purpose of the section was precisely to 'resuscitate' policies which would otherwise defeat the insured's claim for a breach of term.[497]

210. Earlier cases indicate that the courts have taken a rather liberal, yet controlled approach in construing prejudice arguments. Recent case law, however, suggests that a stricter approach has been adopted for determining the existence and the quantity of prejudice. The next section will examine how the courts determine the extent to which an insurer's interests are prejudiced.[498]

Determining prejudice

211. In the earlier case of Ferrcom P/L v Commercial Union Assurance Co. of Australia Ltd. ('Ferrcom'), the existence of prejudice was established upon proof of a breach. The lost opportunity test was then used 'across the board' to quantify prejudice regardless of whether the insurer would have gone 'off-risk' or stayed on risk.[499]

212. In light of the recent High Court decision in Moltoni Corporation P/L v QBE Insurance Ltd ('Moltoni'), it appears that insurers will have to frame their prejudice arguments differently. There are two ways in which the court will assess prejudice.[500] These can be conveniently divided into situations where the insurer would have gone 'off-risk' and where the insurer would not have done so.

Where the insurer would have gone 'off-risk' altogether

213. The Moltoni decision confirmed the Ferrcom approach where the insurer could show that it would have declined to provide further cover to the insured had it known of the insured's act or omission. Prejudice would be established upon proof that a condition of the contract had been breached.[501] In determining the value of a lost opportunity to go 'off-risk,' the insurer must prove that it would have taken certain action had it known the act or omission which has caused the alleged prejudice.[502] The court will then consider past hypothetical facts in estimating the likelihood that the insurer would have in fact exercised that action.[503] This approach was adopted by the High Court in Antico.[504]

214. Where the insurer would have gone 'off-risk' altogether, the amount that fairly represents the prejudice suffered is the total value of the insured's claim.[505] A fire insurance policy, for example, provided that an insured must promptly notify the insurer of any alteration that might increase risk during the policy period. The insured failed to notify the insurer of a subsequent plastics manufacturer tenant and a fire arose through no causal connection with the nature of the tenancy. The insurer argued that it would have declined to continue the cover had it been notified of the change. The Queensland Court of Appeal held that the insurer could refuse to pay the insured's claim under section 54(1), due to prejudice suffered from the loss of an opportunity to go 'off risk'.[506] In effect, this serves to circumvent the first limb of section 54(1) in that the insurer is able to avoid paying the insured when there is no nexus between the insured's breach of the policy and the cause of the loss.

215. Similarly in Ferrcom, the insured took out an insurance policy on its unregistered mobile crane.[507] The insurer required the insured, as a condition precedent to liability, to notify to the insurer of any changes during the policy period which would materially alter the facts and circumstances as existed at the commencement of the policy.[508] The crane later became registered for on road use and the insured's agent failed to notify insured of the registration. The crane was overturned and damaged whilst being used on a construction site.[509] In using a subjective test, the High Court found, amongst other things, that the insured's failure to notify the registration prejudiced the insurer.[510] The original risk increased if the crane was driven on public roads and the insurer would have sought a higher premium had it known the registration. This was, however, only part of the prejudice.[511] The material prejudice was the loss of an opportunity to cancel the policy.[512]

216. To assess the extent to which the insurer's interests were prejudiced, the court found that it must treat the condition precedent as a term which the insured must comply with.[513] A failure to satisfy the condition precedent constituted a breach. Ordinary contractual principles then required the position that the insurer would have been in, had the insured

performed the obligation, to be considered with the insurer's actual position caused by the insured's failure to perform the obligation.[514] In determining the position that the insurer would have been in, the court found it necessary to adopt a hypothesis as to what the actual insurer would have done had it had been notified that the crane was registered.[515]

217. The High Court held that the insurer could escape liability since the value of the insurer's lost opportunity to go off risk was 'the value of a right to go off risk which the insurer would have exercised.'[516] The amount which fairly represented the insurer's prejudice in losing that opportunity was the liability prima facie imposed on the insurer under section 54(1). As a consequence, that prima facie liability was reduced to nil.

Where the insurer would not have gone 'off-risk'

218. Where the insurer could not establish, on the balance of probabilities, that it would have gone 'off-risk,' the amount that fairly represents the prejudice suffered may result in the insured receiving part of its claim.[517] For example, an insurance policy provided for payment of a lump sum for total and permanent disability once the insured had submitted a claim form and daily sum for periods of hospitalisation. The insured suffered injury by accidental means whilst performing electrical work and was rendered totally and permanently disabled. The WA District Court held that the insured was entitled to the hospitalisation benefit, but not the lump sum, since the insurer was prejudiced by the insured's failure to submit a claim form and hence, a lost opportunity to investigate the accident.[518]

219. In Moltoni, the courts were given another opportunity to examine how the insurer's prejudice was to be assessed.[519] In this case, the insured had failed to notify the insurer of the personal injury of a worker for 17 months after the injury had occurred. The insurer argued that it was prejudiced, having lost the opportunity to investigate the claim and refer the worker to a medical practitioner for treatment to lessen the severity of the injuries.[520]

220. The trial judge decided that the insurer had not established on the balance of probabilities that it would in fact have done these things. The judge found in favour of the insured, having concluded that there was no evidence of prejudice.[521]

221. The case was then taken to the Full Court of the WA Supreme Court, where the majority found for the insurer.[522] Justice Ipp found that the opportunity to investigate and refer the worker to an appropriate medical practitioner had value. The loss of that opportunity was therefore an actual loss.[523] To establish prejudice, his Honour held that the insurer was only required to prove there had been a breach of the condition requiring notice. The insurer need not prove on a balance of probabilities that, had timely notice been given, an investigation would have been carried out.[524] Justice Wallwork also found for the insurer, but did not deal with the question of lost opportunity prejudice.[525]

222. Justice Murray, dissenting, employed the narrowest approach and found that to establish prejudice, the insurer must prove that it would have dealt with the claim in a way which would have reduced the damages awarded to the worker.[526] His Honour concluded that the insurer had not given sufficient evidence to establish, on the balance of probabilities, that it had in fact suffered prejudice.[527]

223. Following the Full Court judgment, the insured sought and obtained special leave from the High Court to appeal the decision.[528] In the special leave proceedings, Justice McHugh rejected Justice Ipp's approach that any loss of opportunity constituted prejudice under section 54(1), whether the insurer would have availed itself of it or not.[529] His Honour concurred with Justice Murray's approach that the insurer must show not only that it had an opportunity, but also that it would have availed itself of it.[530]

224. When the case reached the High Court, a majority of the court overturned the WA Supreme Court's decision and found for the insured.[531] The insurer was held to have failed to demonstrate that it had suffered prejudice that had caused or would cause it damage.[532] The court held that in this case, since the insurer would not have gone off-risk, the relevant prejudice suffered was to be established and measured by 'what would have happened (as distinct from what could or might have happened) if the act or omission had not occurred.'[533] The insurer must then prove that the prejudice could be represented in monetary terms.[534]

225. Where the insurer would have gone off-risk, 'it is entirely accurate to speak of the insurer having lost the opportunity to

do so.'[535] Where the insurer would not have gone off-risk, there is a need to examine what the insurer would have done in the circumstances. The test of 'lost opportunity' is not useful here, as it mistakenly focuses on what right the insurer might have exercised, rather than what right the insurer would have exercised.[536]

Summary

226. In general, the High Court in Moltoni held that where the insurer could prove that it would have gone 'off-risk,' prejudice was established upon proof that a condition of the contract has been breached.[537] In quantifying prejudice, the test of lost opportunity as espoused in Ferrcom was relevant.[538] The difference between Moltoni and Ferrcom is where the insurer fails to prove that it would not have gone 'off-risk' but nevertheless seeks to prove that it was prejudiced in the circumstances. According to the reasoning in Moltoni, the insurer must establish that they would have taken certain action had they known the insured's act or omission.[539] What might or could have been done was irrelevant.[540] A subjective test is to be used throughout in assessing prejudice.

227. The High Court did not clearly explain how insurers might discharge the burden of what they would have done. Commentators suggest that insurers should first demonstrate that their own claims procedures would have taken a particular course if the insured had complied with the notice provision.[541] Since the trial judge in Moltoni was unconvinced by a sketchy account by a claims manager of what the insurer's 'model' claims procedure was,[542] commentators suggest that evidence must be supported with specific examples of actual cases in which those procedures were followed.[543] It will not be enough for the insurer to rely solely on its underwriting guidelines if it wants to persuade the court of its position.[544] The insurer may well have to prove that these procedures were, on a statistical analysis, followed in a majority of cases for claims of a similar nature.[545] Insurers would be well advised to keep good records to support their prejudice arguments in the situation where they would not have gone off-risk.[546]

228. In further establishing the existence of prejudice, the High Court held that the insurers must also prove that the implementation of these procedures in the particular case would have led to a quantifiable reduction in the insurer's liability.[547] Where the insurer has, for example, established rehabilitation programs that would have improved the insured's health condition, they will need to provide expert evidence that these steps would help to reduce their liability.[548]

Analysing case law development

229. Over the years, various academics have criticised the courts' decisions regarding the second limb of section 54. Although the criticisms do provide an insight into the difficulties of the prejudice limb, they are not without their weaknesses. This section will examine these arguments whilst criticising those that are unjustifiable.

Reducing a claim to zero

230. Unlike the situation with remedies for non-disclosure and misrepresentation,[549] an insurer's ability to reduce its liability to nil under section 54(1) has received the 'unequivocal imprimatur' of the High Court.[550] From a causal perspective, this is often unfair where the insured's act or omission could not have possibly triggered the happening of a loss.

231. As Tarr argued, in situations similar to those that were later to occur in Ellis, Gibbs Holdings and Ferrcom,[551] it would be incongruous for an insurer to rely upon section 54(1) to reduce its liability to nil where the insured had breached only one of the conditions of the policy.[552] For liability to be reduced to nil, the insurer must show that the act was wholly responsible for the loss.[553] That is, the insurer must establish the operation of section 54(2) where the act of the insured 'could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided,'[554] Tarr's point of view has not generated any further commentary. As will be discussed, however, it could be argued that his analysis is somewhat narrow.[555]

A subjective test for assessing prejudice

232. Furthermore, to assess prejudice from evidence of the insurer's subjective intention presents the same problem facing

any litigant attempting to discharge proof by reference to ex post facto[556] and self-serving statements. It is easy for an insurer to state that the severity of the breach of the condition warranted a conclusion that it would have initially gone 'off risk' altogether had it known of the act or omission.[557] A subjective test would almost always result in a conclusion which favours the insurer's position more than the section's remedial objective to protect the insured and to overcome the disaster of the common law.

233. Ball argues that in Ferrcom, the High Court had assessed as certain that the insurer would have cancelled the policy and not issued a new one.[558] He argued that it is feasible however, that the insurer may have continued the cover, but at a higher premium. In this case, there would be a reduction in the value of the 'lost opportunity,' instead of a total elimination of the insured's claim.[559]

234. The problem with Ball's argument is that the insurer had shown in Ferrcom that, 'had the relevant act or omission not occurred, [it] would have gone off risk altogether.'[560] The insurer in Ferrcom had therefore, according to the High Court in Moltoni, already proven to the court's satisfaction that it would not have issued a new cover with a higher premium.[561]

Form over substance

235. As was discussed earlier, a subjective test is used throughout in assessing prejudice following the High Court's decision in Moltoni. Prior to this case, however, Kelly and Ball argue that Ferrcom's lost opportunity approach in applying the notion of prejudice under section 54(1) had created a rather artificial result.[562] This can be illustrated with two contrasting examples. An insurance policy excluded cover for loss arising where the original risk agreed to by the insurer had been materially altered, but did not require the insured to notify those changes in risk.[563] The insured installed a speed-enhancing booster on its motorcycle and was later involved in an accident due to the fault of another negligent driver. Applying the approach in Ferrcom, the insurer could not have lost the opportunity to do anything since the policy does not require the insured to notify the insurer of anything during the policy period. The prejudice to the insurer was not the loss itself, since that was later caused by another event. Instead, the prejudice to the insurer was the increase in risk as a result of the installation. To measure prejudice, therefore, an objective test should be used to see whether the risk was insurable by reference to whether other insurers would have insured the risk and if so, on what terms.[564] This may require the insurer to adduce statistical evidence of risk, the increased premiums of other insurers to carry the additional risk or other expert evidence.[565]

236. In contrast, suppose that the same insurance policy, instead of having an exclusion clause, now provides that the insured must notify the insurer of any material change in risk during the policy period. The insured installed the booster without notifying the insurer, and a loss occurred after the installation. In this case, following the approach in Ferrcom, the prejudice to the insurer is the loss itself, since there would have been no risk had the insured notified the insurer of the installation and the insurer would have elected to go 'off-risk.' The insurer has lost the opportunity to do so. In measuring prejudice, the Ferrcom approach denoted that a subjective test is used to determine what the particular insurer would have done had it known the registration.

237. The end result of Ferrcom is that the form by which the insurer protects itself against increases in the risk during the period of cover will determine the way in which its prejudice is assessed.[566] If an insurer protects itself with a notice provision, its prejudice will be measured by what the particular insurer would have done. That is, whether the insurer would have been prepared to insure the risk and, if so, on what terms.[567] On the other hand, if an insurer protects itself with an exclusion clause, its prejudice will be measured by whether the risk was insurable.[568] That is, by reference to whether other insurers would have been prepared to insure it, and if so, on what terms. It would undoubtedly become normal practice for an insurer to include a notification provision to take advantage of the subjective test and to increase their own protection at the expense of the insured's interests.[569] The result is simply that the courts have reverted back to allowing the form of the contract to dictate the result. Insurers are therefore able to determine the outcome by drafting their contracts accordingly.

238. Although this blatantly contradicts the ALRC's intention to reform the law in promoting 'substance over form,' there is nevertheless merit in the High Court's approach in a practical sense.[570] Kelly and Ball have slavishly adhered to the fact that there should be no difference between a notice provision and an exclusion and that the effect of a breach of either term should produce the same result. Their views are understandable, since they were members of the ALRC charged with the task of reporting on the state of insurance law. They are thus the 'midwives' of the present Insurance

Contracts Act.[571] The reality, however, is that the insurance industry is comprised of different insurers who draft different types of policies suitable for different types of risks. Where the insurer has used a particular drafting technique to 'flag' a particular concern, rather than to merely enable themselves to later go 'off-risk,' there is no reason why the insurer should not be allowed to manage their own risks. Although these do lead to different results, some cognisance must be given to the contract and the agreement made between the two parties. It could not be the ALRC's intention to make an insurer liable for everything, regardless of what policy they have written and what they want to cover.

239. The better way to make sense of the ALRC's recommendation of 'substance over form' is therefore to limit it to situations where the insurer is relying on a mere technicality, rather than a legitimate concern, in denying liability. This approach would, to some extent, justify the Ferrcom decision. The insured would still stand to benefit, since the insurer would not be entitled to a complete exclusion under the first limb of section 54(1). The insurer would also have to prove that it would have taken certain actions had it known the fact in proving the existence of prejudice.

Characterisation of the act/omission

240. Kelly and Ball criticise the conclusions in Ellis and Ferrcom as being very much dependent upon the court characterising the insured's act or omission as the failure to give notice of circumstances which might have increased the risk of a loss happening.[572] In Ferrcom, this was clearly the case, since the insurance policy expressly required the insured to give notice of any material change in risk from the commencement of the contract during the policy period.[573] The situation was not, however, as clear-cut in Ellis, where the insurance policy did not contain any notification provisions. Kelly and Ball argue that the South Australian Supreme Court could have found that the relevant act or omission was the modification of the vehicle, instead of the failure to give notice of the modification of the vehicle.[574] It would therefore have been more appropriate for the court to measure prejudice using an objective assessment of the increase in risk and hence, the principle of proportionality, rather than what the particular insurer would have done in the circumstance.[575] The High Court's approach therefore depends on how the court interprets the act or omission according to the facts. In some cases, it may be possible to avoid this result by treating the relevant act or omission as one which caused the change in circumstances, rather than the failure to give notice of the change in circumstance.[576] To date, however, the courts have yet to adopt this line of thinking.[577]

241. The problem with Kelly and Ball's argument regarding Ellis, however, is that the authors have failed to consider the fact that the insured was required to obtain consent from the insurer before they could modify the vehicle. In order to gain consent, the insured was implicitly required to notify the insurer of the modification. The court was therefore correct in holding that the relevant act or omission in the circumstance was the failure to notify the insurer of the modification.

Problems with Moltoni's 'would have' test

242. In the writers' view, the Moltoni decision is a step in the right direction. It appears to indicate that the High Court is willing to reconsider the reasoning in Ferrcom in assessing prejudice under section 54. Prior to Moltoni, the lost opportunity test was used for both types of situations where the insurer would have gone off-risk and where it would not have done so. Prejudice was established upon proof of a breach by the insured. Although the would have test in Moltoni only applies where the insurer could not prove that it would have gone 'off-risk,' the decision has effectively tightened the prejudice limb by imposing a tougher test for the insurer in establishing the existence of prejudice.

243. McSweeny argues that by assessing prejudice from what the insurer would have done in the circumstances, the court is effectively moving away from the 'reduction to nil' type of prejudice embraced by Ellis and Ferrcom.[578] He argues that the court is signalling a move to the ALRC's proportionality test based on contractual principles.[579] The approach would see the insurer's liability being reduced proportionately by the extent to which it was prejudiced by the insured's act or omission in the circumstances.[580]

244. The decision in Moltoni is, however, not without its critics. Kelly and Ball argue that in some cases, it may be difficult to determine what the insurer would have done if the insured had given notice of a change in the risk in accordance with the term in the policy.[581] They contend that it would be more consistent with the approach adopted in other areas of the law to analyse the insurer's prejudice in terms of the loss of an opportunity.[582] In other contexts, such as tort or contravention of the Trade Practices Act,[583] the High Court has held that damages for the loss of a

commercial opportunity should be assessed by reference to the chance of that commercial opportunity being realised. The determination on the balance of probabilities whether that commercial opportunity would have been realised was held to be irrelevant.[584]

245. Turk also criticised Moltoni for not giving proper consideration to the less tangible results of the failure to give proper notice.[585] Examining what the insurer would have done may present problems where the evidentiary trail has gone cold and it becomes harder to locate witnesses who may have knowledge relevant to the claim.[586] Take a hypothetical example where the insured's employee had sustained a back injury five years prior to a claim being made. The doctor who had examined the employee's injury had disappeared. The problem for the insurer is: how to assess what it would have done in relation to something that had happened five years ago? The decision would therefore place insurers in a 'Catch 22' position where they have simply been denied the opportunity to gather evidence. Without knowing what that evidence is and hence, the ability to assess what implications it would have had for its liability, the insurer cannot demonstrate that it has been prejudiced.[587] Although there is logic in this argument, the court will most likely circumvent this problem by asking what the insurer would have done had it known of the occurrence.

Suggestions for improvement

246. Although some of the criticisms directed at the court's application of the prejudice limb are unsupportable, there is nevertheless room for improvement for the 'Catcher in the Rye.' This section will propose changes that may be made to enhance the second limb and hence, the overall operation of section 54(1).

A more stringent test for establishing the existence of prejudice

247. As was discussed earlier, the Moltoni decision has effectively divided the prejudice test into two separate scenarios. These are where the insurer could prove that it would have gone 'off-risk,' as in Ferrcom, and where the insurer fails to make this argument, as in the case of Moltoni. The problem is that in the former case, the insurer's liability may be reduced to nil where the insured's act or omission had not caused or contributed to the loss. The fact that the court uses the self-serving subjective intention of the insurer in assessing the existence of prejudice creates the possibility of an iniquitous outcome.

248. This problem could, however, be solved by restricting the Ferrcom type outcome to exceptional circumstances and accepting the Moltoni type outcome as a more common type of situation. Where the insurer seeks to prove that it would have gone 'off-risk,' the court must make sure that it tests that proposition rigorously by requiring a higher standard of evidence. The insurer should be required to rebut the presumption that their case is not one in which Moltoni applies. Where the evidence has been rigorously tested and the court is satisfied that the insurer would have gone 'off-risk,' then it would not be 'incongruous' for the insurer's liability to be reduced to nil when the insured had not caused or contributed to the loss.[588]

Subjective or objective test

249. Following the Moltoni decision, it appears that the court has favoured the use of a subjective test based on the position of the actual insurer in assessing prejudice under section 54(1). The problem with subjective evidence is, however, that it is self-serving and may produce an easier hurdle for the insurer to overcome in proving that they would have performed a certain act had they known the fact.[589]

250. A possible suggestion is that the court should regard subjective intentions as only persuasive evidence and determine the value of the lost opportunity objectively. Justice Priestly found that the words 'fairly represents,' as used in the second limb of section 54(1), required a determination as to what prejudice would be suffered by a reasonable insurer carrying on the relevant type of insurance business.[590]

> '[s.54(1)] seems to me to require the court not to ask what [the insurer] would have done had [the insured] complied with the condition precedent, but rather what prejudice did [the insurer] suffer, as an insurer in a particular field, because of non-fulfilment of the condition precedent.'[591]

251. Recently proposed marine insurance reform has considered the use of an objective test in the area of non-disclosure. It

was suggested where there had been non-fraudulent non-disclosure, the insurer could avoid liability only if it could prove that it and the reasonable insurer would not have entered into the contract had they known of the non-disclosure.[592]

252. Although an objective test may, on its face, result in a fairer outcome, it is a 'malleable concept' that may produce more problems that it solves.[593] To assess what the insurer would have done via a reasonable insurer test is impractical in that the insurance industry is comprised of insurers who specialise in particular areas of risk and draft particular claims-handling guidelines for their needs. It may also produce problems where the test is applied to a 'slack' or incompetent insurer who, for instance, blindly issues policies without properly investigating the risks involved. In these cases, the insurer may in fact benefit from being assessed under the standard of what a reasonable insurer would have done in the circumstances.[594]

253. It is therefore submitted that despite arguments to the contrary, the prejudice assessment should have regard to the subjective intention of the insurer. As was mentioned earlier, however, such evidence should be tested rigorously to produce a just result.[595]

Adopting the principle of proportionality for quantifying prejudice

254. As was discussed earlier, prior to Moltoni, the insurer was only required to prove that the insured had breached a term in establishing the existence of prejudice. The Moltoni decision had formulated a different test by dividing cases into those where the insurer could prove that it would have gone 'off-risk' and those where it would not have done so.[596] The 'would have' test was applied for the latter case.

255. The situation is not as clear as to how the court will quantify prejudice under the new prejudice test espoused in Moltoni. Prior to this case, the High Court in Ferrcom had held that the lost opportunity test should be applied in all instances once the insurer had established the existence of prejudice.[597] In Moltoni, whilst the High Court indicated that the lost opportunity test was more 'accurate' in quantifying prejudice where the insurer would not have gone 'off-risk,' the court did not indicate how prejudice would be quantified where the insured would have gone 'off-risk.' As was mentioned earlier, the judges were not required to quantify prejudice in Moltoni, as the insurer had failed to establish the existence of prejudice.[598]

256. Prior to Moltoni, the High Court quantified prejudice in favour of the insurer by applying the lost opportunity test in both situations where the insurer would have gone 'off-risk' and where the insurer would not have done so. Since the lost opportunity test involves the court evaluating the loss of a chance, rather than the insurer's actual decision in what it would have done, the insurer has a lower hurdle to overcome by arguing that it had lost the opportunity to perform a certain act and hence, its liability should be reduced by the whole amount of the claim.[599]

257. It is suggested that a fairer outcome could be achieved by adopting the ALRC's original recommendation in assessing prejudice and therefore, the value of a lost opportunity via the proportionality test pursuant to ordinary contractual principles.[600] The test should apply to both situations, where the insurer would have gone 'off-risk'[601] and where the insurer would not have done so.[602] As was previously mentioned, given the circumstances in the Moltoni decision, it is unclear whether the High Court will embrace the principle of proportionality as the test by which to quantify prejudice.

258. The ALRC suggested that where the insured's conduct could not have caused or contributed to the loss, the insurer should be restricted to damages assessed under ordinary contractual principles.[603] This would involve applying the principle of proportionality where the insured should be penalised only in proportion to the prejudice that the insurer had suffered as a result of the insured's conduct.[604] Where the conduct had, for instance, increased the risk of a loss, the insurer's liability should be reduced proportionately to the increase in the risk of loss.[605] The word 'proportion' is defined as 'a portion or part in its relation to the whole.'[606] There is no reason why that portion or part could not represent the whole. It follows that the insurer's liability should be capable of being reduced to nil under the principle of proportionality.

259. It could be argued that the principle of proportionality is analogous to the common law principle of contributory negligence.[607] Under that doctrine, the court may consider the extent to which the plaintiff had contributed to the loss in assessing damages.[608] To return to the example of where the insured had installed a speed-enhancing booster

on its motorcycle without the insurer's consent,[609] the principle of proportionality would mean that the insurer's liability should be reduced in proportion to the extra risk it was required to bear.[610]

260. The courts do not, however, seem to favour this approach at all.[611] The High Court has described the task of applying the ALRC's recommendations as 'truly daunting.'[612] In Ferrcom, the court found that it was difficult to assess damages via ordinary contractual principles, since the relevant act or omission was a failure to satisfy a condition precedent to the insurer's liability, rather than a breach of contract.[613] The court held that the only way it could apply section 54 in any case was by treating the act of the insured or third parties as breach of contract and then to examine the prejudice caused by the breach.[614] The court's reasoning is logical, in that it would not make sense for it to treat the situation as if the insured had satisfied the condition precedent, when it had not been and then to assess prejudice from that standpoint. Despite this, the High Court's approach to section 54 is problematic, because section 54 is not concerned with the issue of whether a breach has occurred.[615] Rather, it is concerned with whether the insurer is entitled to refuse to pay a claim because of the insured's act or omission. Only then can there be a qualitative and quantitative determination of what prejudice (if any) has been caused to the insurer.[616]

261. Although the proportionality test may be difficult to apply and may result in lengthy and costly litigation, the courts have faced similar problems in other areas of law.[617] Putting a dollar value on a claimant's general damages for personal injuries is an example.[618] Determining a percentage for contributory negligence in cases of joint tortfeasors is another.[619] A body of case law has, however, developed over time to assist the courts in assessing damages. The courts apply the law to the facts and calculate an appropriate amount of damages drawing on past experience and knowledge. An application of the proportionality test is justified by the need to strike a balance between the interests of the insurer and the insured.[620] As Justice Kirby commented in Perry,

> 'in many cases...the facility for adjustment by the Court as s54(1) allows, will be far from a dead letter.'

262. This comment would suggest that the full potential of the prejudice test should be explored.[621] While this was attempted in Ferrcom, the courts must consider applying the proportionality test to give full justice to the issue. Indeed, as Justice McHugh commented in the special leave application proceedings in Moltoni, the issue of proportionality will 'come to the fore' under the current legal environment.[622] This is consistent with the view that ordinary contractual principles should be applied to situations where a fair balance needs to be struck between the insurer and the insured.[623]

263. The question therefore remains as to whether the wording of section 54 should be amended in light of the controversy surrounding the prejudice limb. With regard to 'claims made and notified' policies and 'claims made and occurrence notified' policies, Chief Justice Gleeson did not consider the prejudice limb to be of much benefit.[624] His Honour stated that;

> 'The concluding words of section 54(1) provide no adequate protection, because the extent to which the insurer's interests were prejudiced may be impossible to measure.'[625]

264. As in the case of 'claims made and notified' policies and 'claims made and occurrence notified' policies, the ISC has also rejected the proposal to amend the second limb of section 54.[626] ASIC and APRA have similarly not considered any changes to the section.[627] One possible method of amending section 54(1) is to insert the word 'proportionately' into the wording of the legislation. This should help to make clear the legislator's intention to assess prejudice via the principle of proportionality. To clarify that the test of proportionately would apply to both situations where the insurer would have gone 'off-risk' and where it would not have done so, it is suggested that the term 'proportionately' be defined under the interpretation section of the ICA.[628] One suggestion of how the amendments could be drafted is as follows;

11. Interpretation

s.11(1). Proportionately means any part of the claim or the whole of the claim.

54. Insurer may not refuse to pay claims in certain circumstances

s54(1). Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some

other person, being an act that occurred after the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced [proportionately] by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.

Summary

265. Section 54 was enacted to inhibit an insurer's reliance upon contractual terms to avoid liability for a particular claim.[629] It has helped to significantly modify the relationship between an insurer and an insured, albeit mainly for the protection and benefit of the insured.[630] Given the court's liberal interpretation of the word 'omission,'[631] a heavy onus is placed on the prejudice limb of section 54(1) to rectify any unjust results that may arise.

266. The current judicial application of the prejudice test could, however, potentially damage the intended effect of section 54. Although the High Court in Moltoni has adopted a more satisfactory approach in determining the existence of prejudice, the courts have yet to accept the principle of proportionality in quantifying prejudice. The insurer's ability to reduce its liability to nil in situations where it would not have gone off-risk and where the insured's act or omission had not caused or contributed to the loss has effectively swung the fate of the insureds closer to their original vulnerable position, as it was before the ICA was enacted. It could well defeat the ICA's primary objective in reforming the law so as to balance the interests of the insurer and the insured. It must, however, be noted that, following the High Court's decision in Australian Hospital Care, an insured who has become aware of an occurrence during the policy period does not need to notify the insurer until an actual claim is made against them.[632] The detriment to the insureds under the prejudice limb is therefore, arguably limited by their ability to speculate that a claim would not later arise and to avoid an increase in premium.[633] The insureds may obtain a wider cover than what they have actually 'paid' for through section 54(1).[634]

267. Due to the relatively few decisions dealing with the notion of prejudice, the long-term effect of the High Court decisions[635] remains to be seen. Given the fact the insurer's liability is not reduced to nil in every case and that it is now harder for the insurer to establish the existence of prejudice, it is submitted that the insurer is only slightly favoured under the prejudice limb. The second limb of section 54(1) therefore appears to be more balanced than the first limb.

268. To produce an even more balanced outcome, it is suggested that that the courts should stringently test the subjective intentions of the insurer as to whether it would have gone 'off-risk.' A subjective test is superior to an objective one given the nature and characteristics of the insurance industry. The courts should also use the proportionality test as a basis for quantifying prejudice under section 54(1). This would help to reduce the chance that the insurer's is reduced to nil in situations where the insured did not cause or contribute to the loss.

A new beginning for section 54

269. Section 54 is 'a section which is of very great importance to this community, not only the commercial community, but generally.'[636] Whilst the effect of the legislation has created much controversy, judges have taken various approaches to search for an outcome that balances the interests of the insurer and the insured.

270. The section has raised a number of issues, especially in relation to 'claims made and notified' insurance. The area has created 'considerable judicial, academic and commercial disquiet' over the years.[637] 'Claims made and notified' and 'claims made and occurrence notified' policies are important aspects of insurance. From East End to Australian Hospital Care, the courts have concluded that where an insured has failed to notify a claim or an occurrence, that is an 'omission' which may be 'excused' under section 54.[638] Whilst it has taken years of legal disputes to arrive at this result, the outcome nevertheless lacks conviction.

271. Given the inherent problems associated with the first limb of section 54, great reliance is placed on the prejudice limb, or the 'Catcher in the Rye,' to achieve a balanced outcome for the insurer and the insured. The High Court's decision in Ferrcom to allow the insurer's liability to be reduced to nil in situations where the insurer would have gone 'off-risk' and where it would not have done so, is less than satisfactory. This is in light of the fact that the insured's act or omission could not be reasonably regarded as having caused or contributed to the loss.

272. The High Court's recent decision in Moltoni has, however, indicated the judges' willingness to revise the current method of assessing prejudice in light of the various criticisms. Insurers now face a tougher hurdle in establishing the existence of prejudice as they must prove what they would have, rather than what they could have or might have done under the circumstances. Whilst it is uncertain whether the courts will adopt the principle of proportionality in quantifying prejudice, it appears that it is limiting the insurer's ability to rely on the prejudice limb to reduce liability to nil. The change in approach is a step in the right direction for the second limb of section 54.

273. Insurance upholds the fabric of our society. It is crucial for Australia to maintain a healthy insurance sector. Apart from the recent public liability and medical indemnity crisis, it was recently reported that, in the field of accounting, up to three-quarters of practitioners are considering abandoning audit work because of spiralling professional indemnity premiums.[639] Whilst it is impossible to determine the extent to which section 54 is in fact a major contributor to the current crisis[640] the courts' decisions regarding the operation of the first limb of section 54 have clearly added uncertainties to the contractual arrangement between the insurer and the insured, at the expense of the insurer. By treating both a failure to notify a claim and a failure to notify an occurrence as 'omissions' that could be excused under section 54, the insured is being put in a tremendously favourable position under the first limb. Following the High Court's decision to tighten up the prejudice limb, the insurer's ability to initiate protection under the second limb of section 54 is reduced. The result is that overall balance is tipped well towards the insured. Whilst the ALRC had intended to reform the law and correct the previous legal environment where the insurers were heavily favoured, it could not have intended to favour the insureds at the expense of the insurers.

274. Given the problems raised in both limbs of section 54, recommendations have been made to improve the operation of each limb. To solve the problems posed by the first limb of section 54(1), it was first suggested that insurers should introduce insurance packages which would 'encourage' insureds to notify early. Amongst other examples, the insurer could offer a decreased premium if the insured chose to notify a claim or occurrence early. Another approach is to take the radical step of reviving the 'omission/inaction' dichotomy as espoused in Perry. Although the distinction between an 'omission' and 'inaction' has been much criticised over the years, it is nevertheless a viable alternative that may be considered for reform. This would involve defining 'omission,' under the interpretation section of the ICA, as the failure to exercise a mandatory requirement to notify, but excluding a failure to elect to exercise the 'right, choice, or liberty' to take certain actions.

275. Limitation periods and liability caps are also recommended to curtail the 'long-tail' problems faced by insurers. As the prescribed period and cap may not be applicable in every circumstance, it is suggested that the court be given the power to intervene where it would be just in the circumstances. Since this approach effectively adopts the High Court's approach in Australian Hospital Care, it is recommended that the word 'omission' be interpreted as including both a failure to exercise a mandatory requirement to notify and a failure to elect to exercise the 'right, choice, or liberty' to take certain actions. This should help to introduce legislative certainty and limit litigation on the issue of whether the insurer could refuse to indemnify the insured where the insured had chosen not to notify. It is submitted that this approach is most attractive and could be combined with the 'commercial solution' alternative to further encourage the insureds to notify early and hence, limit the extent of the 'long-tail' problem.

276. With the assessment of prejudice under the second limb of section 54, it is suggested that the wording of section 54(1) should be amended so as to reflect the spirit of the principle of proportionality in quantifying prejudice. The test should apply to both instances where the insurer would have gone 'off-risk' and where they would not have done so. It is believed that the phrase 'reduced proportionately' should be capable of reducing the insurer's liability to nil where appropriate. The court should also test the insurer's evidence that, had it known a certain fact, it would have gone 'off-risk' more thoroughly to achieve a fairer outcome.

277. Legislators 'must be capable of imagining and executing and insisting on social change if they are to reform.'[641] It is submitted that the proposals as presented in this paper achieve overall effectiveness, since they complement each other in search for equilibrium between the interests of the insurer and the insured under each limb of section 54(1). Although the proposals do not satisfy every benchmark for reform as proposed in this paper, they are merely individual factors which must be considered when considering a reform.[642] Achieving one factor may lead to the difficult task of satisfying another factor whose benefits outweigh the cost of not achieving the other.[643] It is hard to achieve greater certainty and more contractual freedom simultaneously; however, it is hoped that the proposals in this article will prove useful in the debate about the reform of section 54.

Appendix

Australia

INSURANCE ACT 1902 (NSW)

SECTION 18

Powers of court in relation to insurance contracts

(1) In any proceedings taken in a court in respect of a difference or dispute arising out of a contract of insurance, if it appears to the court that a failure by the insured to observe or perform a term or condition of the contract of insurance may reasonably be excused on the ground that the insurer was not prejudiced by the failure, the court may order that the failure be excused.

(2) Where an order of the nature referred to in subsection (1) has been made, the rights and liabilities of all persons in respect of the contract of insurance concerned shall be determined as if the failure the subject of the order had not occurred.

INSURANCE CONTRACTS ACT 1984

SECTION 28

Division 3 Remedies for non-disclosure and misrepresentation General insurance

(1) This section applies where the person who became the insured under a contract of general insurance upon the contract being entered into:

(a) failed to comply with the duty of disclosure; or

(b) made a misrepresentation to the insurer before the contract was entered into;

but does not apply where the insurer would have entered into the contract, for the same premium and on the same terms and conditions, even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into.

(2) If the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.

(3) If the insurer is not entitled to avoid the contract or, being entitled to avoid the contract (whether under subsection (2) or otherwise) has not done so, the liability of the insurer in respect of a claim is reduced to the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred or the misrepresentation had not been made.

SECTION 40

Certain contracts of liability insurance

(1) ������ This section applies in relation to a contract of liability insurance the effect of which is that the insurer's liability is excluded or limited by reason that notice of a claim against the insured in respect of a loss suffered by some other person is not given to the insurer before the expiration of the period of the insurance cover provided by the contract.

(2) ������ The insurer shall, before the contract is entered into:

(a) ������ clearly inform the insured in writing of the effect of subsection (3); and

(b) ������ if the contract does not provide insurance cover in relation to events that occurred before the contract was entered into, clearly inform the insured in writing that the contract does not provide such cover.

Penalty: 300 penalty units.

(3) ������ Where the insured gave notice in writing to the insurer of facts that might give rise to a claim against the insured as soon as was reasonably practicable after the insured became aware of those facts but before the insurance cover provided by the contract expired, the insurer is not relieved of liability under the contract in respect of the claim, when made, by reason only that it was made after the expiration of the period of the insurance cover provided by the contract.

SECTION 54

Division 3 Remedies Insurer may not refuse to pay claims in certain circumstances

(1) Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.

(2) Subject to the succeeding provisions of this section, where the act could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract, the insurer may refuse to pay the claim.

(3) Where the insured proves that no part of the loss that gave rise to the claim was caused by the act, the insurer may not refuse to pay the claim by reason only of the act.

(4) Where the insured proves that some part of the loss that gave rise to the claim was not caused by the act, the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act.

(5) Where:

(a) the act was necessary to protect the safety of a person or to preserve property; or

(b) it was not reasonably possible for the insured or other person not to do the act;

the insurer may not refuse to pay the claim by reason only of the act.

(6) A reference in this section to an act includes a reference to:

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(a) an omission; and

(b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.

SECTION 55

No other remedies

The provisions of this Division with respect to an act or omission are exclusive of any right that the insurer has otherwise than under this Act in respect of the act or omission.

LIMITATION ACT 1935 (WA)

SECTION 38A

38A. Extended limitation period in certain cases

(1) In this section --

"latent injury" means a disease or injury of such a nature that, at the time it is suffered by a person, that person does not know and could not reasonably be expected to know that he has suffered the disease or injury;
"the amending Act" means the *Acts Amendment (Asbestos Related Diseases) Act 1983* .

(2) Where the period of limitation within which an action, suit, or other proceeding may be brought would, but for this section, be fixed by section 38 (1) (c) of this Act and --

(a) the cause of action arises from a person having suffered a latent injury that is attributable to the inhalation of asbestos;
(b) the person who suffered the latent injury had knowledge of the relevant facts before 1 January 1984; and

(c) the period of limitation that would be applicable thereto had the amending Act not come into operation had expired before 1 January 1984,

that action, suit, or other proceeding may be commenced within the period of 3 years after the coming into operation of the amending Act.

(3) Where in an action, suit, or other proceeding to which subsection (2) of this section applies it is proved that --

(a) the person who suffered the latent injury had knowledge of the relevant facts before 1 January 1984; and
(b) the period referred to in paragraph (c) of that subsection had expired before 1 January 1984 and before the action, suit, or other proceeding was commenced,

damages shall not be awarded except in respect of pecuniary loss and the total amount of the damages awarded shall not in any case exceed $120 000.

(4) Where the period of limitation within which an action, suit, or other proceeding may be brought would, but for this section, be fixed by section 38 (1) (c) of this Act and --

(a) the cause of action arises from a person having suffered a latent injury that is attributable to the inhalation of asbestos;
(b) the person who suffered the latent injury had knowledge of the relevant facts before 1 January 1984; and
(c) the period of limitation that would be applicable thereto had the amending Act not come into operation had not expired before 1 January 1984,

that action, suit, or other proceeding may be commenced within the period referred to in paragraph (c) of this subsection or, if that period expires less than 3 years after the coming into operation of the amending Act, may be commenced within the period of 3 years after the coming into operation of that Act.

(5) Where in an action, suit or other proceeding to which subsection (4) of this section applies it is proved that --

(a) the person who suffered the latent injury had knowledge of the relevant facts before 1 January 1984; and
(b) the period referred to in paragraph (c) of that subsection had expired before the action, suit, or other proceeding was commenced,

damages shall not be awarded except in respect of pecuniary loss and the total amount of the damages awarded shall not in any case exceed $120 000.

(6) Where the period of limitation within which an action, suit, or other proceeding may be brought is fixed by section 38 (1) (c) of this Act and --

(a) the cause of action arises from a person having suffered a latent injury that is attributable to the inhalation of asbestos; and
(b) the person who suffered the latent injury did not have knowledge of the relevant facts before 1 January 1984,

the period of limitation so fixed shall run not from the time provided by section 38 of this Act but from the time when that person has knowledge of the relevant facts.

(7) For the purposes of this section a person has knowledge of the relevant facts in relation to a cause of action when he has knowledge --

(a) that the injury in question was significant;
(b) that the injury was attributable in whole or in part to the act or omission which is alleged to constitute the cause of action;
(c) of the identity of the defendant; and
(d) if it is alleged that the act or omission was that of a person other than the defendant, of the identity of that person and the additional facts supporting the bringing of an action against the defendant,

and knowledge that any acts or omissions did or did not, as a matter of law, give rise to a cause of action is irrelevant.

(8) For the purposes of this section an injury is significant if the person whose knowledge is in question would reasonably have

considered it sufficiently serious to justify his instituting proceedings for damages against a defendant who did not dispute liability and was able to satisfy a judgment.

(8a) For purposes of this section, an injury --

(a) that is a disability within the meaning of the *Workers' Compensation and Rehabilitation Act 1981* ; and
(b) in respect of which proceedings in which damages are sought have not been instituted before 4 p.m. on 30 June 1993,

is not to be treated as being significant unless either the parties to proposed proceedings have agreed, or a medical panel as described in section 36 (1) of that Act has determined, that the degree of the disability assessed as prescribed in section 93D (3) of that Act, is 30% or more.

(9) For the purposes of this section a person's knowledge includes knowledge which he might reasonably have been expected to acquire --

(a) from facts observable or ascertainable by him; or
(b) from facts ascertainable by him with the help of medical or other appropriate expert advice which it is reasonable for him to seek,

but a person shall not be fixed under this subsection with knowledge of a fact ascertainable only with the help of expert advice so long as he has taken all reasonable steps to obtain (and, where appropriate, to act on) that advice.

(10) Unless the context otherwise requires, a reference, however expressed, in this Act or in any other Act or law to the time from which a period of limitation runs shall, where the period of limitation is one to which subsection (6) of this section applies, be read as if it were a reference to the time from which it is provided by that subsection that the limitation period shall run.

SECTION 47A

47A. Protection of persons acting in execution of statutory or other public duty

(1) Notwithstanding the foregoing provisions of this Act but subject to the provisions of subsection (2) and (3) of this section, no action shall be brought against any person (excluding the Crown) for any act done in pursuance or execution or intended execution of any Act, or of any public duty or authority, or in respect of any neglect or default in the execution of the Act, duty or authority, unless --

(a) the prospective plaintiff gives to the prospective defendant, as soon as practicable after the cause of action accrues, notice in writing giving reasonable information of the circumstances upon which the proposed action will be based and his name and address and that of his solicitor or agent, if any; and
(b) the action is commenced before the expiration of one year from the date on which the cause of action accrued,

and for the purposes of this section, where the act, neglect, or default is a continuing one, no cause of action in respect of the act, neglect, or default accrues until the act, neglect or default ceases but the notice required by paragraph (a) of this subsection may be given and an action may thereafter be brought while the act, neglect or default continues.

(2) A person may consent in writing to the bringing of an action against him at any time before the expiration of six years from the date on which the cause of action accrued whether or not the notice as required by subsection (1) of this section has been given.

(3) (a) Notwithstanding the foregoing provisions of this section application may be made to the Court which would but for the provisions of this section have jurisdiction to hear the action, for leave to bring an action at any time before the expiration of six years from the date on which the cause of action accrued, whether or not notice as required by subsection (1) of this section has been given to the prospective defendant.

(b) Where the Court considers that the failure to give the required notice or the delay in bringing the action as the case may be, was occasioned by mistake or by any other reasonable cause or that the prospective defendant is not materially prejudiced in his defence or otherwise by the failure or delay, the Court may if it thinks it is just to do so, grant leave to bring the action, subject to such conditions as it thinks it is just to impose.

(c) Before an application is made under the provisions of paragraph (a) of this subsection, the party intending to make the application shall give notice in writing of the proposed application and the grounds on which it is to be made to the prospective defendant, at least fourteen days before the application is made.

(4) (a) In this section "person" includes a body corporate, Crown agency or instrumentality of the Crown created by an Act or an official or person nominated under an Act as a defendant on behalf of the Crown.

(b) This section is to be construed so as not to affect the provisions of the *Crown Suits Act 1947* .

(5) Where an action is one to which this section applies and --

> (a) the cause of action arises from a person having suffered a latent injury that is attributable to the inhalation of asbestos; and
> (b) the person who suffered the latent injury had the knowledge referred to in section 38A of this Act before 1 January 1984,

the period limited by this section for the doing of any thing in relation to that action shall run not from the time otherwise provided by this section but from the time of the coming into operation of the amending Act.

(6) Where in an action to which subsection (5) of this section applies it is proved that --

> (a) the person who suffered the latent injury had the knowledge referred to in section 38A of this Act before 1 January 1984; and
> (b) the period of 6 years applicable under subsection (3) (a) of this section as in force before the coming into operation of the amending Act had expired before the action was commenced,

damages shall not be awarded except in respect of pecuniary loss and the total amount of the damages awarded shall not in any case exceed $120 000.

(7) Where an action is one to which this section applies and --

> (a) the cause of action arises from a person having suffered a latent injury that is attributable to the inhalation of asbestos; and
> (b) the person who suffered the latent injury did not have the knowledge referred to in section 38A of this Act before 1 January 1984,

the period limited by this section for the doing of any thing in relation to that action shall run not from the time otherwise provided by this section but from the time when that person has the knowledge referred to in section 38A of this Act.

(8) After the coming into operation of the amending Act --

> (a) a notice may be given;
> (b) an action may be commenced; or
> (c) consent may be given, or leave may be granted, to bring an action,

in accordance with subsection (5) or (7) of this section notwithstanding that the period of limitation applicable before the coming into operation of the amending Act in respect thereof had expired before the coming into operation of that Act.

(9) In subsections (5), (6), (7), and (8) of this section --

"latent injury" has the same meaning as is given to that expression by section 38A of this Act;
"the amending Act" means the *Acts Amendment (Asbestos Related Diseases) Act 1983* .

New Zealand

9.Time limits on claims under contracts of insurance��

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(1)A provision of a contract of insurance prescribing any manner in which or any limit of time within which notice of any claim by the insured under such contract must be given or prescribing any limit of time within which any suit or action by the insured must be brought shall��

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(a)If that contract of insurance is embodied in a life policy and the claim, suit, or action relates to the death of the insured, not bind the insured; and�

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(b)In any other case, bind the insured only if in the opinion of the arbitrator or Court determining the claim the insurer has in the particular circumstances been so prejudiced by the failure of the insured to comply with such provision that it would be inequitable if such provision were not to bind the insured.�

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(2)Where��

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(a)The insured under any contract of insurance to which subsection (1)(b) of this section applies fails to give notice of any claim in any manner or within any limit of time prescribed by the contract; and�

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(b)The cost of repairing, replacing, or reinstating any property when it falls [sic: fails] to be met is greater than that which would have applied if the notice had been given in the manner or within the time so prescribed,��

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that greater cost shall not constitute prejudice to the insurer for the purposes of subsection (1)(b) of this section, but the insurer shall not be obliged to apply or pay in repairing, replacing, or reinstating the property a greater sum than that for which he would have been liable if the notice of claim had been given in the manner or within the time so prescribed.�

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11.Certain exclusions forbidden��

Where��

(a)By the provisions of a contract of insurance the circumstances in which the insurer is bound to indemnify the insured against loss are so defined as to exclude or limit the liability of the insurer to indemnify the insured on the happening of certain events or on the existence of certain circumstances; and�

�(b)In the view of the Court or arbitrator determining the claim of the insured the liability of the insurer has been so defined because the happening of such events or the existence of such circumstances was in the view of the insurer likely to increase the risk of such loss occurring,��

�the insured shall not be disentitled to be indemnified by the insurer by reason only of such provisions of the contract of insurance if the insured proves on the balance of probability that the loss in respect of which the insured seeks to be indemnified was not caused or contributed to by the happening of such events or the existence of such circumstances.

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United States:

SECTION 13. Arkansas Insurance Code 23-79-306:

The insurer must provide at no additional charge an automatic sixty-day extended reporting period upon cancellation or termination of the policy by either the insured or insurer.

SECTION 1. 10-4-419 (2) (d), Colorado Revised Statutes, 1994 Repl. Vol.

10-4-419. Claims-made policy forms.

(2) A claims-made policy shall not be delivered or issued for delivery to any person in this state unless:

(d) The policy offers, at the insured's option, the purchase of an extended reporting period of at least one year for claims not filed during the expiring reporting POLICY period. Such coverage shall be equal to the aggregate limit of the policy coverage. The premium may not exceed two hundred percent of the expiring policy premium unless the adjusted premium is determined by the commissioner to be inadequate based upon section 10-4-403 and based upon an opinion of a qualified actuary submitted on behalf of the insurer.

Recommendations for reform:

First Limb of section 54(1):

Alternative B: Limitation period and liability cap

������������ s.54(7) Limitation period and insurer�s extent of liability

Notwithstanding the preceding provisions of this section;

(a)(i). in any insurance policy which requires the insured to notify a *claim* made against them during the policy period, where a claim was made against the insured during the original policy period, the insured must notify the insurer of that claim within 3 months from the expiry of the original policy; or

(a)(ii)(A). in any insurance policy which requires or allows the insured to notify an *occurrence* that they become aware of during the policy period, where:

(1). the insured has become aware of an occurrence during the original policy period that, in their opinion, may or may not later give rise to a claim; and

(2). the claim eventuates after the original policy has expired,

the insured may seek to be indemnified under the original insurance policy provided the insured *notifies the insurer of the claim* within 3 months from when it is first made against the insured. The insurer shall only be liable to indemnify to the extent of 30 percent of the claim made against the insured when this subsection applies; or

(a)(ii)(B). where:

(1). the insured has become aware of an occurrence during the original policy period that, in their opinion, may or may not later give rise to a claim; and

(2). the claim eventuates after the original policy has expired,

the insured may seek to be indemnified under the original insurance policy provided the insured *notifies the insurer of that occurrence* within 3 months from the expiry of the original policy;

(b)(i). In regard to policies to which subsections (7)(a)(i) and (7)(a)(ii)(A) apply, the court shall have the discretion to extend the period within which the insured may notify the insurer of a claim or an occurrence and seek to be indemnified under the original insurance policy where it thinks it is just to do so; and/or

(b)(ii). In regard to policies to which subsection (7)(a)(ii)(A) apply, the court shall have the discretion to reassess the extent of the insurer�s liability in accordance with the court�s assessment of the extent to which the insurer�s interests were prejudiced in the circumstances where it thinks it is just to do so.

Alternative C: Statutory revival of the �omission/inaction� dichotomy

11 Interpretation

s.11(1) ***omission*** means the failure to perform an act, obligation, or requirement, but *does not include* an election not to exercise a right, choice, or liberty to take certain actions as provided under the contract of insurance.

Second limb of section 54(1)

11. Interpretation

s.11(1). ***Proportionately*** means any part of the claim or the whole of the claim.

54. Insurer may not refuse to pay claims in certain circumstances

s54(1). Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced **[proportionately]** by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.

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Notes

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[3] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982), [19].

[4] Ibid.

[5] Ibid.

[6] R v Cohen ex parte Motor Accidents Insurance Board (1979) 27 ALR 263, per Mason J at 270; the concept of insurance did not require the existence of a contract.

[7] Supple, B, The historian and the business of insurance (Manchester : Manchester University Press, 1984), 1

[8] Pynt, G, Main type of commercial and property risks: Take cover! Approach insurance with an air of assurance, paper presented to The Law Society of Western Australia, Perth 2002

[9] Niven, D, How to make an insurance claim (Melbourne : Consumer Law Centre of Victoria Limited, 1996), 3

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[11] Ibid, [2].

[12] Ibid

[13] The World Book Encyclopedia. (London: World Book Inc., 1992) p. 281

[14] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [215].

[15] Ibid

[16] Ibid, [2].

[17] Horseley, K. "Section 54 of the Insurance Contracts Act" (1996) ILJ Lexis 8

[18] Ibid

[19] Australian Bureau of Statistics http://www.abs.gov.au/CA25670D007E9EA1/0/A30255BA102B5EB3CA2568F2002BF327?Open&Highlight=0,insurance (11 November 2002)

[20] The Insurance Ombudsman Bureau http://www.theiob.org.uk/digest/u/utmost_good_faith.html (31 August 2002)

[21] Above, note 14, [19].

[22] ALRC, Review of the Marine Insurance Act 1909: Report (NSW : ALRC, 2001) p.33

[23] Commercial Union Assurance Co. of Australia v Ferrcom P/L (1991) 22 NSWLR 389, at 398, per Kirby P

[24] Amongst other things, these included the remedies for nondisclosure and misrepresentation.

[25] Ibid.

[26] Ibid, per Kirby P who referred to the Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982), [139]

[27] See section 3.6. or appendix for the full text of section 54

[28] Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 176 CLR 332 per Brennan, Deane, Dawson, Gaudron and McHugh JJ at 340

[29] Commercial Union Assurance Co. of Australia v Ferrcom P/L (1991) 22 NSWLR 389, at 398, per Kirby P)

[30] The Judicial Conference of Australia's Colloquium http://www.jca.asn.au/lavarch.doc (1 November 2002); The

Australian Bar Association Conference
http://www.hcourt.gov.au/speeches/mchughj/mchughj_london1.htm#FOOTBODY_54 (3 November 2002)

[31] See, for example, FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38 where a failure to notify a claim or an occurrence is treated as an 'omission' under section 54(1); refer to sections 4.3.5. and 4.3.7. for further details

[32] Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 176 CLR 3

[32] is an example; refer to section 5.3.1. for further details

[33] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38 and Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 176 CLR 332; see sections 4.3.5., 4.3.7. and 5.3.1. for further details

[34] Mann P & Lewis C, Annotated Insurance Contracts Act, 3rd ed. (Pyrmont, N.S.W. : Lawbook Co., 2001), 9

[35] The phrase 'claims' policies is used in this paper to denote 'claims made and notified' policies and 'claims made and occurrence notified' policies.

[36] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982), [32]

[37] Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001), 89

[38] Above, note 35, [215]

[39] See for example, ICA s.28

[40] In other words, not insuring against third party injury which is covered under a statutory scheme. See for example, Motor Vehicle (Third Party Insurance) Act 1943 (WA)

[41] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0090]

[42] Ibid.

[43] Another example is McInerney v Schultz (1981) 28 SASR 542; (1982) 2 ANZ Ins Cas 60-458 (FC): the policy indemnified an employer where an employee was injured in the ordinary course of carrying out their duties in respect of the employer's 'motor garage (repairs and service)' business.

[44] Ibid

[45] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0090]

[46] Ibid.

[47] Ibid.

[48] Hewitt v London General Insurance Co Ltd (1925) 23 Ll L Rep 243; Marine Insurance Act 1909 (Cth) s.51 (recent proposed reforms affect this : Australian Law Reform Commission, Review of the Marine Insurance Act 1909, Report No 91 (2001) [9])

[49] Above, note 44, [5.0100]

[50] Ibid,

[51] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002), [5.0100]

[52] This is a variation of the actual clause in Rogers v HIH Casualty & General Insurance (NZ) Ltd (High Court of New Zealand, 11 November 1999); Another example is Kent Farms Inc. v. Zurich Insurance Co. No. 67635-6, Wash. Sup., 25 -

This policy 'does not apply to bodily injury arising from a diesel fuel spill.'

[53] Rogers v HIH Casualty & General Insurance (NZ) Ltd High Court of New Zealand, 11 November 1999

[54] That is, the insurer is 'off-risk' while a set of circumstances exists.

[55] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [216].

[56] Tarr, A, Australian insurance law, (NSW : North Ryde, 1987), 149; In the law of insurance, a breach of warranty is equivalent to a breach of condition in general law.

[57] Mammone v RACV Insurance P/L [1976] VR 617

[58] Above, note 54; The insurer may also sue for damages. As an insurer is unlikely to have suffered a loss as a result of the breach, damages are therefore rarely sought for a breach of warranty.

[59] MacGillivray & Parkington, Insurance Law Relating to all Risks other than Marine, 7th ed. (London : Sweet & Maxwell, 1981) [533]

[60] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982), [216]; the report uses property instead of vehicle.

[61] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002), [5.0010]

[62] See sections 3.3 and 3.4 for further details

[63] Australian Law Reform Commission, Insurance Contracts, Report No. 20, NSW Government Printer, 1982

[64] Australian Law Reform Commission, Insurance Contracts, Report No. 20, NSW Government Printer, 1982; McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16, p.4 of 26

[65] The Insurance Council of Australia http://www.ica.com.au/publications/ausinsindprofile.pdf (16 August 2002)

[66] Ibid.

[67] Ibid.

[68] Ibid.

[69] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [16].

[70] Australia Courts Act 1828

[71] Mabo v State of Queensland (No.2) (1992) 175 CLR 1; per Brennan, Mason and McHugh JJ at 29.

[72] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [16].

[73] For example, Hire Purchase Act 1959 (WA) Pt V ss.20-23; Workers' Compensation and Rehabilitation Act 1981 (WA) Pt X

[74] Life Insurance Act 1945 (Cth)

[75] Above, note 71.

[76] Newell, R. "The ambit of section 54 of the Insurance Contracts Act (Cth)" (1993) Current Issues in Insurance Law;LSWA

[77] Greig, D, & Davis, J, The Law of Contract, Law Book Co, Sydney, 1987, 22-32

[78] Maughan, C, "Economics and the law" (1994) March New Zealand Law Journal 110

[79] Greentree v FAI General Insurance Co. Ltd. (1998) 158 ALR 592

[80] Insurance Act 1902 (NSW) s.18 - see appendix for full text; see also Instruments Act 1958 (Vic) s.27

[81] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [221].

[82] Khoury v Government Insurance Office (NSW) (1984) 165 CLR 622

[83] Marine Insurance Act 1909 (Cth) s.40

[84] Civil Aviation (Carriers' Liability) Act 1959 (Cth) s.41D

[85] see Farr v Motor Traders Mutual Insurance Society [1920] 3 KB 669; and Provincial Insurance Co Ltd v Morgan [1932] 2 KB 70 (HL) for examples of UK cases.

[86] Bashtannyk v New India Assurance Co Ltd [1968] VR 573

[87] Ibid, at 575

[88] Bashtannyk v New India Assurance Co Ltd [1968] VR 573; at 575

[89] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [219]

[90] Commercial Union Assurance Co. v Federal Commission of Taxation (1977) 14 ALR 651

[91] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16, 4 of 26

[92] Above, note 88, [16].

[93] Azevedeo v Australian and International Insurances Ltd, unreported; Supreme Court of NT; 275/73; 18 August 1976

[94] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002), [5.0110.1]

[95] Ibid.

[96] Ibid.

[97] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [1], [16]

[98] Ibid.

[99] Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001), 7

[100] Insurance Contracts Act 1984 (Cth) s.9; These include insurance entered into in the course of state insurance or Northern Territory insurance (Workers' Compensation and Rehabilitation Act 1981 (WA) is an example), motor vehicle third party personal injury liability insurance (Motor Vehicle (Third Party Insurance) Act 1943 (WA); and Motor Accident Insurance Act 1994 (Qld)) and insurance to which the Marine Insurance Act 1909 (Cth) applies.

[101] See sections 1.3. and 2.2. for further details

[102] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [218].

[103] Ibid.

[104] See also Provincial Insurance Company Limited v. Morgan [1932] 2 KB 70

[105] Above, note 101, [224].

[106] Ibid.

[107] Ibid.

[108] Ibid, [219].

[109] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982) [219].

[110] Ibid, [224].

[111] Ibid, [228]

[112] Ibid.

[113] Ibid.

[114] Ibid.

[115] Ibid.

[116] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982), [226]

[117] Ibid.; This seems to recognise the insurer's ability to reduce its liability to nil.

[118] Greentree v FAI General Insurance Co Ltd (1999) 10 ANZ Ins Cas 61-423; per Mason P at 74,744.

[119] Ibid.

[120] Insurance Contracts Act does not apply to State insurance - see Insurance Contracts Act 1984 (Cth) s. 9(2); Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001), 13

[121] For example, sections 53 and 58 of the ICA.

[122] Commercial Union Assurance Co. of Australia v Ferrcom P/L (1991) 22 NSWLR 389; per Kirby P at 398

[123] A reference to an 'act' under s.54 includes a reference to 'an omission.' (section 54(6))

[124] See ICA s.54(2)

[125] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 2

[126] See ICA ss.54(2)&(3)

[127] De Vito v Commercial Union Assurance Co Ltd (2000) 11 ANZ Ins Cas 61-470; Austcan Investments P/L v Sun Alliance Insurance Ltd (1992) 7 ANZ Ins Cas 61-116

[128] Ferrcom P/L v Commercial Union Assurance Co. of Australia Ltd. (1993) 176 CLR 332

[129] Australian Associated Motor Insurers Ltd v Ellis (1990) 54 SASR 61; 6 ANZ Ins Cas 60-957

[130] FAI General Insurance Ltd. v Jarvis (1999) 46 NSWLR 1; per clause 5(f) of the policy.

[131] Ibid.

[132] The NSW Court of Appeal in FAI General Insurance Ltd. v Jarvis agreed with this.

[133] Baumol, W Economics: Principles and policy (Sydney: Harcourt Brace, 1992), 393

[134] See ICA section 54(1)

[135] Australian Associated Motor Insurers Ltd v Ellis (1990) 6 ANZ Ins Cas 60-957; at 76,328 per Cox J

[136] Ibid.

[137] See section 5 for further discussion

[138] See FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38

[139] Mead, P, 'The Effect of section 54 of the Insurance Contracts Act 1984 and proposals for reform'1997 ILJ LEXIS 12

[140] Ibid.

[141] Evans, M. Outline of equity and trusts (Sydney: Butterworths, 1996), 43

[142] Insurance Law Reform Act 1977 (NZ) s. 9 - see appendix for full text; see Section 4 for more details on 'claim' policies.

[143] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002), [5.0190.25]

[144] Sinclair Horder O'Malley & Co v National Insurance Co of New Zealand Ltd [1995] 2 NZLR 257; (1995) 8 ANZ Ins Cas 61-255

[145] Ibid, at 75,866 per McKay J

[146] Ibid.

[147] Insurance Law Reform Act 1977 (NZ) s. 11 - see appendix for full text

[148] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.25]

[149] Nupin Distribution Ltd v Harlick (1988) 5 ANZ Ins Cas 60-874 (CA)

[150] Above, note 147

[151] Ibid.

[152] State Insurance Ltd v Electronic Navigation Ltd (1992) 7 ANZ Ins Cas 61-115; Barnaby v The South British Insurance Co Ltd (1980) 1 ANZ Ins Cas 60-401

[153] New Zealand Insurance Co Ltd v Harris [1990] 1 NZLR 10; (1989) 6 ANZ Ins Cas 60-952; Harbour Inn Seafoods Ltd v Switzerland General Insurance Co Ltd (1991) 6 ANZ Ins Cas 61-048.

[154] State Insurance Ltd v Electronic Navigation Ltd (1992) 7 ANZ Ins Cas 61-115

[155] Above, note 147.

[156] Ibid.

[157] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.25]

[158] State Insurance Ltd v Electronic Navigation Ltd (1992) 7 ANZ Ins Cas 61-115, at 77,546

[159] Dodson v Grew (1767) ER 100 at 108, per Wilmot CJ

[160] Greentree v FAI General Insurance Co Ltd (1999) 10 ANZ Ins Cas 61-423; at 74,744 per Mason P

[161] See sections 4 &5 for further details

[162] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 2

[163] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 2

[164] FTP Inc. Insurance Wholesalers http://www.ftpins.com/comp6.html (19 October 2002)

[165] Reid Crowther & Partners Ltd v Simcoe & Erie General Insurance Co [1993] 1 SCR 252 at 262-264, per McLachlin J

[166] Ibid.

[167] FAI General Insurance Company Limited v Australian Hospital Care P/L [2001] HCA 38

[168] Examples include doctors, lawyers and engineers; Reid Crowther & Partners Ltd v Simcoe & Erie General Insurance Co [1993] 1 SCR 252 at 262-264, per McLachlin J

[169] Ibid.

[170] Ibid.

[171] www.PersonalInjuryLawyers.com.au http://www.personalinjurylawyers.com.au/case.asp (14 September 2002)

[172] Mesotheliomaweb http://www.mesotheliomaweb.org/faq.htm (14 September 2002)

[173] Above, note 167

[174] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 2

[175] Above, note 167

[176] Ibid.

[177] Ibid.

[178] Ibid.

[179] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 2

[180] Sparke Helmore http://www.sparke.com.au/Sparke_Practice.nsf/a63e3486cced2c844a2569a4001b5110/235b9efdfa68439c4a2565d8002721ce?OpenDocument (5 October, 2002)

[181] Breville Appliances P/L v Ducrou (1992) 7 ANZ Ins Cas 61-125, at 77,627 per Cole J

[182] Newcastle City Council v GIO (1997) 9 ANZ Insurance Cases 61-380; cited merely as 'terms of the policy' without relevant clause number and other descriptions.

[183] Breville Appliances P/L v Ducrou (1992) 7 ANZ Ins Cas 61-125 at 77,627

[184] Ibid.

[185] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 2

[186] Sparke Helmore
http://www.sparke.com.au/Sparke_Practice.nsf/a63e3486cced2c844a2569a4001b5110/235b9efdfa68439c4a2565d8002721ce?OpenDocument (5 October, 2002)

[187] Schoombee, A, Recent decisions on notification of claims & circumstances, sections 54 & 40 of the Insurance Contracts Act, paper presented to the Law Society of Western Australia Continuing Legal Education Programme, Perth 1997, 1

[188] Above, note 184

[189] HIH Casualty & General Insurance Aust P/L v DellaVedova (1999) 10 ANZ Ins Cas 61-431 at 74,871: Clause 2 of the 'Accountants' Professional Indemnity Insurance Certificate of Insurance'

[190] Greentree v FAI General Insurance Co Ltd (1999) 44 NSWLR 706, at 718 per Mason P; Breville Appliances P/L v Ducrou (1992) 7 ANZ Ins Cas 61-125 at 77,627 per Cole J

[191] Reid Crowther & Partners Ltd v Simcoe & Erie General Insurance Co [1993] 1 SCR 252 at 262-264, per McLachlin J

[192] Ibid.

[193] Ibid.

[194] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 2

[195] Ibid, p.3

[196] For example, FAI General Insurance Co Ltd v Perry (1993) 30 NSWLR 89; 7 ANZ Ins Cas 61-164

[197] Above,note 193, p.3

[198] As part of its disclosure prior to entering into an insurance contract; Ibid, p.3; see also ICA s.28.

[199] FAI General Insurance Company Ltd v Australian Hospital Care P/L (1999) 10 ANZ Ins Cas 61-445 per Derrington J at 75,088.

[200] An example from FAI v Aust Hospital Care P/L [1999] QCA 243

[201] HIH Casualty & General Insurance Aust P/L v DellaVedova (1999) 10 ANZ Ins Cas 61-431 at 74,871: Clause 2 of the 'Accountants' Professional Indemnity Insurance Certificate of Insurance'

[202] HIH Casualty & General Insurance Aust P/L v DellaVedova (1999) 10 ANZ Ins Cas 61-431 at 74,871 - 74,872 - The Full Court of the Federal Court of Australia (Lee, North, Mansfield JJ) held that a more positive state of awareness about the prospect of a claim against the insured might be required in some cases.

[203] Permanent Trustee Australia Ltd v FAI General Insurance Co Ltd (1998) 153 ALR 529 per Hodgson J at 567-568

[204] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 3

[205] FAI General Insurance Company Ltd v Australian Hospital Care P/L (1999) 10 ANZ Ins Cas 61-445 per Derrington J at 75,086

[206] Above, note 203

[207] Schoombee, A, "Antico's case and other recent decisions on notification of claims and circumstances: Sections 54 and 40 of the Insurance Contracts Act" (1997) ILJ Lexis 8, p.1

[208] Ibid.

[209] FAI General Insurance Co Ltd v Perry (1993) 7 ANZ Ins Cas 61-164, at 77,893 per CJ Gleeson

[210] Einfeld v HIH Casualty & General Insurance (1999) 10 ANZ Ins Cas 61-450; FAI General Insurance Co Ltd v Perry (1993) 7 ANZ Ins Cas 61-164, at 77,893 per CJ Gleeson

[211] See section 3.6 for a fuller explanation of s.54

[212] See section 4.4.2. for further details regarding how later policies may not, for various reasons, respond to the claim.

[213] East End Real Estate P/L v C E Heath Casualty and General Insurance Ltd (1991) 7 ANZ Ins Cas 61-092 (NSW CA - Gleeson CJ, Mahoney, Clarke JJ)

[214] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 4

[215] Above, note 212, at 77,358

[216] Ibid, at 77,360; per Gleeson CJ

[217] East End Real Estate P/L v C E Heath Casualty and General Insurance Ltd (1991) 7 ANZ Ins Cas 61-092, at 77,360; per Gleeson CJ

[218] Ibid, at 77,364; per Mahoney J

[219] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 4

[220] Above, note 216, at 77,363; per Mahoney J

[221] Ibid, at 77,360; per Gleeson CJ

[222] C E Heath Casualty & General Insurance Ltd v East End Real Estate Pty Ltd (1992) 7 Leg Rep SL 2

[223] Antico v Heath Fielding Australia P/L (1997) 188 CLR 652

[224] Ibid.

[225] FAI General Insurance Co Ltd v Perry (1993) 7 ANZ Ins Cas 61-164

[226] Ibid, at 77,892

[227] Ibid, at 77,889

[228] Ibid.

[229] Majority being Gleeson CJ and Clarke JA. Kirby P dissented; Above, note 224, at 77,890

[230] Ibid.

[231] Ibid., at 77,893 per Gleeson CJ

[232] FAI General Insurance Co Ltd v Perry (1993) 7 ANZ Ins Cas 61-164, at 77,893 per CJ Gleeson

[233] Ibid.

[234] Ibid.

[235] Ibid. Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 5; See also Clarke, J, "After the Dust Settles on Antico: FAI v Perry Lives" (1995) ILJ LEXIS 16

[236] Above, note 231, at 77,893 per CJ Gleeson

[237] Clarke, J, "After the Dust Settles on Antico: FAI v Perry Lives" (1995) ILJ LEXIS 16

[238] Above, note 231, at 77,893 per Gleeson CJ; Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 5

[239] See section 4.4.1.1. for details on such criticisms.

[240] See section 3.5. for further details on ALRC's recommendations.

[241] See section 4.4.1.1. for further details on such criticisms.

[242] Seery and anor v. John R Carr and Associates P/L and Ors, unreported; Supreme Court of NSW, 3 November 1995; see also Kelly v NZ Insurance Co Ltd (1996) 9 ANZ Ins Cas 61-317 - the Full Court of the WA Supreme Court held that the insured's failure to provide list of valuable items meant that the insured had chosen not to expand the level of cover. It was therefore, an inaction.

[243] Antico v Heath Fielding Australia P/L (1997) 188 CLR 652

[244] Ibid, <AUSLii> p.4 of 16; per Dawson, Toohey, Gaudron and Gummow JJ

[245] Khoury v Government Insurance Office (NSW) (1984) 165 CLR 622 at 638. per Mason, Brennan, Deane and Dawson JJ

[246] Antico v Heath Fielding Australia P/L (1997) 188 CLR 652 <AUSLii> p.14 of 16

[247] Ibid, 188 CLR 652 at 669-670

[248] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 8; Not every failure to exercise a 'right, choice or liberty' given under an insurance policy is, however, an omission under section 54. The section required that there be a sufficient causal connection between the insurer's refusal to pay a claim and the act or omission of the insured before the failure could be construed as an omission. (see Antico v Heath Fielding Australia P/L (1997) 188 CLR 652 <AUSLii>)

[249] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 8

[250] An example is Greentree v FAI General Insurance Co Ltd (1999) 10 ANZ Ins Cas 61-423, at 74,750

[251] Greentree v FAI General Insurance Co Ltd (1999) 10 ANZ Ins Cas 61-423, at 74,750

[252] The insured was unable to satisfy the judgement debt.

[253] see the Law Reform (Miscellaneous Provisions) Act 1946 (NSW) s.6

[254] Ibid, at 74,737

[255] Greentree v FAI General Insurance Co Ltd S171/1998 (18 June 1999)

[256] Above, note 250 at 74,741 per Spiegelman J

[257] Ibid.

[258] Ibid.

[259] Permanent Trustee Australia Ltd v FAI General Insurance Co Ltd (1998) 153 ALR 529; 10 ANZ Ins Cas 61-408

[260] Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001) 165,166

[261] Ibid.

[262] Permanent Trustee Australia Ltd v FAI General Insurance Co Ltd (1998) 153 ALR 529; 10 ANZ Ins Cas 61-408, at 74,510

[263] Ibid.

[264] Allens Arthur Robinson Publications Insurance High Court delivers judgment in FAI v Australian Hospital Care http://www.aar.com.au/publications/fobhjul01.htm#Andrea Martignoni (21 September 2002)

[265] See FAI General Insurance Company Ltd v Australian Hospital Care P/L (1999) 10 ANZ Ins Cas 61-445, per Chesterman J at 75,100; See also Einfeld v HIH Casualty & General Insurance (1999) 10 ANZ Ins Cas 61-450; 75,166

[266] Antico v CE Heath Casualty & General Insurance Ltd (1995) 8 ANZ Ins Cas 61-268 at 76,011 per Giles CJ Comm Div

[267] Ibid

[268] FAI General Insurance Company Ltd v Australian Hospital Care P/L (1999) 10 ANZ Ins Cas 61-445

[269] Ibid.

[270] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 12

[271] Ibid.

[272] HIH Casualty & General Insurance Aust P/L v DellaVedova (1999) 10 ANZ Ins Cas 61-431

[273] The case dealt with a provision identical with that considered in the Hospital Care case. The Full Federal Court held that a failure as a matter of choice to exercise the right to extend the cover of the policy by notifying the insurer of the relevant occurrence would be an omission to which section 54 would apply.

[274] FAI General Insurance Company Ltd v Australian Hospital Care P/L [1999] QCA 243, at [2]

[275] Ibid, at [4-5] per Derrington J

[276] Ibid, at [4]

[277] Ibid, at [4-5] per Derrington J

[278] Ibid, at [22-24] per Derrington J

[279] FAI General Insurance Company Ltd v Australian Hospital Care P/L [1999] QCA 243 at [21] per Derrington J

[280] Ibid.

[281] Ibid.

[282] Ibid, at [19] per Derrington J

[283] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 16

[284] Einfeld v HIH Casualty [1999] NSWSC 867

[285] Einfeld v HIH Casualty [1999] NSWSC 867

[286] Ibid, [25]

[287] Ibid, [45]

[288] Ibid, [55-56]

[289] Insurance and Superannuation Commission "Sections 40 and 50 of the Insurance Contracts Act 1984' Insurance Contracts Act Circular No. IC1/95, Sept 1995. http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[290] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38 at [48]

[291] McHugh, Gummow, Kirby and Hayne JJ; Gleeson CJ dissenting

[292] Ibid, at [88]

[293] Ibid, at [39]

[294] Ibid, at [41]; (emphasis added.)

[295] Muscillo, M, "The lesser of two evils: FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd" [2001] QUTLJJ 20 (AustLII: July 30, 2002)

[296] Ibid, at [42]

[297] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38 at [42]

[298] Ibid.

[299] Stapleton & Anor v NTI Limited [2002] QDC 204

[300] Stapleton & Anor v NTI Limited [2002] QDC 204 at [13]

[301] Stapleton & Anor v NTI Limited [2002] QDC 204 at [29]

[302] Ibid. at [79,80,81]

[303] Ibid, at [79,80]; See section 4.3.4. for more details

[304] Permanent Trustee Australia Ltd v FAI General Insurance Co Ltd (1998) 44 NSWLR 186 at 227; See section 4.3.4. for more details

[305] See section 4.3.4. for more details

[306] Above note, at [84,85]

[307] Ibid, at [44] per McHugh, Gummow and Hayne JJ

[308] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38 at [9]

[309] Muscillo, M, "The lesser of two evils: FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd" [2001] QUTLJJ 20 (AustLII: July 30, 2002)

[310] See section 3.5. for details on these recommendations

[311] East End Real Estate P/L v C E Heath Casualty and General Insurance Ltd (1991) 25 NSWLR 400; 7 ANZ Ins Cas 61-092; see also King v McKean & Park Ors (2002) 12 ANZ Ins Cas 61-534

[312] Antico v Heath Fielding Australia P/L (1997) 188 CLR 652 and FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38

[313] Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001), 169

[314] See section 4.3.1. for details on the case.

[315] See section 4.3.2. for details on the case.

[316] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38; and Einfeld v HIH Casualty & General Insurance (1999) 10 ANZ Ins Cas 61-450

[317] See sections 4.1.2. and 4.1.3. for details regarding the distinction between the two types of policies

[318] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 18

[319] Insurance and Superannuation Commission "Sections 40 and 50 of the Insurance Contracts Act 1984' Insurance Contracts Act Circular No. IC1/95, Sept 1995. http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[320] See sections 4.1.1. and 4.2. for details regarding the distinction between the two types of policies

[321] See section 4.1. for details on the 'long tail' problem

[322] Insurance and Superannuation Commission "Sections 40 and 50 of the Insurance Contracts Act 1984' Insurance Contracts Act Circular No. IC1/95, Sept 1995. http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[323] Reinsurance involves the original insurer (the reinsured) taking out insurance cover with another insurer (the reinsurer) to indemnify the reinsured against liability or payments under the original contract of insurance. (Nygh P & Butt P (eds.), Butterworths Concise Australian Legal Dictionary, (Australia : Ligare Pty Ltd, 1997, 341)

[324] Above, note 318;

[325] Insurance Council of Australia http://www.ica.com.au/liabilitysub/pressure.asp (6 October 2002)

[326] Above, note 318; e.g., solvency calculations, profit and loss calculations and taxation accounts.

[327] Breville Appliances P/L v Ducrou (1992) 7 ANZ Ins Cas 61-125 at 77, 628; per Cole J

[328] Baumol, W "Economics: Principles and policy" (Sydney: Harcourt Brace, 1992) p.393

[329] ABC Online: Govts reach agreement on public liability laws http://www.abc.net.au/news/australia/nt/metnt-15nov2002-7.htm (18 November 2002); 7.30 Report http://www.abc.net.au/7.30/s569235.htm (5 June 2002)

[330] See section 3.5. for details on the ALRC's recommendations on reforming the law

[331] FAI General Insurance Company Ltd v Australian Hospital Care P/L [1999] QCA 243 (9 July 1999) at [12], per Pincus JA

[332] Ibid.

[333] See section 4.3.7. for details on the 'inherently important' test

[334] FAI General Insurance Company Ltd v Australian Hospital Care P/L [1999] QCA 243 (9 July 1999) at [45] per Chesterman J; Note the effect of section 54(5) - see the appendix for full text.

[335] Rolfe J in Einfeld; Chesterman J in Australian Hospital Care; Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 6; See also Clarke, J, "After the Dust Settles on Antico: FAI v Perry Lives" (1995) ILJ LEXIS 16

[336] Clarke, J, "After the Dust Settles on Antico: FAI v Perry Lives" (1995) ILJ LEXIS 16

[337] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 5

[338] Ibid.

[339] Einfeld v HIH Casualty 10 ANZ Ins Cas 61-450 at 75,167, per Rolfe J

[340] See FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38

[341] ISC Circular 1/95 'Section 40 and 50 of the ICA' http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002);

[342] Ibid.; Although realistically, if the insured does not notify during the original policy period, they would have to notify in the next policy period when they have a pre-contractual duty to disclose facts and circumstances.

[343] This is subject to non-disclosure rules and other terms of the contract; See section 4.4.2. for further details on this.

[344] Above, note 337;

[345] Doctors face levy under indemnity deal http://news.ninemsn.com.au/National/story_28388.asp (23 October 2002)

[346] Ibid.

[347] Ibid.

[348] Ibid.

[349] Other reforms include tort law reform

[350] Craig, W.J., ed., All's Well that Ends Well: The Complete Works of William Shakespeare. (London: Oxford University Press, 1914) Act IV. Scene III verse 28

[351] Although it should be noted that where the situation concerned an optional occurrence notification clause, the claim would most likely be covered by a later policy anyway. See section 4.4.2. for further details.

[352] This would, however, be difficult to prove.

[353] An example is where the insured has honestly believed that a claim would not later arise after having obtained legal advice; See section 4.3.7. for further details on the example

[354] That is, whether the insured honestly believes that the occurrence would not later give rise to a claim.

[355] ISC Circular 1/95 'Section 40 and 50 of the ICA' http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002); Although it should be noted that where the situation concerned an optional occurrence notification clause, the claim would most likely be covered by a later policy anyway. See section 4.4.2. for further details.

[356] see section 3.5. on the ALRC's recommendations

[357] Above, note 351; see section 3.5 regarding the spirit of the ALRC in reforming the law

[358] See section 3.5. for further discussions

[359] Ibid.

[360] ISC Circular 1/95 'Section 40 and 50 of the ICA' http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2003); See section 4.3. for more details on why the insured may not want to notify certain things.

[361] See section 5 for further discussion on the issue of prejudice

[362] Salinger, Jerome, Catcher in the Rye (Boston : Little, Brown & Co., 1951), 173

[363] For example, Kirby P in FAI General Insurance Co Ltd v Perry (1993) 30 NSWLR 89 at 103

[364] FAI General Insurance Company Ltd v Australian Hospital Care P/L (1999) 10 ANZ Ins Cas 61-445, at 75,089 per Derrington J; also Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 21

[365] Ibid.

[366] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 21

[367] See section 5

[368] FAI General Insurance Company Ltd v Australian Hospital Care P/L [1999] QCA 243, at [52], per Chesterman J

[369] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 19

[370] Newcastle City Council v GIO (1997) 9 ANZ Insurance Cases 61-380

[371] That is, the insurer's liability is limited or excluded because notice of a third party's claim is not given to the insurer to the insurer during the policy period - See sections 4.1. and 4.2. for further information on the distinction between these policies.

[372] Above, note 368

[373] ICA s.40(3)

[374] AHC

[375] ISC Circular 1/95 'Section 40 and 50 of the ICA' http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002); See sections 4.1.1. and 4.2. for more details on the distinction between the two types of policies.

[376] Greentree v FAI General Insurance Co Ltd (1999) 10 ANZ Ins Cas 61-423, at 74,748 per Mason P

[377] Above, note 371;

[378] whether intentional or unintentional

[379] Einfeld v HIH Casualty & General Insurance (1999) 10 ANZ Ins Cas 61-450; per Rolfe J at 75,165

[380] East End Real Estate P/L v C E Heath Casualty and General Insurance Ltd (1991) 7 ANZ Ins Cas 61-092, at 77,364 per J Mahoney

[381] Ibid

[382] Ibid, at 77,365, per Clarke J

[383] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 20

[384] Ibid.

[385] FAI General Insurance Co Ltd v Perry 7 ANZ Ins Cas 61-164 at 77,02, per Clarke J

[386] East End Real Estate P/L v C E Heath Casualty and General Insurance Ltd (1991) 25 NSWLR 400; 7 ANZ Ins Cas 61-092; per Gleeson CJ

[387] Gosford City Council v GIO General Ltd (2002) 12 ANZ Ins Cas 61-527

[388] See sections 4.3.5. and 4.3.6. for further details on these cases.

[389] Finn, C, "Insurers claw back ground on s.54" (2002) 13 ILJ 290

[390] MEC McInally Nominees P/L v HTW Valuers (Brisbane) P/L (2001) 188 ALR 439; ANZ Ins Case 61-507

[391] Ibid, at 75,889

[392] Gosford City Council v GIO General Ltd (2002) 12 ANZ Ins Cas 61-527

[393] Ibid., [2002] NSWSC 511, at [38]

[394] Ibid.

[395] Finn, C, "Insurers claw back ground on s.54" (2002) 13 ILJ 290, 293

[396] Ibid, 292

[397] Gosford City Council v GIO General Ltd [2003] NSWCA 34

[398] See section 4.2. for further discussion on this

[399] Finn, C, "Insurers claw back ground on s.54" (2002) 13 ILJ 290, 292

[400] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 20

[401] Ibid., p.22

[402] Ibid., p.2

[403] Above, note 400

[404] Ibid, p.23

[405] as he then was; now High Court judge

[406] FAI General Insurance Co Ltd v Perry (1993) 30 NSWLR 89; 7 ANZ Ins Cas 61-164, at 77,900 per Kirby P

[407] Ibid.

[408] QBE Insurance Ltd v Moltoni Corporation P/L (2000) 11 ANZ Ins Cas 61-468

[409] Insurance and Superannuation Commission "Sections 40 and 50 of the Insurance Contracts Act 1984' Insurance Contracts Act Circular No. IC1/95, Sept 1995. P.9 http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[410] Ibid.

[411] The successor of the ISC. Insurance Journal - The Property Casualty Magazine http://www.insurancejournal.com/magazines/west/2002/12/16/newsbriefs (21 February 2003)

[412] The writer contacted by email APRA and ASIC regarding this issue on Oct 8, 2002.

[413] The writer contacted by email the Treasury regarding this issue on Oct 21, 2002.

[414] ICA http://www.ica.com.au/liabilitysub/pressure.asp (6 October 2002)

[415] A Submission by the Insurance Council of Australia for Amendment to Section 54 of the Insurance Contracts Act 1984 December 2001 http://www.aph.gov.au/senate/committee/economics_ctte/publib_insur/submissions/67_G.doc (1 October 2002)

[416] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 24; ISC Circular 1/95 'Section 40 and 50 of the ICA' http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[417] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 24; ISC Circular 1/95 'Section 40 and 50 of the ICA'

[418] ISC Circular 1/95 'Section 40 and 50 of the ICA' 'http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[419] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 24

[420] Limitation Act 1935 (WA) s.38A(6); see appendix for full text

[421] Limitation Act 1935 (WA) s.38A(3)

[422] ABC Online: Ministers show support for negligence laws http://www.abc.net.au/news/2002/10/item20021002084547_1.htm (2 October 2002); although there is a difference in policy between a liability cap under the Limitation Act and a liability cap under the public liability insurance reform. The cap under the public liability crisis is not so much concerned with the 'long-tail' business type issue.

[423] See section 4.4.2.2. for further discussion on this.

[424] ISC Circular 1/95 'Section 40 and 50 of the ICA' 'http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[425] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 24

[426] ISC Circular 1/95 'Section 40 and 50 of the ICA' 'http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[427] Select Ins. Co. v. Superior Court (1990) 226 Cal.App.3d 631, 639.

[428] Burns v. International Insurance Co 929 F.2d (9th Cir. 1991)

[429] Slater v. Lawyers' Mutual Ins. Co. (1991) 227 Cal.App.3d 1415, 1421-1422, 1424.

[430] Above, note 423.

[431] Ibid, in this case, 60 days

[432] Above, note 421.

[433] Arkansas Insurance Code 23-79-306, s.13; See appendix for full text

[434] Colorado Revised Statutes, 1994 Repl. Vol. 10-4-419 (2) (d), s.1; See appendix for full text

[435] See section 4.4.1.3 for further details

[436] Ibid.

[437] Cases of 'double insurance' might arise where the insured was aware of an occurrence, but had honestly believed that a claim would not later arise as a result of an occurrence: see Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [10.0010]

[438] As was the case in Greentree: see section 4.3.4. for further details

[439] See section 4.3.4 for details on Greentree

[440] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38, at [42]

[441] See section 4.4.1.1. for more details on this

[442] See section 4.4.1.3. for details on these cases.

[443] that both a failure to notify a claim and an occurrence are treated as 'omissions' that may be 'excused' under section 54; see section 4.3.5. for further details on Australian Hospital Care.

[444] Please refer to the appendix for the proposed legislation without the explanations.

[445] See section 4.4.1.3. for further details regarding the difference between section 54 and section 40.

[446] See section 4.2 for details

[447] as will be discussed in Section 5

[448] See section 54(7)(a)(ii)(A) for more details

[449] See section 4.4.1.1. for further details

[450] This is as opposed to situations where the insured had honestly believed that a claim would not later arise. In which case, that should be an omission under section 54(1): see section 4.4.1.1. for more details on this.

[451] See section 4.4.1.1. for other arguments for reviving the 'omission/inaction' dichotomy.

[452] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38; per Gleeson CJ at [11]

[453] See section 4.4.2.2. for comparision

[454] See section 4.4.2. for the situation where the insured was not aware of an occurrence during the policy period.

[455] ISC Circular 1/95 'Section 40 and 50 of the ICA' http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002);

[456] FAI General Insurance Company Ltd v Australian Hospital Care P/L [1999] QCA 243 (9 July 1999) at [24] per Derrington J

[457] Ibid.

[458] Ibid.

[459] Breville Appliances P/L v Ducrou (1992) 7 ANZ Ins Cas 61-125 at 77, 628; per Cole J

[460] Ibid.

[461] Ibid.

[462] Sutton, K, Section 54 - is Perry a terminal Hospital Case?, paper presented to the Australian Insurance Law Association, Perth 2001, 4

[463] See sections 4.1. and 4.2. for further details regarding the 'long tail' problems

[464] Australian Law Reform Commission, Review of the Marine Insurance Act 1909, Report No 91 (2001) [9.62]: Amongst other things, the ALRC considered the broad implications that section 54 and the Australian Hospital Care decision might impose on 'held covered' clauses that allowed the insured to extend the level of cover provided by a policy upon the notification of a certain fact. (Ibid, [9.105]) The Institute Time Clause Hulls contract terms, for example, include a 'held covered' clause that allows the insured to remain covered under the policy following a breach of warranty as to 'cargo, trade, locality, towage, salvage services or date of sailing' provided notice is given to the insurer. (Ibid, [9.106]) Where the insured had failed to notify the insurer of a certain fact, the current approach in section 54 would allow an insured's failure to notify to be 'excused.'(Ibid, [9.106]) The ALRC found this to be unacceptable, since the insured is permitted to 'unilaterally alter the bargain made by the parties, arguably to the extent of fundamentally changing the scope of the insurance.' (Ibid, [9.120])

[465] Australian Law Reform Commission, Review of the Marine Insurance Act 1909, Report No 91 (2001) [9.106]

[466] Little, W et al. Oxford English Dictionary, (Oxford : Clarendon press, 1973), 1655

[467] Collins Dictionary, (London : HarperCollinsPublishers, 1993), 1130

[468] McSweeny, M, "Current issues in insurance law: Aspects of prejudice in insurance law" [2001] ILJ LEXIS 16

[469] Ibid.

[470] Limitation Act 1935 (WA) s.47A(3)

[471] Stollznow v Calvert [1980] 2 NSW LR 749; Micallef v ICI Australia Operations Pty Ltd & Anor [2001] NSWCA 274

[472] ICA s.28(3)

[473] Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001), 89

[474] ICA s.31(2)

[475] ICA s.52(1)

[476] Akai P/L v Peoples Insurance Co Ltd (1996) 188 CLR 418

[477] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16; see section 3.6 or the appendix for the exact wording of s.54

[478] Ibid., p.22 of 26

[479] Masel, G, 'Antico v Heath Fielding Australia Pty Ltd' (1997) 12 Aust Ins LB 90 at 92.; Insurance and Superannuation Commission "Sections 40 and 50 of the Insurance Contracts Act 1984' Insurance Contracts Act Circular No. IC1/95, Sept 1995. P.9 http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[480] Kennedy v NZI Insurance Aust Ltd Unreported, QDC, Robin QC DCJ, 16 April 1992

[481] Mannolini, J "The uncertain ambit of section 54 of the Insurance Contracts Act" (1996) Aug ABLR p.209

[482] Masel, G, 'Antico v Heath Fielding Australia Pty Ltd' (1997) 12 Aust Ins LB 90 at 92.

[483] See Section 4 for further discussions on this

[484] See section 4.4.1.2. x for further discussion on this

[485] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38, at [21]

[486] Ibid.

[487] Jimaco Clothing Pty Ltd v Norwich Winterthur Insurance (Aust) Ltd (1985) 3 ANZ Ins Cas 60-640; Stevenson v Metropolitan Meat Industry Commission (1937) 37 SR (NSW) 109

[488] See section 4.3.1. for more details on East End

[489] East End Real Estate P/L v C E Heath Casualty and General Insurance Ltd (1991) 7 ANZ Ins Cas 61-092; at 77,801

[490] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16, p.14 of 26; see section 4.3.3. for more details on the case

[491] Ibid.

[492] Antico v C E Heath Casualty and General Insurance Ltd, unreported; Supreme Court of NSW; 17 December 1998

[493] Ibid.

[494] Zollo v National Australia Bank, unreported; Supreme Court of South Australia (FC); 21 March 1997

[495] Above, note 487.

[496] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38; per Kirby J at [61]

[497] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38; per Kirby J at [61]

[498] Section 54(1) See section 3.6 or the appendix for full text of the section

[499] Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 176 CLR 332; 7 ANZ Ins Cas 61-156 (HC)

[500] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73

[501] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73 at [18]; Ferrcom P/L v Commercial Union Assurance Co. of Australia Ltd. (1993) 176 CLR 332; 340

[502] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73 at [18]

[503] QBE Insurance Ltd. v Moltoni Corporation P/L (2000) 11 ANZ Ins Cas 61-468

[504] Antico v Heath Fielding Australia Pty Ltd (1997) 188 CLR 652, 673-4.

[505] Above, note 496

[506] Gibbs Holdings P/L v Mercantile Mutual Insurance (Australia) Ltd. [2000] QCA 524

[507] Ferrcom P/L v Commercial Union Assurance Co. of Australia Ltd. (1993) 176 CLR 332

[508] Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001) 173

[509] Above, note 501, 336 (Darling Harbour site in Sydney)

[510] Ibid, 341

[511] Ibid, 342

[512] Ibid.

[513] Ibid, (1993) 7 ANZ Ins Cas 61-156 at 77,831

[514] Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 7 ANZ Ins Cas 61-156 at 77,831

[515] Ibid, (1993) 176 CLR 332, at 341

[516] Ibid, at 342

[517] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73, [20]

[518] Tillotson v ANZ Life Assurance Co. Ltd (1996) 17 SR (WA) 34

[519] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73

[520] Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001), 178

[521] Above, note 513.

[522] QBE Insurance Ltd v Moltoni Corporation P/L (2000) 11 ANZ Ins Cas 61-468; Justices Ipp and Wallwork (Justice Murray dissenting)

[523] QBE Insurance Ltd v Moltoni Corporation P/L [2000] WASCA 82 [22]

[524] Ibid.

[525] Ibid; as cited by Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001), 178

[526] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16, p.16 of 26

[527] Ibid.

[528] Moltoni Corporation P/L v QBE Insurance Ltd HCA (27 October 2000) Special Leave Application p.4

[529] Ibid.

[530] Ibid.

[531] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73

[532] Ibid, at [24]

[533] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73, at [18]

[534] Ibid.

[535] Ibid, at [19]

[536] Ibid.

[537] Ibid, at [20]; This reaffirmed the position in Ferrcom.

[538] Ferrcom P/L v Commercial Union Assurance Co. of Australia Ltd. (1993) 176 CLR 332; 342; Above, note 527.

[539] Above, note 527

[540] Ibid.

[541] High Court Rules on Notice of Claims Provision www.pwturk.com.au/Downloads/Articles/QBEvMoltoni.pdf (19 October 2002)

[542] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73, at [21]

[543] Above, note 535

[544] Advance (NSW) Insurance Agencies Pty Limited v Matthews (1987) 4 ANZ Ins Cas 60-813 at 74,989

[545] Pickering, M, "Proving Underwriting Practices in Court on Issues of Non-Disclosure and Breach of Contract" (1991) 4 ILJ 52, 69

[546] Insurance and Superannuation Commission "Sections 40 and 50 of the Insurance Contracts Act 1984' Insurance Contracts Act Circular No. IC1/95, Sept 1995. P.9 http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[547] Above, note at [20]

[548] High Court Rules on Notice of Claims Provision www.pwturk.com.au/Downloads/Articles/QBEvMoltoni.pdf (19 October 2002)

[549] ICA s. 28(3)

[550] Mann, P "Annotated Insurance Contracts Act" (Sydney: Lawbook Co., 2001), 173

[551] See section 3.6.2 for facts of Australian Associated Motor Insurers Ltd v Ellis (modification of the vehicle without consent); see section 5.2.1. for Gibbs Holdings P/L v Mercantile Mutual Insurance (Australia) Ltd. (failure to notify a change in tenancy); and see section 5.2.1. for Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (failure to give notice of registration of the crane);

[552] Tarr, A, 'The Insurance Contracts Act Revisited', (1991) 4 Aust Ins LB 216 at 239.

[553] Ibid.

[554] ICA s.54(2); Above, note 546.

[555] See section 5.4.1. for further discussion.

[556] From a subsequent event.

[557] Pickering, M, "Proving Underwriting Practices in Court on Issues of Non-Disclosure and Breach of Contract" (1991) 4 ILJ 52, 69

[558] Ball, M, "Ferrcom P/L v Commercial union Assurance Co of Australia Ltd" (1993) 6 ILJ 85

[559] Ball, M 'Case Note' (1993) 6 ILJ 85

[560] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73 at [18]

[561] Ibid.

[562] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.20]

[563] Note that the insurer has a limited right to cancel the policy under s.60 of the ICA

[564] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.20]

[565] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16, p.10 of 26

[566] Above, note 561.

[567] Ibid.

[568] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.20]

[569] Ibid.

[570] See section 4.4.1.1. for further discussion on these recommendations

[571] Koning, JPM "Book review: Principles of Insurance by Kelly and Ball" (2001) 12 ILJ 281

[572] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.20]

[573] See section 5.2.1. for details on Ferrcom

[574] Above, note 566.

[575] See section 5.2.2. for further discussion

[576] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.20]

[577] Ibid.

[578] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16, p.17 of 26

[579] Ibid.

[580] See section 3.5. for the ALRC's recommendation of proportionality

[581] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.20]

[582] Ibid, at [8.0080.30]

[583] Trade Practices Act 1974 s.52

[584] Poseidon Ltd v Adelaide Petroleum NL (1994) 179 CLR 332; 120 ALR 16

[585] High Court Rules on Notice of Claims Provision www.pwturk.com.au/Downloads/Articles/QBEvMoltoni.pdf (19 October 2002)

[586] Ibid.

[587] Ibid.

[588] See Tarr's argument in section 5.3.1.

[589] See section 5.3.2. for further discussion

[590] Commercial Union Assurance Co. of Australia v Ferrcom P/L (1991) 6 ANZ Ins Cas 61,042 at 77,004; per Priestley JA

[591] Ibid.

[592] Australian Law Reform Commission, Review of the Marine Insurance Act 1909, Report No 91 (2001) [10.36-10.46]

[593] Australian Law Reform Commission, Review of the Marine Insurance Act 1909, Report No 91 (2001) [10.24]

[594] Australian Law Reform Commission, Review of the Marine Insurance Act 1909, Report No 91 (2001) [10.24]

[595] See section 4.4 for the benchmarks for reform

[596] See section 5.2. for more details on these tests

[597] That is, whether or not the insurer would have gone 'off-risk.'; See section 5.2. for more details on this.

[598] See section 5.3.5. for details

[599] See sections 5.3.1. and 5.3.2. for details

[600] See section 3.5 for details on the principle of proportionality.

[601] As in Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 176 CLR 332

[602] As in Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73

[603] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982), [228]

[604] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16; p.5 of 26

[605] Ibid, p.7 of 26

[606] The Shorter Oxford English Dictionary, (Oxford : Clarendon Press, 1992) p.1688

[607] That is, that principle after the reform contained in the contributory fault legislation: see Astley v Austrust Limited (1999) 197 CLR 1; also Law Reform (Miscellaneous Provisions) Amendment Act 2000 (NSW)

[608] Luntz, H, Torts: cases and commentary, (NSW : Butterworths, 1995) p.354

[609] See section 5.3.3. for details on example

[610] Horseley, K. "Section 54 of the Insurance Contracts Act" (1996) ILJ Lexis 8

[611] Kelly and Ball, Principles of Insurance Law, Butterworths, Sydney, 2001 at 5439 [5.0190.20]; Kelly, D, 'Further Thoughts on the Ferrcom case A re-examination of the Principal of "Proportionality"' (1993) 8 Aust Ins LB 57 at 59

[612] Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 176 CLR 332, at 341

[613] Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 176 CLR 332; at 341

[614] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16, p.12 of 26

[615] Kelly, B, & Ball, M, Principles of insurance law, (Australia : LexisNexis Butterworths, 2002) [5.0190.20]

[616] Ibid.

[617] See section 4.4. for the benchmarks for reform

[618] Luntz, H, Torts: cases and commentary, (NSW : Butterworths, 1995), 525

[619] Ibid, 354

[620] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982), [228]

[621] Insurance and Superannuation Commission "Sections 40 and 50 of the Insurance Contracts Act 1984' Insurance Contracts Act Circular No. IC1/95, Sept 1995. http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[622] Moltoni Corp Pty Ltd v QBE Insurance Ltd HCA (27 October 2000) Special Leave Application. P.4 of 5

[623] McSweeny, M. "Current Issues in Insurance Law: Aspects of prejudice in insurance law" 2001 ILJ LEXIS 16, p.17 of 26

[624] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38; per CJ Gleeson at [11]; see section 4.3.5 and 4.3.7. for further discussion on the case.

[625] FAI General Insurance Company Ltd v Australian Hospital Care P/L [2001] HCA 38; per CJ Gleeson at [11]

[626] Insurance and Superannuation Commission "Sections 40 and 50 of the Insurance Contracts Act 1984' Insurance Contracts Act Circular No. IC1/95, Sept 1995. http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/ic1-95.pdf/$file/ic1-95.pdf (5 October 2002)

[627] See section 4.4.1.4. for further information on the email sent earlier

[628] ICA s.11

[629] Australian Law Reform Commission, Insurance Contracts, Report No 20 (1982), [228]

[630] Hancy, G, Recent case trends in insurance law, paper presented to the Law Society of Western Australia, Perth 1994, 27

[631] See section 4 for discussion

[632] See section 4.3.7. for further details.

[633] Ibid.

[634] Australian Insurance Law Association: Winning Formula - Mid-Term alterations in the risk - What can be done? (NSW : International Business Communications P/L, 1990) p.23

[635] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73; Ferrcom P/L v Commercial Union Assurance Co of Aust Ltd (1993) 176 CLR 332; Australian Associated Motor Insurers Ltd v Ellis (1990) 54 SASR 61;and Antico v Fielding Australia P/L (1997) 146 ALR 385

[636] Moltoni Corporation P/L v QBE Insurance Ltd [2001] HCA 73 p. 4 of transcript per McHugh J

[637] Greentree v FAI General Insurance Co Ltd (1999) 10 ANZ Ins Cas 61-423, at 74,744

[638] See sections 4.3.3. and 4.3.5 for details on Antico and Australian Hospital Care respectively.

[639] Fabro, A & Clout, J, "Auditing gets the axe as premiums spiral", The Australian Financial Review [F2 Network] 12 Nov 2002

[640] This is a question which is, in any event, outside the scope of this paper.

[641] Andrews R, Cassell Dictionary of Contemporary Quotations, (Finland : Sterling Publishing Co. Inc., 1999), 391

[642] See section 4.4. for the benchmarks for reform