DIRECTORS' AND OFFICERS' INSURANCE AND THE GLOBAL FINANCIAL CRISIS

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SYNOPSIS

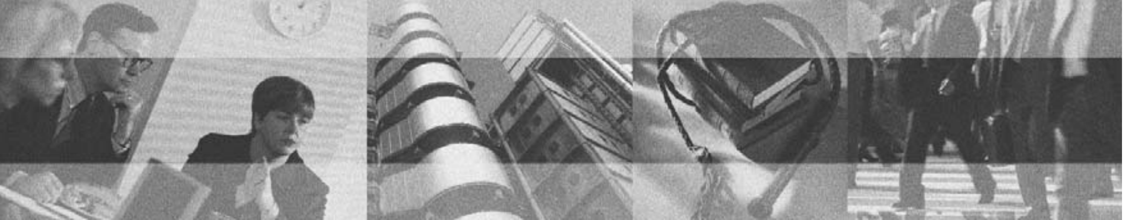
An economic downturn may be thought of as a situation in which the customers have stopped ordering. An economic crisis may be thought of as a situation in which the customers who never intended to pay have stopped ordering.[1]

The Global Financial Crisis of 2008-2009 has led to a mass of claims against directors, officers, auditors and others in a number of jurisdictions, most importantly in the United States. Claims are being brought by shareholders alleging negligence in bank lending policies, and also against companies who have bought up bank loans which have proved to be toxic. Less plausibly, but equally true, claims are being brought by debtors against creditors on the basis that, without negligence, loans would not have been made to them and they would not have incurred unaffordable liabilities. For these reasons, Directors' & Officers' policies have been dusted off and scrutinised. However, the present writer believes that – as with the Y2K fiasco – the insurance market is not going to find itself facing a mass of successful claims. This is so for two reasons. First, the US apart, the law is unlikely to impose liability upon directors in their personal capacities, because duties are not owed to shareholders individually or third parties dealing with the company, but only to the company itself. Secondly, even where liability is established, it is most unlikely to be covered by a D&O policy. So the substantive coverage of a D&O policy is in most cases going to prove illusory.

Underwriters are likely to face successful claims of only two types. The first is in respect of the costs of defending proceedings. D&O policies contain a variety of different provisions for defence costs: some will respond and some will not. It is interesting to note that online advertisements for D&O cover on broker and insurer sites all say how significant D&O cover is, but the examples given of coverage provided in the cases on those websites all relate to defence costs or the costs of defending regulatory proceedings. It is also interesting to note that the cases on D&O policies (and there are many from Australia, New Zealand, Canada and England) are concerned almost exclusively with defence costs cover, and there is – and that is arguable – only one on substantive coverage. The second is an issue mainly for the London market, namely, claims against reinsurers by D&O carriers in other jurisdictions, particularly the US market. Reinsurance claims raise issues of allocation of losses between policy years, aggregation and – the last resort of the scoundrel – compliance with claims conditions.

· With thanks to Peter Mann, who provided a wealth of valuable information both on the law and the market. He will recognise his hand at various points in this paper.

1 This was said by either WC Fields or Groucho Marx, the author has forgotten which.



This paper examines some of the more common problems which arise in respect of D&O claims at both the direct and the reinsurance levels.

LIABILIITES FACED BY DIRECTORS

Directors face an array of common law, equitable and statutory liabilities: many of these duties are codified or otherwise contained in the Corporations Act 2001 (Cth). The statutory duties, which give rise to civil penalties of up to $200,000 per breach as well as liability at common law or in equity (see s 185, which makes the remedies cumulative and not alternative), are as follows.

(a) Discharging duties with the degree of care and diligence that would be exercised by a director in the company's circumstances (s 180(1))[2] – a business judgment satisfies this provision if: it is made in good faith and for a proper purpose; the director does not have a personal interest in the subject matter; the director informs himself appropriately; and the director rationally believes that the judgment is in the company's best interests (s 180(2)).

(b) Exercising powers and discharging duties in good faith in the company's best interests and for a proper purpose (s 181). There is a criminal sanction for a dishonest or reckless director (s 184(1)).

(c) Not using his position to gain an advantage for himself or to cause detriment to the company (s 182). There is a criminal sanction for a dishonest or reckless director (s 184(2)).

(d) Not using information to gain an advantage for himself or to cause detriment to the company (s 183). There is a criminal sanction for a dishonest or reckless director (s 184(3)).

Directors also face strict criminal liability for regulatory infringements relating to the registered office, the issue of shares, making returns and complying with ASIC requirements. [3]In the last decade ASIC has been particularly active in bringing regulatory proceedings – criminal, civil and disqualification – against directors for their conduct in office. A director also faces strict criminal liability for failing to disclose other directors of any material conflict of interest. Finally, there is a civil penalty under s 588G where a director permits the company to incur a debt when it is insolvent and he knows or ought to know of that insolvency.

Apart from the Corporations Act, directors may face strict criminal liability where their company has committed an offence under one or more of a battery of regulatory provisions.[4] In addition, a director owes common law duties of care and skill and equitable duties: these mirror those codified in the legislation. The proper claimant in respect of these duties is the company itself (or its subsidiaries – s 187), and not, other than in exceptional circumstances, individual shareholders. That means that a harm done to the company must be remedied by an action on behalf of the company, which means that if the wrongdoers control the

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2 The test is objective: *ASIC v Rich* [2003] NSWSC 85; *ASIC v Vines* [2005] NSWSC 738.

3 *ASIC v Hardie* [2009] NSWSC 211.

4 Taxation Administration Act 1953 (Cth); Trade Practices Act 1974 (Cth); Environmental Protection and Biodiversity Conservation Act 1999 (Cth). As regards state liability, see: Protection of the Environment

company a class action on behalf of the shareholders (a "derivative" action) will be necessary. The number of class actions has been increasing, and the approval of litigation funding for such actions[5] is likely to see a further rise in that number.

That said, directors do not owe common law duties to creditors, employees or indeed third parties, although statutory liabilities may be incurred for infringement of regulatory or trading legislation. The common law set its face against personal liability to third parties in *Williams v Natural Life Health Foods Ltd*.[6] Here, a director of a company negotiated with a potential franchisee and presented a very favourable view of the business and of likely future income. The franchisee was persuaded and proceeded to suffer significant losses. A claim against the director for negligence was dismissed, their Lordships holding that the director was acting on behalf of the company and had not undertaken any personal responsibility towards the franchisee – the claim was against the (insolvent) company only. The interesting point about this case, which will be referred to again later, is that the only situation in which a company director can incur personal liability to a third party is where he is acting outside his capacity as director and on his own behalf, a finding which would of course take him outside the scope of any D&O cover that he might hold.

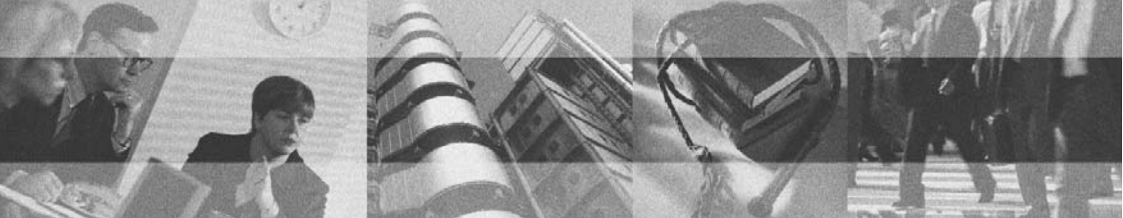
In this context, note should also be taken of the House of Lords' final decision before being pensioned off as a court on 30 July 2009, *Stone & Rolls Ltd v Moore Stephens*.[7] Here, a one-man company embezzled several millions from banks who financed fictional trading deals and paid against false bills of lading. The banks sought to recover their money, but the company and its controller were hopelessly insolvent. The liquidator, in an audacious move, commenced proceedings against the company's auditors, alleging that they owed a duty of care to make sure that the company was not defrauding its creditors. By a 3:2 majority the House of Lords dismissed the claim, which they recognised as in effect an indirect attempt by the banks to obtain funds from the auditors' professional indemnity insurers, a claim which could not have been brought directly because auditors do not owe duties of care to third parties. The outcome turned on the fact that the company was a one-man company, and his acts were those of the company – had there been any independent directors or shareholders, the outcome might have been different. Lord Mance, dissenting, argued persuasively and with a strong sense of outrage that auditors who had allowed a "Ponzi Scheme" to flourish ought not to be able to walk away. For those who have not checked, the eponymous inspiration was one Charles Ponzi, who flourished in the US in the first half of the twentieth century and who clocked up several hundred fraudulent schemes. But, as he said of his victims in mitigation, "Even if they never got anything for it, it was cheap at that price".

Operations Act 1997 (NSW); Contaminated Land Management Act 1997 (NSW); Occupational Health and Safety Act 2000 (NSW).

5 *Campbells Cash and Carry Pty Limited v Fostif Pty Limited* [2006] HCA 41

6 [1998] 2 All ER 577.

7 [2009] UKHL 39.



THE COMPANY'S POWER TO INDEMNIFY AND INSURE

The ability of a company to indemnify its directors against liability incurred by them is set out in the Corporations Act 2001, Part 2D.2

Section 199A(1) does not permit a company to exempt a director from liability to the company. Any exemption has to be by the court, under s 1318, but only where the director has acted honestly and the court considers that the director should fairly be exempted from liability.

A company may indemnify a director against liability, including liability for legal costs. However restrictions are imposed upon each possibility.

As far as general liability is concerned, s 199A(2) states that a company must not provide an indemnity in respect of :

(a) a liability owed to the company or a related body corporate;

(b) a liability for a pecuniary penalty order under s 1317G or a compensation order under ss 1317H or 1317HA;

(c) a liability that is owed to someone other than the company or a related body corporate and did not arise out of conduct in good faith.

As far as legal costs are concerned, s 199A(3) denies the right of indemnity where the costs are incurred:

(a) in defending or resisting proceedings in which the person is found to have a liability for which they could not be indemnified under s 199A(2);

(b) in defending or resisting criminal proceedings in which the director is found guilty; or

(c) in defending or resisting proceedings brought by ASIC or a liquidator for a court order (disqualification, oppression, civil penalties or injunction) the grounds for making the order are found by the court to have been established, although the company can provide an indemnity to cover the director's costs incurred if the director is represented in any investigation leading up to proceedings; or

(d) in connection with proceedings for relief to the person under this Act in which the Court denies the relief.

The prohibition applies to the proceedings themselves and any appeal (s 199A(4)).

Section 212(2) permits a company to advance a loan to a director to pay for defence costs unless the proceedings fall within 199A, and if the outcome falls within s 199A then the loan has to be repaid. Any loan must, under s 212(2), be reasonable.

These provisions apply also to civil and other liabilities incurred under the Trade Practices Act 1974 (Cth) (see s 77A of that Act).

Insurance against liability is governed by s 199B of the Corporations Act. It is lawful for a

company to take out insurance to indemnify a director. However, under s 199B(1), a company must not pay, or agree to pay, a premium for a contract insuring a person who is or has been an officer or auditor of the company against a liability (other than one for legal costs) arising out of:

(a) conduct involving a wilful breach of duty in relation to the company; or

(b) a contravention of section 182 or 183.

Breach of the section is a strict liability criminal offence (s 199B(2)). Any agreement which contravenes ss 199A or 199B is void to that extent (s 199C).

THE NATURE OF D&O POLICIES[8]

And so to the nature of D&O policies. This form of insurance has its origins in Australia in 1975, and now represents some 20% of total professional indemnity insurance.[9] Three types of cover are found in the market.

Side A Cover: the insurers agree to pay any loss suffered by a director where the director has not been indemnified by the company. Some clauses go on to exclude liability if the company is permitted to indemnify the director. If that is the case, then Side A cover becomes illusory, because s 199A impliedly authorises the company to indemnify its directors other than in the situations set out in s 199A(2) (a claim by the company, liability for a pecuniary or compensation order or a claim by a third party where conduct was in bad faith) and 199A(3) (defence costs arising out of s 199A(2) liability, criminal liability, ASIC claims and a liability under the Act for which relief is denied). A proviso of this type will defeat a claim under Side A in the vast majority of cases, and the director must look to the company.[10] Side A cover may be thought to be necessary where the company is insolvent or refuses to provide indemnity (assuming that Side A does not exclude cover where the company is permitted to indemnify but refuses to do so), or is precluded by the law from doing so. However, as suggested below, if the company is not permitted by law to indemnify the director, there are relatively few (and possibly no) other cases in which the Side A can respond either as a matter of general law or accordingly to its terms. Unsurprisingly Side A is the cheapest form of cover.

Side B Cover: the policy covers any sums paid by the company to the director by way of indemnification for the director's own liability. A director may not himself sue under Side B cover: the only insured person in respect of that cover is the company.[11] The company is not insured by Side B against any personal liability faced by the company itself. It was thus held in *Intergraph Best (Vic) Pty Ltd v QBE Insurance Ltd*[12] that if a company takes upon itself the

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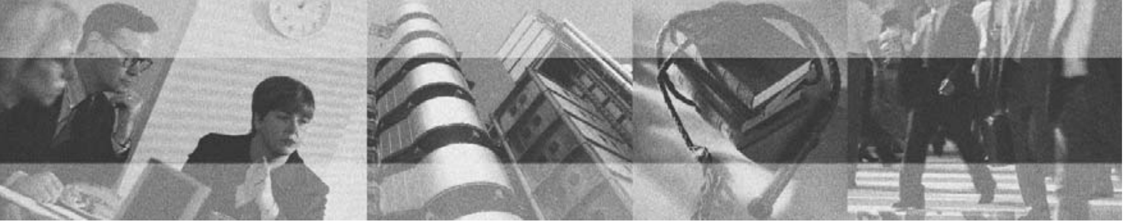
8 See:http://books.google.co.uk/books?id=7U6fXluV3eQC&pg=PP5&lpg=PP5&dq=directors+and+officers+liability+insurance&source=bl&ots=xihpg0WRFk&sig=uQWQg2MESYg9oR6CjdGb8bGzXoI&hl=en&ei=sEnHSrStFJOs4QaPv6THAQ&sa=X&oi=book_result&ct=result&resnum=8#v=onepage&q=&f=false. See also Paolini and Nambisan, *Directors' and Officers' Insurance,* 2008, Informa, London.

9 *Overview of Professional Indemnity and Public and Product liability Insurance,* National Claims and Policies Database, 20 July 2006, p 12

10 *Porter v* GIO 2002 NSWSC.

11 *Porter v GIO* 2002 NSWSC.

12 2005 VSCA 180. The decision contains copious citation of US authority on the distinction between a company which indemnifies its directors and a company which assumes direct liability for them.



liability for meeting the legal costs incurred by directors in proceedings covered by the policy, as opposed to indemnifying the directors for costs incurred by them in those proceedings, the policy does not respond to a claim by the company. In such a case the company is seeking to recover its own legal costs, not those of the directors. The distinction is a technical one, in that the policy would have responded had the company required the directors to incur the costs for themselves and then indemnified the directors. That, however, did not happen. Care thus has to be taken in drafting a settlement where the potential liability of the directors is at stake. In *Vero Insurance v Baycorp Advantage*[13] a claim was made against a company and its directors, and the company entered into a settlement "on behalf of itself and each of the" directors for a sum which exceeded the amount claimed from the directors themselves. The New South Wales Court of Appeal held that the company, by entering into that settlement, had not thereby rendered the directors personally liable for the agreed amount.

Side C Cover: the company insures against its own personal liability. This may be found in Australian D&O policies, and there is stand-alone Side C Cover now on offer. There is an increasing trend in shareholder actions against the company itself. That trend was given a significant boost by the majority of the High Court in *Sons of Gwalia Ltd v Margaretic*.[14] This case concerned a provision of English company law going back to the nineteenth century and re-enacted in Australia as s 563A of the Corporations Act 2001. This provides that "Payment of a debt owed by a company to a person in the person's capacity as a member of the company, whether by way of dividends, profits or otherwise, is to be postponed until all debts owed to, or claims made by, persons otherwise than as members of the company have been satisfied." The majority of the High Court ruled that this section did not operate to postpone a claim by shareholders against the company for loss sustained by the purchase of shares in the company as the result of misleading selling: the Court reasoned that a debt of this type was not owed to the shareholders in their capacities as members so that the claim ranked equally with, and was not subordinated to, the claims of other unsecured creditors. The danger of this ruling for directors is that a major claim against the company will erode whatever personal cover is open to directors under Side A.[15] For that reason, Side C cover has been removed from some Australian policies and may instead be purchased as a stand-alone product.

In addition, directors may seek their own private insurance cover if they fear that Side A cover may not be adequate for their needs. This may be the case in particular where the policy provides for A, B and C cover, and the limits of indemnity are eroded by B and C claims. Such products are found on the Australian market.

There are a number of features of D&O policies which are noteworthy.

(1) Cover is based upon liability arising from the status of the assured, ie, in his capacity as director.

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13 [2004] NSWCA 390.

14 [2007] HCA 1. The position is the same in England, *Soden v British and Commonwealth Holdings plc* [1998] AC 298.

15 It is understood that some policies now contain order of payment clauses which require directors to be paid first. However, these can work only if claims against directors are simultaneous, otherwise the common law "first past the post" principle will apply to insurance recoveries. Attempts are being made to draft clauses which give director indemnity claims priority.

(2) Cover is written on the basis of claims made during the currency of the policy, and not on the basis of events or losses occurring during the currency of the policy. Occurrences or losses occurring insurance is typically used for public liability or employers' liability insurance, whereas claims made is used for professional indemnity policies of most types. The difference between events and losses occurring insurance is not relevant today, although note that it is a key question in the coverage of employers' liability cover for asbestos claims, in the Court of Appeal in England in November 2009 (*Durham v BAI Run-off*).

(3) The directors are parties to the insurance in their own right, as co-assureds, even though the insurance is in the name of the company.[16] Policies are composite, in that each individual director is an assured in his own right. The law on composite insurance is not fully developed in Australia, but in England at least it is now clear that the conduct of any one director which takes him outside the protection of the policy does not necessarily affect the rights of others: see *Arab Bank v Zurich Insurance Co*.[17] This is often specifically stated in the policy, eg, "This policy covers each Insured for its own individual interest. No statements made by or on behalf of an Insured or breach of any term of this policy, or any information or knowledge possessed by an Insured, shall be imputed to any Insured for the purpose of determining whether any individual Insured is covered under this policy."[18]

(4) Policies may have per claim deductibles and aggregate cover limits, which vary in their terminology and effect. A policy may provide for automatic reinstatement when policy limits have been exhausted, although care needs to be taken where insurance is arranged in layers as there is very often a dispute as to whether reinstatement is "round the clock" or whether it kicks in as soon as the limits on that particular policy are exhausted.

(5) Global policies may operate as excess only covers where there are local policies in force, although there is generally a "drop down" clause which allows the excess layer to be treated as a primary layer policy on the terms of the local policy where local limits have been exhausted.[19]

(6) Policies provide for both substantive cover for legal liability and also for defence costs.

It has recently been held that shareholders are entitled to inspect a company's D&O policy to determine whether it is worth bringing an action against the company or its directors.[20]

SUBSTANTIVE COVERAGE

Capacity

D&O policies apply to any director or person who incurs liability in his capacity as a director, whether or not appointed to that post. Some policies restrict cover to a director solely whilst acting in that capacity, and others exclude liability arising from professional services (the territory of an ordinary public liability policy). The major problem posed by

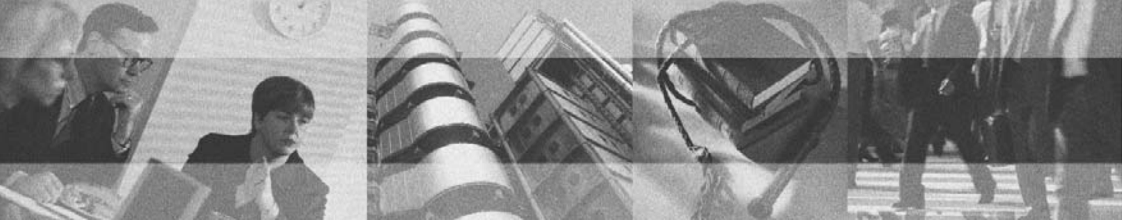
16 *Carden v CE Heath Casualty and General Insurance Ltd; CE Heath Casualty and General Insurance v Grey* 1993 NSW LEXIS 8082.

17 [1999] 1 Lloyd's Rep 262.

18 AIG wording.

19 *Flexsys America LP v XL Insurance Company Ltd* [2009] EWHC 1115 (Comm).

20 *Re Style Ltd, Merim Pty Ltd v Style Ltd* [2009] FCA 314. There is a conflict of authority on this matter in England.



the limitation of cover to a person acting, solely or otherwise, in his capacity as director, is that the present state of the common law does not recognise that a director can incur personal liability to a third party while he is acting in his capacity as director: see *Williams v Natural Life Health Foods Ltd*,[21] discussed above. Accordingly, absent special words of extension, in the exceptional circumstances where liability is incurred to a third party, it will not be protected by D&O cover.

Liability incurred by a director in his capacity as an employee of the company rather than by reason of his capacity as director is not covered by a D&O policy.[22] In *Tosich v Tasman Investment Management Ltd*[23] it was held that typical coverage wording "relates to those duties or liabilities imposed upon a director or senior officer as such, rather than all conduct in the course of employment" does not extend to employment duties. However, it has been held in Canada that a shareholder/director who allegedly oppressed minority shareholders does so in his capacity as director and not shareholder.[24]

Insured perils

Wordings vary, but a D&O policy covers sums for which a director becomes legally liable to pay by way of damages resulting from liability at law. Liability may be established by a judgment, arbitration award or settlement,[25] at which point the obligation to pay is triggered, although the insurers always retain their right to challenge any settlement reached by the assured on the ground that it does not fall within the terms of the insuring provisions.[26]

Cover is aimed primarily at tort claims: contract claims are regarded as excluded[27] unless the policy otherwise provides or unless the claim is one which could have been brought in either contract or tort. Employee claims are also often excluded. Separate cover is available for Securities Claims, namely, claims alleging a violation of any law or regulation regulating the purchase or sale or offer or solicitation of an offer to purchase or sell securities. But just how valuable is all of this cover?

We know from the *Williams* case that third party claims will fall outside the scope of a D&O policy. What, then of claims against a director in his capacity as director – which of those are insurable as a matter of the general law? Three propositions may be put forward.

The first is that a director cannot make a claim where his own deliberate or reckless conduct has caused the loss: just as an arsonist cannot recover when he has chosen to burn down his premises,[28] a director cannot recover if he acts in a way designed to cause loss to the company.

Secondly, there can be no recovery where the director makes profits to which he is not entitled. If, therefore, a director takes advantage of a corporate opportunity, or corporate information,

21 [1998] 2 All ER 577.

22 *Ross v American Home Assurance Co* 1999 OTC 360.

23 2008 FCA 377.

24 *Alofs v Temple Insurance Co* [2005] OJ No 4372.

25 *Baycorp Advantage Ltd v Royal and Sun Alliance Insurance Australia Ltd* 2003 NSWSC 941.

26 *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* [2007] HCA 36; *Commercial Union Assurance Co v. NRG Victory Reinsurance Ltd* [1998] Lloyd's Rep IR 439.

27 On the basis that they give rise to "private" liability and not "public" liability: *Tesco Stores Ltd v Constable* [2008] EWCA Civ 362.

28 Unless he can prove that he was clinically mad at the time and thus not responsible for his actions: *Porter v Zurich Insurance Co* [2009] EWHC 376 (QB).

to make secret profits, and a restitutionary action is brought against him by the company for the profit to be disgorged, D&O insurance cannot respond. In many cases the company will not have suffered any loss, but breach of fiduciary duty does not rest upon the beneficiary proving loss but rather on the fiduciary making a profit.[29] That point aside, as was said by Lord Phillips in *Stone & Rolls Ltd v Moore Stephens*,[30] "If a person starts with nothing and never legitimately acquires anything he cannot realistically be said to have suffered any loss."

The third, and perhaps the most complex, is that if the director has infringed the law, then he may be unable to recover. The scope of the public policy rule is a matter of some contention, and the most recent discussions of the point, by the House of Lords in *Tinsley v Milligan,*[31] *Gray v Thames Trains*[32] and *Stone & Rolls* itself are inconclusive. The stated principles are that an assured cannot recover if he has to rely upon his own illegality or if he is seeking to make a profit from his own illegality. This means that if a claim against a director has arisen following an infringement of the Corporations Act which gives rise to criminal liability, the policy – whatever it might say – cannot respond.[33] We have already seen that s 199A(2) states that a company must not provide an indemnity in respect of a liability for a pecuniary penalty order under s 1317G or a compensation order under ss 1317H or 1317HA. It has not yet been decided whether or not liabilities under those sections is insurable as a matter of law, although it would seem that common law principles would not preclude insurance where the liability arises from mere negligence. Therefore, in principle, there may be a possibility of cover where a compensation order is made by a court in circumstances of pure negligence. It might be thought that that scenario is relatively uncommon.[34]

Careful analysis of the situations in which a director may face liability to the company show that most (I am reluctant to use the word "all", although that is my view) involve conduct on his part which is in the vast majority of cases uninsurable as a matter of law. As Sam Goldwyn would have said, a D&O policy stripped of defence costs cover, and just like an oral contract, is not worth the paper that it is written on.[35] There are only limited exceptions. One is that of a compensation order made in circumstances where there is nothing more than negligence involved. Another is demonstrated by the facts of *Green v CGU Insurance Ltd*,[36] in which the insurers chose not to rely upon a coverage defence[37] by way of response to a claim by the directors for liability incurred under s 588M of the Corporations Act 2001 in respect of insolvent trading contrary to s 588G. Section 588G(2) is infringed where there are reasonable grounds for suspecting that the company may be insolvent, and s 588G(3) goes further and creates a criminal offence in the case of dishonesty. It may be, therefore, that a claim under s 588M is insurable if it is shown that the directors were negligent but not dishonest. The

29 *Boardman v Phipps* [1967] 2 AC 46, although the position is different if the company has authorised the profit – *Queensland Mines Ltd v Hudson* [1978] 2 AJLR 379.

30 [2009] UKHL 39, para 5.

31 [1993] 3 All ER 65.

32 [2009] UKHL33.

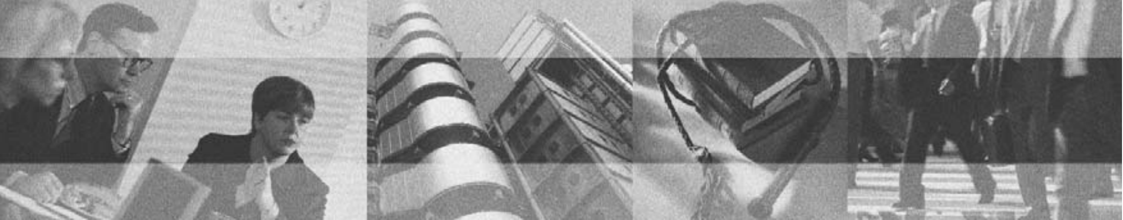
33 See, eg, *KR v Royal & Sun Alliance plc* [2007] Lloyd's Rep IR 268.

34 Although see *Rich v ASIC* (2004) 209 ALR 271.

35 In making this statement I appear to have infringed another of Sam Goldwyn's most important strictures: "Never make forecasts, especially about the future."

36 [2008] NSWSC 825.

37 Instead they successfully pleaded breach of the duty of utmost good faith.



response of the market to that possibility has been to adopt insolvency clauses of various types, the effect of which is to exclude liability under the policy if the claim arises out of or relates to the inability of the company to pay its debts. In *Green* the insurers pleaded non-disclosure of the declining financial fortunes of the company, a large claim against it and other significant indications of potential insolvency. The court held, under s 28 of the Insurance Contracts Act 1984, that the insurers were entitled to have their liability under the policy reduced to nil because, had full disclosure been made, an insolvency clause would have been inserted to remove potential liability for insolvency claims.

Exclusions

D&O policies typically exclude liability arising from: (i) any conduct or contravention in respect of which a liability is the subject of a prohibition in s 199B(1) of the Corporations Act 2001 (Cth); or (ii) the committing of any deliberately dishonest or deliberately fraudulent act. In either case, these matters have to be established by final adjudication of a judicial or arbitral tribunal[38] or by any formal written admission by the assured. It will be seen that these exclusions are in most cases little more than confirmatory: the law does not permit recovery in either of these circumstances unless, at least in the case of compensation orders, no fraud is involved. The concluding words of the exclusion become significant where a dispute arises in relation to defence costs: insurers cannot refuse to defend or pay defence costs simply because fraud has been alleged, they only have the right to withdraw coverage once fraud is proved: see *Wilkie v Gordian Run Off Ltd*[39] and *Silbermann v CGU Insurance Ltd*,[40] discussed below.

A further common exclusion is that for "Insured v Insured" claims. This provides that there is no cover for claims by directors, or by the company against a director where the director is himself a shareholder and thus would benefit from the claim.[41] To that extent the "Insured v Insured" exclusion protects the insurers against collusive claims, although it may be wider and apply to, for example, claims brought by ASIC on behalf of shareholders. Some policies limit this exclusion to US claims, a jurisdiction in which derivative and stockholder class actions are common fare. Another version of this exclusion confines it to "consensual claims" so that its scope is limited to collusion. Once the company has gone into liquidation and proceedings are brought by the liquidator, it would seem that the clause no longer applies, and the insurers are liable to provide an indemnity to the directors in proceedings brought by the liquidator,[42] although this possibility is often specifically excluded independently. Further, the clause does not apply where the director is sued by a person in his capacity as employee of the company.[43] It may be that the clause is unnecessary: in *Moore Stephens v Stone & Rolls* Lord Brown was firmly of the view that a director/shareholder could never benefit from a derivative claim brought by the company against him in his capacity as director.

38 See *Herley Industries Inc v Federal Insurance Co Inc* 2009 BL 179695 (ED Pa, Aug 21, 2009).

39 2005 HCA 17.

40 [2003] NSWCA 203.

41 See *Kohanski v St Paul Guarantee Insurance Co* 78 OR (3d) 684 (2006).

42 *Re People's Department Stores Ltd (1992) Inc* (1998) 23 CBR (4th) 200; *Markham General Insurance Co v Bennett* 81 OR (3d) 389 (2006); *Cigna Insurance Co v Gulf United States Corp* 1997 WL 1878757 (D Idaho 1997); *Township of Center v First Mercury Syndicate Inc* 117 F 3d 115 (3rd Cir 1997)..

43 *Conklin Co Inc v National Union Fire Insurance Co* 1987 WL 108957 (D Minn 1987).

The significance of the "claim"

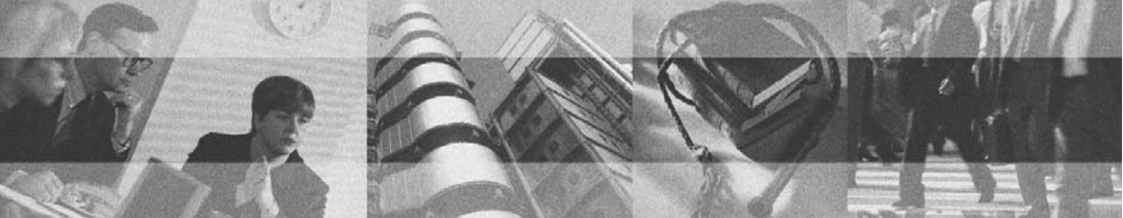
The term "claim" is important in a number of respects. First, there has to be a claim against the assured within the currency of the policy, so that the claim can be notified to the insurers. Secondly, there may be an aggregate limit on the sum insured for all claims or there may be a deductible to be borne for each claim. Thirdly, in determining coverage under the policy, the claim must relate to loss arising from an insured peril as opposed to an uninsured or excluded peril. Policies often define the term "claim" but rarely for each of these purposes, because the term has a different meaning in each of them. Because the word is used to cover a series of different matters, there is sometimes difficulty in ascertaining whether what is being referred to is the claim by or against the assured, as where the assured is required to notify "claims" to the insurers: whose is being referred to? Fortunately, most, but not all, modern wordings draw the necessary distinctions. In the present context of coverage, the third use of the word "claim" identified above, the question is one of coverage, namely, to what extent are the insurers bound by the manner in which the third party claimant against the assured has framed his claim. The third party may have set out a series of facts and alleged negligence, when it is quite clear that what is being asserted is fraud (always an excluded peril) or breach of contract (generally an excluded peril). It is settled law that the courts are entitled to go behind the allegations to determine exactly what is being asserted by the third party.[44]

Allocation of losses

Australian policies typically state that the insurer will be liable only for loss to the extent that it arises from a covered claim. Therefore, if a claim involves both covered and uncovered matters, or both insured and uninsured persons, then the assured and insurer are required to use commercially reasonable efforts to determine a fair and equitable allocation of the loss based on established judicial allocation principles which take into account the legal and financial exposures, and the relative benefits obtained by the relevant parties. In the absence of agreement, any dispute is to be resolved by Senior Counsel. There is no definitive legal principle as to how allocations should be carried out. As was said in *New Zealand Forest Products Ltd v New Zealand Insurance Co Ltd*:[45]

44 *West Wake Price & Co v Ching* [1956] 2 Lloyd's Rep 618; *Australia & New Zealand Bank Ltd v Colonial & Eagle Wharves Ltd* [1960] 2 Lloyd's Rep 241; *Walton v National Employers' Mutual General Insurance Association Ltd* [1973] 2 NSWLR 73; *Trollope & Colls Ltd v Haydon* [1977] 1 Lloyd's Rep 244; *Transport Industries Insurance Co Ltd v NSW Medical Defence Union Ltd* (1986) 4 ANZ Ins Cas 60-736; *Capel-Cure Myers Capital Management Ltd v McCarthy* [1995] LRLR 498; *Murphy & Allen v Swinbank* [1999] NSWSC 934; *Citibank NA v Excess Insurance Co Ltd* [1999] 1 Lloyd's Rep 1R 122; *Rouleston Clarke Pty Ltd v FAI General Insurance Co Ltd* (2000) 11 ANZ Ins Cas 61-465; *Redbridge LBC v Municipal Mutual Insurance Ltd* [2001] Lloyd's Rep IR 545; *Mabey & Johnson Ltd v Ecclesiastical Insurance Office plc (No 2)* [2003] Lloyd's Rep IR 724; *LPLC v Resource Underwriting Pacific Pty Ltd* 2004 VSC 418; *Baulderstone Hornibrook Engineering Pty Ltd v Gordian Runoff Ltd* 2006 NSWSC 223; *McCarthy v St Paul International Insurance Co Ltd* 2007 FCAFC 28. See also, for similar US authority, *Valley Forge Insurance Co v Swiderski Electronics, Inc* 223 Ill 2d 352 (2006); *Audit Bureau of Circulations v Axis Specialty Insurance Co* 2009 BL 183575 (ND Ill, Aug. 27, 2009). If the policy excludes cover for allegations of (as well as actual) fraud, the court is entitled to examine the nature of the claim to determine whether there is any underlying assertion of fraud even though the word is not used: *MDIS v Swinbank* [1999] Lloyd's Rep IR 516.

45 [1996] NZLR 20.



> "A study of the United States decisions[46] texts and articles available to us (which now extends considerably beyond material cited in argument) indicates universal acceptance of the basic proposition that there must be allocation between covered and uncovered claims. Beyond that no single principle can be identified as governing allocation. The Courts have employed approaches and methods of allocation considered appropriate to the circumstances of particular cases. It perhaps could be said that the method adopted has been that which is considered best to effect equitable allocation in the circumstances."

NOTIFICATION REQUIREMENTS

Policy provisions

Australian D&O liability policies are written on "a claims made and notified" basis: English policies tend to be written on a "claims made" basis.[47] The claim must result from a wrongful act. In the absence of any express policy provision, the date of the wrongful act is irrelevant, as all that matters is that the claim in respect of the wrongful act is made against the assured, and the assured has notified the insurers of the claim, within the policy period. Policies often make provision for the date of the wrongful act: in some cases there is no limit; in some cases there is a retroactive date in the policy, so that claims arising from any wrongful act earlier than that date are excluded; and in some cases the wrongful act, the claim and the notification of the claim to the insurers must all have occurred in the policy period.[48]

The primary trigger for cover under a claims made and notified policy is that a claim by a third party against the assured is first made during the currency of the policy. That does not suffice in Australia, however, because the assured must notify the claim to the insurers as soon as practicable and in any event during the policy period. There may be a notification problem if the claim is made towards the end of the policy year, and for that reason there is generally a short post-policy period – 30 to 60 days after the date of the claim – for notification. That period can be extended on payment of an additional premium. It should be noted that full use of the extended period is not an entitlement, but rather it is a maximum period, because the controlling obligation is to notify as soon as practicable.[49]

A secondary trigger for cover arises where the policy is not renewed or replaced. Policies

46 Notably *Harbour Insurance Co v Continental Bank Corporation* 922 F 2d 357 (7th Cir, 1990) and *Nordstrom Inc v Chubb & Son Inc* 54 F 3d 1424 (9th Cir, 1995), *Caterpiller Inc Great American Insurance* 62 F 3d 955 (7th cir, 1995), *Safeway Stores Inc v National Union Fire Insurance Co* 64 F 3d 1282 (9th cir, 1995) which adopted the "larger settlement" rule, namely that if the settlement is not enlarged by the inclusion of uninsured persons, the insurers are liable for the full sum. This is also the Canadian approach: *Coronation Insurance Co v Clearly Canadian Beverage Corp* (1999) 117 BCAC 22.

47 Although sum require notification to be during the policy or within a limited period thereafter.

48 This type of policy is unlawful in some jurisdictions. See *Sparks v St. Paul Insurance Co* 100 NJ 325 (1985), in which the New Jersey Supreme Court, in striking down such a policy, stated that it "combine[d] the worst features of 'occurrence' and 'claims made' policies and the best of neither."

49 The opposite conclusion was reached by Morison J in *AIG Europe (Ireland) Ltd v Faraday Capital Ltd* [2007] Lloyd's Rep IR 267, holding that the assured was entitled to notify within the specified period. The point did not arise on appeal and Morison J was reversed on other grounds, [2008] Lloyd's Rep IR 454. A majority of the Court of Appeal in *HLB Kidsons v Lloyd's Underwriters* [2009] Lloyd's Rep IR 178 held that an obligation to notify as soon as practicable and within 15 days of the expiry of the policy conferred a right to notify up to the expiry of that period rather than merely imposing a long-stop.

tend to offer a Discovery Period, running for 30/60/90 days (it varies from policy to policy) from the termination of the policy. If a claim is first made against the director during the discovery period in respect of a wrongful act taking place before the commencement of the discovery period, there is cover subject to notification of the claim to the insurers as soon as practicable or within 30/60 days of the termination of the Discovery Period. In the case of a retired director, the Discovery Period is often much longer: policies range from 84 months to no limit.

The tertiary trigger for cover, and in practice perhaps the most significant, is that the assured is given the right during the policy period (or, if appropriate, Discovery Period) to notify the insurers of any circumstances which may/is likely to/may reasonably be expected to, give rise to a claim. This right is almost always contractual, but if there is no relevant contract term then one is implied by s 40 of the Insurance Contracts Act 1984 (Cth). Section 40 is based on a recommendation of the Australian Law Reform Commission's 1982 Report,[50] and attempts to deal with the limited cover given by claims made and notified policies. The section applies to a liability policy the effect of which is that the insurer's liability is excluded or limited where the assured fails during the currency of the policy to give notice of a claim against him (s 40(1)). Section 40(3)[51] then provides that if the assured gives notice to the insurers of facts that might give rise to a claim as soon as reasonably practicable after he became aware of them, the insurer is not relieved of liability only by reason of the fact that the claim was made after the expiry of the policy. This is, therefore, a statutory notification of circumstances provision. Australian policies which do contain notification of circumstances clauses appear (unlike their English counterparts) not to impose any obligation to notify circumstances within a fixed or other timeframe as long as notification happens during the policy period or Discovery Period. Any contractual notification of circumstances is normally required to include the reasons for anticipating a claim, and full relevant particulars with respect to dates, the nature of the wrongful act and the identity of the potential claimant. If circumstances are notified under a contractual extension or under s 40(3), any later claim is deemed to have been made during the period of insurance, so that the claim is dragged back into the policy year of notification by way of "deeming". Some policies are framed as imposing an obligation on the assured to notify circumstances which may give rise to a claim, but it is clear from the leading English authority, *HLB Kidsons v Lloyd's Underwriters*,[52] that the notification of circumstances and the making of claims are entirely distinct heads of cover, so that a failure to notify circumstances does not preclude a subsequent notification of a claim against the assured arising from those circumstances later in the policy year. In short, the notification of circumstances is an option which may be exercised by the assured.

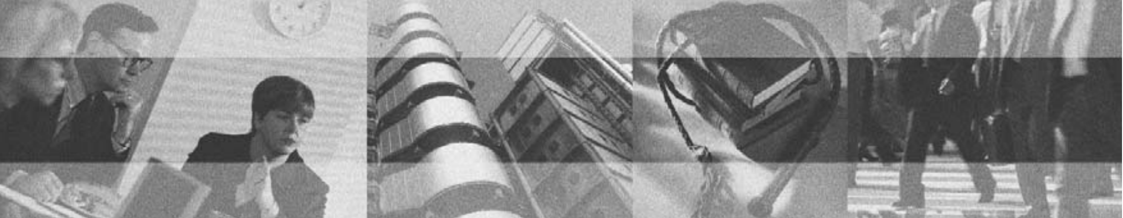
Notification of claims

Some policies define "claim". A typical definition is: "a civil proceeding commencing by the

50 ALRC 20, paras 215-244.

51 It has been held that s 40 applies to claims made policies as well as claims made and notified policies: *Newcastle City Council v GIO* (1997) 191 CLR 85.

52 [2009] Lloyd's Rep IR 178.



service of a complaint, summons, statement of claim, writ or similar pleading ...against an Insured Person alleging facts or circumstances that constitute a Wrongful Act".[53] In the absence of any definition, it is possible to make a number of generalisations. The service of a writ on the assured is the most obvious form of claim, as is the receipt of a letter before action. Short of these possibilities, a claim is "a communication by [a third party] to the [assured] of some discontent which will, or may, result in a remedy expected from the [assured]",[54] although this has to be distinguished from a statement that action is under consideration.[55] In *Rothschild Assurance Ltd v Collyear*[56] Rix J considered the situation in which a financial services provider was ordered by its regulator to investigate its selling of products to customers to determine if there had been mis-selling, and then to notify any affected customers of their rights: each notification was held to amount to a claim against the assured.

A director may find himself in the unfortunate position that a claim has been made against him of which he is unaware. This may arise, typically, where a writ has been issued within the policy period but it is not served until the policy period has expired. In *Robert Irving & Burns v Stone*[57] the court ruled that a writ which has not been served is not a claim. By contrast, if a writ has been issued and the assured has been informed of that fact, then a claim has been made against him as of the latter date: *Thorman v New Hampshire Insurance Co Ltd*.[58]

Notification of circumstances

The main alternative trigger of cover is notification of circumstances. A number of different elements of the clause, which was analysed in detail by the Court of Appeal in the *Kidsons* case, call for comment.

First, notice in writing must be given either to the subscribing underwriters individually[59] or to their nominated agents. What is said must be capable of constituting "notice", the test being whether a reasonable recipient with knowledge of the terms of the policy and the overall context would have understood the communication as a notice of circumstances. In *Kidsons* it was held by a majority of the Court of Appeal that a letter to the underwriters from the assured's partnership secretary setting out the concerns of an employee was a notification of circumstances even though it was not entirely satisfactory for that purpose. The test was not whether the notification had left the underwriters in no doubt. The assured's intention is not normally material,[60] and it is now established in English law that there can be a valid objective communication of circumstances even though it was not the assured's intention to notify.[61]

53 Royal and Sun Alliance.

54 *Robert Irving & Burns v Stone* [1998] Lloyd's Rep IR 258. See also: *West Wake Price & Co v Ching* [1956] 2 Lloyd's Rep 618; *Rothschild Assurance Ltd v Collyear* [1999] Lloyd's Rep IR 6; *Forrest v Glasser* [2006] EWCA Civ 1086.

55 *Immerzeel v Santam Ltd,* December 2005, unreported (Supreme Court of Appeal of South Africa).

56 [1999] Lloyd's Rep IR 6. See also: *Forrest v Glasser* [2006] 2 Lloyd's Rep 392; *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* [2007] HCA 36.

57 Following *St Paul Fire & Marine Insurance Co v Guardian Insurance Co of Canada* [1983] 1 DLR 342.

58 [1988] 1 Lloyd's Rep 7.

59 If the insurance is arranged in layers, notification to the primary layer alone will not suffice unless the policy states otherwise.

60 In *Kidsons* Rix LJ commented that: "in certain exceptional circumstances intention may not be irrelevant to a unilateral question such as the giving of a notice."

61 *Friends Provident Life & Pensions Ltd v Sirius International Insurance Corporation* [2006] Lloyd's Rep IR 45; *BP plc v Aon* [2006] Lloyd's Rep IR 577.

Secondly, some, but not all, policies require notification to be made as soon as practicable after the assured has become aware of the relevant circumstances. Four issues arise. (1) The assured must be aware of the circumstances themselves: in *Harbourfield Engineering Co Ltd v Falcon Insurance Co (Hong Kong) Ltd*[62] it was held that notice of prosecution does not necessarily imply awareness of a possible civil claim arising from the same events. (2) The assured must have the requisite degree of knowledge of the possibility that the circumstances may give rise to a claim. Dicta in *Kidsons* were somewhat conflicting, but it has been established in later cases that the test is an objective one, and that there has to be "a real as opposed to a fanciful risk of the underwriters having to indemnify the assured and that in determining whether there was such a risk the court applied an objective test, taking into account the knowledge that the assured possessed in order to determine the extent to which the assured was aware of, and hence capable of notifying, occurrences which may give rise to an indemnity".[63] The same question was considered in *CGU Insurance Ltd v Corrections Corporation of Australia Staff Superannuation Pty Ltd*.[64] At first instance – *Kernaghan v Corrections Corporation of Australia Staff Superannuation Pty Ltd*[65] – the trial judge left open the question whether awareness was objective (in that the assured had to be actually aware of the facts and objectively aware that the facts were capable of giving rise to a claim) or subjective (in that the assured had to be actually aware of the facts and also that the facts were capable of giving rise to a claim), because in his view both tests were satisfied. The appellate court preferred the view that the test was objective,[66] so that a notification was valid even if the assured was not actually aware of the type of claim that might flow from the facts known to him. The Court pointed out that indemnity flowed from a "wrongful act", but it could not be predicted at the outset exactly what sort of claim might be made in respect of it. (3) The knowledge must be of an individual whose status is sufficient to justify a finding that the knowledge is imputed to the organisation as a whole. The knowledge of one director may not be the knowledge of the company itself, and thus not the knowledge of the other directors. Further, if the knowledge is that of a director who has himself defrauded the company, there is an argument that the knowledge is not to be imputed to the company.[67] (4) There may be a time limit, requiring notification to be given as soon as (reasonably) practicable as well as within the policy period or within a fixed number of days thereafter.

Thirdly, the notification must relate to "circumstances". A circumstance is a matter which may give rise to a loss or claim against the assured and is one which, objectively evaluated, creates a reasonable and appreciable possibility that it will give rise to a loss or claim against the assured. In *Rothschild v Collyear* Rix J felt that a notification from a regulator to the assured requiring it to investigate potential misselling was a circumstance capable of

62 [2003] HKEC 959.

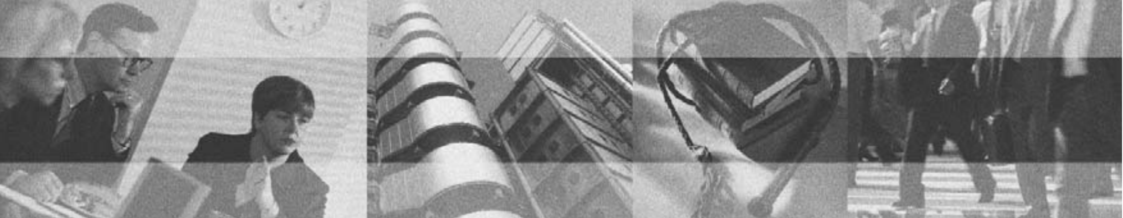
63 *Aspen Insurance UK Ltd v Pectel Ltd* [2008] EWHC 2804 (Comm); *Laker Vent Engineering Ltd v Templeton Insurance Ltd* [2009] EWCA Civ 62.

64 [2008] FCAFC 173.

65 2006 FCA 2.

66 Although it agreed with the trial judge that subjective knowledge had been demonstrated on the facts.

67 Based on *Re Hampshire Land Co* [1896] 2 Ch 743. There is an unresolved issue as to whether the knowledge of a fraudulent director which is withheld from the company falls within the *Hampshire Land* principle. This was held to be the case by Rix J in *Arab Bank v Zurich Insurance Co* [1999] Lloyd's Rep IR 262, but the fate of that case is uncertain after *Stone & Rolls v Moore Stephens*.



notification. However, the same judge expressed the view in *Kidsons* that doubts that an assured may have as to the legality of its conduct could not amount to a notifiable circumstance (although the parties conceded the point so it did not arise for decision).

Finally, there has to be a causal link between the circumstances and the possibility of a claim. As seen above, various formulations may be used. The phrase "likely to give rise to a claim" means more likely than not.[68] "May" is plainly wider.

Failure to notify

Australian law has been bedevilled by the problem of late notification under liability policies. The effect of an assured's failure to notify circumstances or a claim within the period allowed by the policy is governed by the complex interplay between ss 40 and 54 of the Insurance Contracts Act 1984. It has already been commented that s 40 implies a right to notify circumstances and thereby to bring future claims arising from those circumstances back into the policy year, although in the vast majority of cases there is a contractual right to that effect and s 40 need not be relied upon. Section 54 is concerned generally with failure by the assured to comply with his obligations, and removes the right of the insurers to refuse to pay a claim in appropriate circumstances. Paraphrased, s 54 provides that if the insurer has the right to refuse to pay some or all of a claim by reason of an act or omission[69] of the assured or some other person, being an act or omission after the contract was entered into, the insurer cannot refuse to pay the claim by reason only of that act or omission although his liability is to be reduced by an amount representing the prejudice suffered by the insurer (s 54(1)). The principle is disapplied where the assured's act or omission could reasonably be regarded as being capable of causing or contributing to the insured loss (s 54(2)), so that s 54(1) is confined to the case in which his act or omission is quite distinct from the loss. In the case of an act or omission which is capable of causing a loss, the assured is entitled to recover if he can prove that no part of the loss giving rise to the claim was caused by his act or omission (s 54(3)), and if the assured can prove that some part of the loss giving rise to the claim was not caused by his act or omission, the insurer may not refuse to pay the claim to that extent. Because s 54 is concerned with all policies, including first party covers, and not just liability policies, its proper interpretation would appear to be that the losses and claims referred to are the assured's losses and claims, not those of the third party. That would mean that s 54(1) cannot be applied to late notification, because lateness may well affect the assured's loss in that the insurers may be deprived of full opportunity to investigate the circumstances and mount a proper defence. The cases nevertheless proceed on the basis that s 54(1) is the relevant provision, although in practical terms the same outcome is achieved by applying either s 54(1) or 54(3). The case law on ss 40 and 54 is not easy to reconcile, but in general the following propositions may be put forward.

First, if there is nothing in the policy which permits the assured to notify circumstances of

68 *Sinclair Harder O'Malley Ltd v National Insurance Co of New Zealand* [1992] 2 NZL.R 706: *Layher Ltd v Lowe* [2000] Lloyd's Rep IR 510; *Jacobs v Coster* [2000] Lloyd's Rep IR 506; *Laker Vent Engineering Ltd v Templeton Insurance Ltd* [2009] EWCA Civ 62 (a legal expenses case, but the issues are much the same)

69 S 54(6).

which he becomes aware during the policy period and which may give rise to a claim, then s 40 fills the gap and requires notification as soon as reasonably practicable, whether the notice is given inside or after the expiry of cover. If the assured fails to comply with the time limits, then he cannot seek to rely upon s 54 to excuse him: it is simply the case that he has failed to take advantage of a statutory concession.[70]

Secondly, if the policy – as it almost always will in D&O cases – expressly permits notification of circumstances as a trigger for liability, then the assured's failure to notify timeously, or indeed within the policy period itself, is capable of being excused under s 54(1) to the extent that there is no prejudice to the insurers.[71] The High Court decision in *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd*[72] thus confirms that an omission for the purposes of s 54 includes a failure by the assured to exercise a right, choice or liberty which he enjoys under a contract of insurance, and is not restricted to obligations.

Thirdly, if a claim is made against the assured but he fails to notify it within the time permitted by the policy, ie, as soon as reasonably practicable but in any event within the policy (or extended) period, there is an omission which falls within s 54(1) and it may be excused to the extent that it has not caused prejudice.[73] The effect is that a claim could potentially be notified to the insurers years after it has been made against the assured. Section 54 does not, however, assist an assured against whom a claim has been made during the policy period but he has not become aware of it: plainly he cannot notify such a claim, and the third party is not to be regarded, for the purposes of s 54(1), as "some other person" whose default – failure to notify the assured – can be excused.[74]

The second and third propositions are plainly highly contentious. As to the second, the essence of the right to notify circumstances is to bring any future claim back into the year of notification. It plainly makes little sense for an assured who has become aware of circumstances in year 1, to be allowed to notify them in year 2 when a claim has been made arising out of them, as the effect is to treat what is properly a year 2 claim as one deemed to have been made in year 1 while depriving the year 1 insurers of their immediate right to investigate what has happened. The third proposition is plainly contrary to the notion of a claims made and notified cover, and in essence treats it as a claims made cover.[75]

The problem of claims made and notified policies was reviewed by the Australian Law

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70 *Gosford City Council v GIO General Ltd* (2003) 56 NSWLR 542.

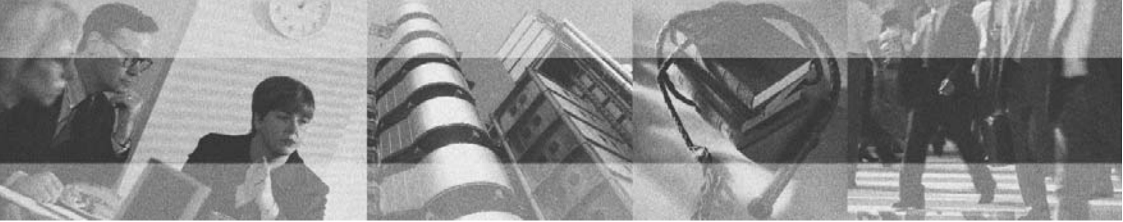
71 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) CLR 641, overruling *FAI General Insurance Co Ltd v Perry* (1993) 30 NSWLR 89 and also the reasoning in *Greentree v FAI General Insurance Co Ltd* (1998) 158 ALR 592 and *Permanent Trustee v FAI General Insurance Co Ltd* (1998) 44 NSWLR 186. See also *CGU Insurance Ltd v Corrections Corporation of Australia Staff Superannuation Pty Ltd* [2008] FCAFC 173.

72 [2001] HCA 38.

73 *East End Real Estate Pty Ltd v C E Heath Casualty & General Insurance Ltd* (1992) 25 NSWLR 400.

74 *Greentree v FAI General Insurance Co Ltd* (1998) 158 ALR 592; *Gosford City Council v GIO General Ltd* [2003] NSWCA 34.

75 For criticism of the law, see: Schoombee "Antico's Case and Other Recent Decisions on Notification of Claims and Circumstances: Sections 54 and 40 of the Insurance Contracts Act' (1997) 8 Ins LJ 167; Mead "The Effect of Section 54 of the Insurance Contracts Act 1984 and Proposals for Reform' (1997) 9 Ins LJ 1; J Clarke "After the Dust Settles on Antico: FIA v Perry Lives" (1997) 9 Ins LJ 29; Sutton "The High Court Widens the "Reach" of the Insurance Contracts Act" (1998) 26 Australian Business Law Review 57; Masel "Taking Liberties with Claims Made Policies" (2000) 11(2) Ins LJ 104.



Reform Commission in its investigation into marine insurance, ALRC 91, (2001)[76] but such policies are not found in the marine context –

cover is generally based on occurrences – and no action was recommended. However, a report published in 2003 following an investigation instigated by the Treasury[77] recommended changes to the law. The Report reflected the consensus amongst respondents that s 54 should not be used to condone, after the expiry of the policy period, notification of circumstances potentially leading to a claim. However, the Report did not take the further step of recommending any restriction on the use of s 54 to justify notification of actual claims outside the year of the policy, on the basis that the industry had accepted the position and was not unduly prejudiced by it. The proposals found their way into a draft Insurance Contracts Amendment Bill 2007, which remains unimplemented. Under the Bill, s 40 would be amended so that an assured who, during the policy year, became aware of circumstances that might give rise to a claim, is not debarred from relying on s 40 if he gives notice to the insurer as soon as reasonably practicable after becoming aware of the facts and in any event no later than 45 days following the expiry of the insurance. A new s 54A removes the right to seek relief under s 54 for late notification of circumstances.

Waiver of policy obligations

A question discussed recently by both the English and Australian courts, albeit with them providing different answers, is whether compliance with notification obligations is to be treated as waived where insurers have indicated that they intend to rely upon a policy defence in the event that a claim is made. In *CGU Insurance Ltd v AMP Financial Planning Pty Ltd*[78] the High Court reached the conclusion that a direction to the assured to act as a "prudent uninsured" operated to waive insurers' procedural rights to insist upon a claim in accordance with policy terms, although[79] the insurers retained their ultimate right to assert that the policy by its terms did not provide coverage. The English view is that an insurer who informs the assured that a claim will not be met does not thereby waive compliance with claims provisions.[80] A particularly strong case is *Lexington Insurance Co v Multinacional de Seguros SA*,[81] in which reinsurers asserted a breach of a claims co-operation clause, leading the reinsured to withdraw co-operation and to settle, only to find the reinsurers ultimately (and successfully) relying on the withdrawal of co-operation as a valid defence.

CLAIMS DEVELOPMENT

Once a claim has been made and notified, or circumstances have been notified, so that policy coverage is triggered, there arises a tricky question of claims development. This can manifest

76 Paras 9.81-9.111.

77 There were two Treasury reports, the first on s 54 and the second on the Insurance Contracts Act 1984 (Cth) generally.

78 [2007] HCA 36.

79 Kirby J dissenting.

80 *Diab v Regent Insurance* [2006] 1 Lloyd's Rep IR 779; Cf the view in New Jersey: *Popovitch & Popovitch, LLC v Evanston Insurance Co* 2009 BL 174676 (DNJ, 17 August 2009), which holds that an assured is not discharged from adhering to claims notification clauses even though insurers have indicated that they intend to rely on a policy exception (prior occurrences).

81 [2009] Lloyd's Rep IR 1.

itself in two ways. First, what has been notified is a single transaction but, subsequently, other equivalent transactions come to light: are they to be treated as part of the original notification? Secondly, what has been notified may prove to have been the tip of an iceberg, so that all manner of other claims arise from the notification. It is essential for notifications to be accurate. If an assured notifies too little, he may be caught by the following typical clause under which the insurers deny liability for:

(1) facts alleged or the same or related Wrongful Act(s) alleged or contained in any Claim which has been [or could have been] reported or in any circumstances of which notice has been or could have been given under any earlier policy,[82] or

(2) any pending or prior civil, criminal, administrative or regulatory proceeding, investigation, arbitration or adjudication of which an Insured had notice ...., or alleging or deriving from the same or essentially the same facts as alleged in such actions.

So, in essence, if the assured has notified claims or circumstances under one policy year, then they will be excluded from coverage under a later policy year. A robust general notification encompassing the known and the unknown (the "hornet's nest") will probably be an invalid notification of circumstances under the earlier policy, but it will nevertheless have been a notification and thus excluded from the later year in which this wording operates. Equally, if the assured could have notified under an earlier policy year but failed to do so, he is again caught: there is no liability under the earlier policy because of lack of notification, and the later policy will not respond because there could have been notification under the earlier policy. There is less of a problem for the assured[83] where the same insurer is on risk for consecutive periods, as it is common to find a "continuation" clause of the following type.

This applies where:

> the claim or circumstance could have been notified in an earlier policy year, as long as the same insurer is on risk and the failure to notify was not fraudulent,[84] and in such a case the cover is that under the earlier policy.

Some policies go on to deal with the problem of the scope of a notification. Three illustrations suffice.

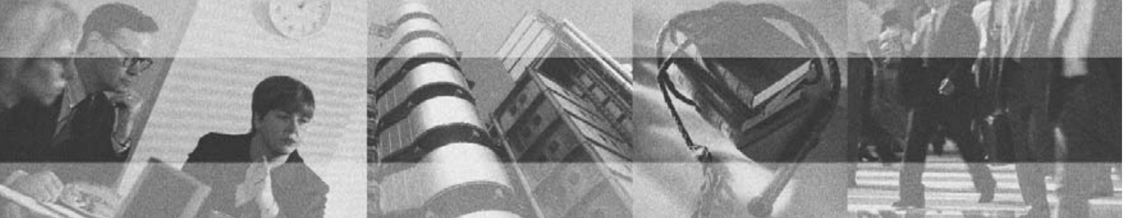
> If a Claim or circumstance is notified under this policy, then any subsequent Claim, alleging, arising out of, based upon or attributable to the facts or Wrongful Act alleged in that Claim, or described in that circumstance, shall be deemed to have first been made at the same time as that Claim was first made or that circumstance notified, and notified to the Insurer on the date the notices were first provided.[85]

82 In *CGU Insurance Ltd v Porthouse* 2008 HCA 30 an objective test was applied to the question of whether the assured was aware of outstanding claims. The test is whether a reasonable person in the assured's professional position, and disregarding personal idiosyncracies, would have thought that the matter might result in a claim covered by the policy.

83 What reinsurers would say about this is another matter.

84 A limitation which does not appear in all policies.

85 AIG.



> All related claims are a single claim.[86]
>
> Two or more claims arising out of a wrongful act or a series of related wrongful acts will be treated as a single claim. All such claims will be treated as having been made when the first claim was made.[87]

The function of these provisions is primarily aggregation, a matter considered below, but they also serve to define what happens when a claim develops. The clauses operate differently. The first one is concerned with additional claims arising out of notified facts. The second lumps together related claims. The third appears to do both. The key word is "related", on which there is no real authority.

The cases are of some assistance, although they deal with a limited number of points. Where a claim form has been served, and that fact is notified to the insurers, all of the specific claims subsequently made under it are treated as having been validly notified.[88] Where a single claim is notified, and it is subsequently discovered that the events giving rise to a claim had been replicated many times over, later claims may be treated as forming a part of the original notification.[89]

The same issue arises in respect of circumstances. The principle, as set out by Gloster J in *Kidsons*, is as follows:

> "At the end of the day, it is ... largely a question of interpretation and analysis of the document setting out the notification, in the context of the facts known to the assured, as to what precise circumstance or set of circumstances has in fact been notified to insurers. I am not therefore convinced that semantic cavilling over the precise formulation of the test assists the ultimate resolution of the problem. There may well be uncertainty at the time of notification as to what the precise problems or potential problems are; there well may be, whether known, or unknown, to the assured a 'hornets' nest which may give rise to numerous types of claims of presently unknown quantum and character at the date of the notification. Whilst in principle, there is no reason why such a state of affairs should not be notified as a circumstance if the assured is aware of it, in each case the extent and ambit of the notification and the claims that are covered by such notification will depend on the particular facts and terms of the notification."

Thus, notification of circumstances relating to flooding of walkways on a building was held not to encompass findings in later years that the entire building was unstable,[90] although notification that a tax avoidance scheme had run into problems did not affect other schemes operated by the same assured.[91]

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86 Chubb.

87 Ace.

88 *Thorman v New Hampshire Insurance Co Ltd* [1988] 1 Lloyd's Rep 7.

89 *Hamptons Residential Ltd v Field* [1998] 2 Lloyd's Rep 248.

90 *Kajima UK Engineering Ltd v Underwriter Insurance Co Ltd* [2008] Lloyd's Rep IR 391.

91 *Kidsons*.

Subsequent co-operation

Following notification, the policy normally imposes a variety of co-operation obligations on the assured. There is generally a policy obligation on the assured not to admit liability to any third party. There is Hong Kong authority for the proposition that a duty not to admit liability does not include a guilty plea in criminal proceedings.[92]

AGGREGATION

Significance of aggregation clauses

Aggregation clauses have three functions in a D&O policy. First, where the policy has aggregate limits for all losses or claims arising out of a particular set of circumstances, it is essential to be able to define exactly how many sets of circumstances there are so that the number of aggregate limits payable by the insurers can be determined. Secondly, at the other end of the scale, there may be a per claim or per event deductible borne by the assured, so again it is necessary to define the number of deductibles involved. Thirdly, and as noted above, given that the insurers are liable only for claims notified within the policy period, it becomes crucial to determine exactly what a "claim" actually is, and how many different causes of action can be treated as amounting to a single claim. This section is concerned only with aggregation for the purposes of deductibles and aggregate limits.

Representative wordings

Australian policies define these matters by reference to the number of claims. The following clauses are representative of what is out there.

(1) Any Claim arising out of, based upon or attributable to (i) the same or similar originating cause or Wrongful Act (defined as "any actual or alleged, act, error or omission, breach of duty, breach of trust, misstatement, misleading statement or breach of warranty of authority," (ii) a single Wrongful Act, (iii) one matter or transaction, or a number of matters or transactions involving the same or similar underlying source, (iv) a series of continuous, repeated, related or connected Wrongful Acts, or (v) the same or similar originating causes or Wrongful Acts involving a number of matters or transactions; whether or not committed by more than one Insured Person and whether directed to or affecting one or more person or entity; shall be considered a single Claim for the purposes of this policy.[93]

(2) All causally connected or interrelated or continuous or repeated Wrongful Acts, whether committed by a director individually or one or more director and whether directed to or affecting one, or more than one, entity shall jointly constitute a single wrongful act. Where a single wrongful act gives rise to more than one claim, all such claims shall jointly constitute one claim under the policy, and only one excess shall apply.[94]

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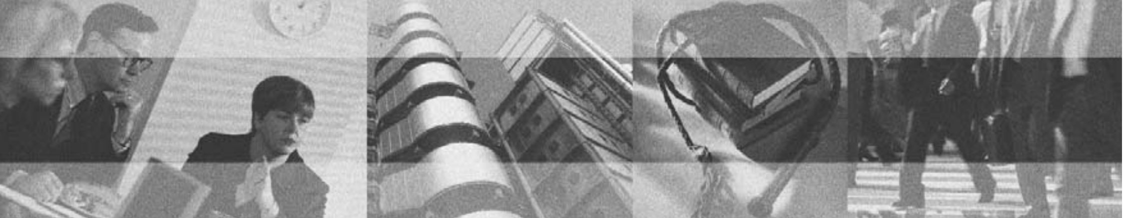
92 *Harbourfield Engineering Co Ltd v Falcon Insurance Co (Hong Kong) Ltd* [2003] HKEC 959. The court was of the view that if the relevant clause had precluded a guilty plea in criminal proceedings then it would have been void as contrary to public policy.

93 AIG.

94 QBE.



(3) Any number of claims which arise out of or are attributable to or connected in any way with a single wrongful act or the same conduct, or a series of the same, related, interconnected or continuous wrongful acts or conduct shall constitute a single claim.[95]

(4) Two or more claims arising out of a wrongful act or a series of related wrongful acts will be treated as a single claim.[96]

(5) All related claims shall be regarded as a single claim.[97]

Thus, where there is a "per claim" deductible, or a "per claim" aggregate of loss, it is necessary to define exactly what the claim may be. As can be seen from the above clauses, which are listed in ascending order of complexity but not necessarily breadth, the search is not straightforward.

Clause (5) requires claims to be "related". This term can mean a number of things: the claims arise out of the same act; the claims arise out of identical acts performed on a number of different occasions; the claims arise out of similar acts performed on a number of different occasions; the claims all have a common cause. A further range of possibilities can be added once it is appreciated that a number of different directors may be implicated: how does the clause work if two or more directors misbehave in similar fashion on different occasions and towards different victims?

The remaining clauses all refer to a "wrongful act", generally defined in the policy (and in (1) above, in the clause itself) as something akin to the wording itself, ie, "any actual or alleged, act, error or omission, breach of duty, breach of trust, misstatement, misleading statement or breach of warranty of authority." So at least it is clear that as a starting point the claims must arise from what may be thought of in generic terms as a specific incident.

Clause (4) then expands the notion by looking at a series of related specific incidents, thereby taking us back to the conundrum raised by clause (5) as to the meaning of related. So, in reality, clauses (4) and (5) require the same analysis.

Clause (3) is even more general. Claims may be aggregated if they "arise out of or are attributable to or connected in any way with a single wrongful act", so that causation is dispensed with and we are concerned with a loose relationship to the wrongful act. Thus far the clause could be saying no more than that the claims must be related, as per clauses (4) and (5). However, clause (3) then elaborates that claims may be aggregated if they "arise out of or are attributable to or connected in any way with ... the same conduct". Plainly "conduct" cannot be the same as a "wrongful act" or it would not be there. Conduct implies, in the ordinary sense of the word, something more than a single isolated act, so this wording is indicating that claims may be aggregated if they bear a loose connection with the assured's conduct, very broad wording indeed. Not content with that, the clause goes on to say that claims may be aggregated if they "arise out of or are attributable to or connected in any way with ... the same conduct, or a series of the same, related, interconnected or continuous

95 Allianz.
96 Ace.
97 Chubb.

wrongful acts or conduct ..." So the clause now provides for aggregation if the claims are loosely connected to a series of individual acts which are related, interconnected or continuous, or if the claims are loosely connected to different courses of conduct which are related, interconnected or continuous. As with clauses (4) and (5), the possibility that there may be different actors is not expressly countenanced. That said, it is difficult to think of anything which would not be aggregated by these words.

Clause (2), a deductible clause, is the first of the group to deal expressly with the possibility of different actors and different victims. Claims are to be aggregated if the wrongful acts giving rise to them are "causally connected or interrelated or continuous or repeated" and irrespective of the number of directors and entities affected. There is no reference to "conduct" in this clause, so it more closely resembles (4) and (5) than (3).

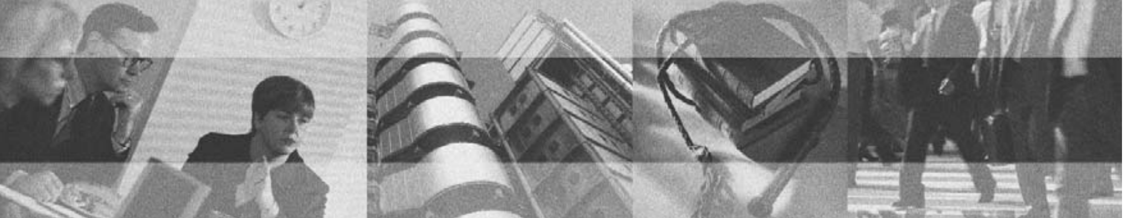
Clause (1) is awe-inspiring. Breaking it down into its constituent parts is something of a challenge, but it provides for aggregation of claims arising out of or based on or attributable to (ie, loosely connected with): the same originating cause; a similar originating cause; a single wrongful act; one or more matters or transactions involving the same underlying source; one or more matters or transactions involving a similar underlying source; a series of continuous, repeated, related or connected wrongful acts; the same wrongful acts involving a number of matters or transactions, whether or not committed by more than one director and whether directed to or affecting one or more person or entity; similar wrongful acts involving a number of matters or transactions, whether or not committed by more than one director and whether directed to or affecting one or more person or entity; the same originating causes involving a number of matters or transactions whether or not committed by more than one director and whether directed to or affecting one or more person or entity; and similar originating causes involving a number of matters or transactions, whether or not committed by more than one director and whether directed to or affecting one or more person or entity. The draftsman could have saved on several gallons of black coffee and midnight oil by simply saying, "everything". Regrettably, draftsmen, like lawyers, often assume that they are paid by the word.

What is remarkable about these clauses is how they play fast and loose with different concepts: causation is out of the window; courses of conduct and wrongful acts are treated as interchangeable; phrases which have never been judicially defined ("source") are introduced as if they were meaningful. So how are these wordings to be interpreted?

Approaches to interpretation

The precise wordings which are used in these cases have not been reviewed judicially, even though there is a growing jurisprudence on the meaning of aggregating terms. A number of points may be made initially.

First, there are numerous concepts that can be used to establish aggregation. These include 'event', 'accident', 'happening', 'occurrence' 'cause' and 'source'. Although there is authority on the meaning of some of these terms, it would be wrong to assume that a single word bears a consistent meaning across all policies or even within the same policy, as there has been a tendency by those drafting insurance policies to use the different words



interchangeably and the same word in different ways. This leads to the unfortunate possibility that the same word may bear different meanings in the same policy:[98] as noted earlier, the term "claim" is a particular victim of this problem. As with all contracts, context is all.

Secondly, because aggregation affects both the maximum sum insured and the deductible, different definitions may be found of the same term in the same policy.[99]

Thirdly, although the wordings are frequently ambiguous, it is generally impossible to adopt a *contra proferentem* approach to interpretation. This is because, where the same terminology is used for both deductible and policy limits provisions, it is impossible to say on which side of the argument the assured and the insurers might be in any one case. In general terms, an assured who has suffered a series of small losses will wish to argue that there is only one claim so that he bears only one deductible. By contrast, if there are major claims against the assured giving rise to aggregate losses well in excess of policy limits, the more claims there are the better as far as the assured is concerned. What is needed, therefore, is a consistent approach to interpretation which confers settled meanings on standard wordings.

The authorities on aggregation

The cases are numerous and range over a variety of forms of policy, including product liability, public liability and professional indemnity. There is nevertheless a basic distinction to be drawn between the "what" and the "why".[100] The "what" is generally expressed in the interchangeable terms "event" and "occurrence", words which refer to something which has happened at a particular time, at a particular place and in a particular way,[101] somewhat akin to a "wrongful act". The "why" is the underlying state of affairs which has set the stage for individual claims, often expressed as the "cause" or "originating cause": the latter phrase is much wider:[102]

> "A cause ... is something altogether less constricted. It can be a continuing state of affairs; it can be the absence of something happening. Equally, the word "originating" ... opens up the widest possible search for a unifying factor in the history of the losses which it is sought to aggregate."

The distinction between "event/occurrence" and "originating cause" can be illustrated in a series of cases. If there is a series of identical acts of theft or fraud then each of those acts is an event even if carried out by the same person,[103] although individual losses arising from a series of such acts may be aggregated so as to amount to an originating cause.[104] Where an underwriter has, euphemistically, a "blind spot" and writes a series of negligent contracts which cause losses to investors in the underwriter's syndicate, the blind spot is the

98 See *Midland Mainline Ltd v Commercial Union Assurance Co Ltd* [2004] Lloyd's Rep IR 22.

99 *Countrywide Assured Group plc v Marshall* [2003] Lloyd's Rep IR 195.

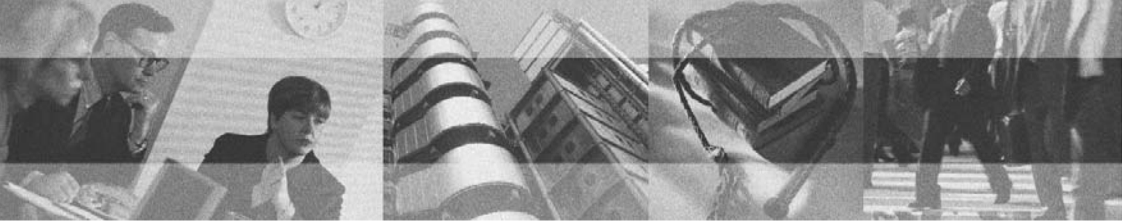
100 The memorable distinction in *Countrywide Assured Group plc v Marshall*[2003] Lloyd's Rep IR 195

101 *Axa Reinsurance (UK) plc v Field* [1996] 3 All ER 517.

102 *Axa Reinsurance (UK) plc v Field* [1996] 3 All ER 517.

103 *Philadelphia National Bank v Poole* [1938] 2 All ER 199; *Equitable Trust Co of New York v Whittaker* (1923) 17 Ll LR 153; *Pennsylvania Co for Insurance on Lives and Granting Annuities v Mumford* [1920] 2 KB 537.

104 *Municipal Mutual Insurance Ltd v Sea Insurance Ltd* [1998] Lloyd's Rep IR 421.



originating cause[105] whereas each negligently written contract entered into by him is an event.[106] Thus the focus of "event" is an individual loss rather than the conduct which has led to that loss, whether that conduct is general negligence in manufacture[107] or decision-making.[108]

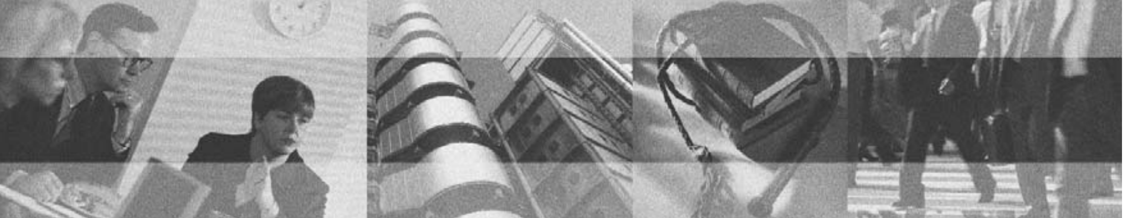
"Claims" cases

Clearly of most significance for the present discussion are cases involving clauses of a similar nature to those found in the D&O policies set out above. Where claims are defined in terms of originating causes or events, the distinction between the two concepts is paramount. In *Countrywide Assured Group plc v Marshall* the definition of "claim" as being "one occurrence or all occurrences of a series consequent upon or attributable to one source or original cause" was held to mean that the assured's general failure to provide training to its employees was the originating cause and thus the claim, so that all individual claims against the assured could be aggregated. The usual meaning of "originating cause" prevailed. A useful distinction is *Forney v Dominion Insurance Ltd*,[109] a case concerning a professional indemnity policy, taken out by a firm of solicitors, which imposed a cap on liability as follows: "(a) in respect of any one claim or number of claims arising out of the same occurrence – £3,000; (b) in respect of all claims under this policy – £15,000." The firm, in handling a personal injury motor case for the victim, failed commence proceedings within the limitation period, thereby preventing recovery by three individuals, and committed another act of negligence which precluded any recovery by the administratrix. The court held that the ensuing four claims arose from two occurrences, ie, the acts of negligence, and not the single propensity to act negligently.

In some bespoke policies there may be limitations imposed on the term "claim". In *Standard Life Assurance Ltd v Oak Dedicated Ltd*,[110] a financial products mis-selling liability policy, the deductible clause imposed an "each and every claim and/or claimant" deductible of £25 million. This wording, while unique, was held to mean what it said, so that there was a per claimant deductible, leading the assured to rue the fact that no one claimant was ever likely to recover more than £10,000. It is to be hoped that the brokers who had arranged this cover had made a better fist of their own professional indemnity cover.

By contrast, if the term "claim" is not defined in accordance with established terms such as cause and event, or indeed is not defined at all, then there are two issues to be resolved. The first is whether the "claim" is by or against the assured. The second is analysing what has actually been claimed. In general terms, unless the wording provides otherwise, the claim against the assured is what has to be considered. In analysing the claim, its true nature has to be ascertained.[111] In *Mabey & Johnson Ltd v Ecclesiastical*

105 *Cox v Bankside Members Agency Ltd* [1995] 2 Lloyd's Rep 43.
106 [1995] LRLR 433.
107 *Seele Austria GmbH & Co KG v Tokio Marine Europe Insurance Ltd* [2008] EWCA Civ 441.
108 *Midland Mainline Ltd v Commercial Union Assurance Co Ltd* [2004] Lloyd's Rep IR 22.
109 [1969] 3 All ER 831.
110 [2008] EWHC 222 (Comm).
111 Copious citation of authority on this point was given above.



Insurance Office plc (No 2)[112] the claimant assured designed and built bridges in various parts of the world. The assured's claims made policy had a limit of indemnity of "£2,000,000 for a Single Claim" but with a per claim deductible of £100,000. A bridge constructed by the assured in Ethiopia partially collapsed in September 1996. Unfortunately, the same design had been used for a number of bridges supplied and to be supplied to the Government of Ghana. Three bridges were to be supplied under an initial contract, Ghana I, and a further three were to be supplied under an extension to the contract, Ghana II. At the time of the September 1996 collapse three bridges had been supplied in Ghana, all of which had to be replaced, and three more were under construction, all of which required modification. The cost of the repair work exceeded the per claim limit of indemnity, and the assured thus claimed that there were two separate claims, one under the Ghana I contract and a further claim under the Ghana II contract. The insurers' argument was that there was in reality only one claim, in that Ghana II was no more than an extension of Ghana I, so that there was only one contract. Applying the principle that what mattered was not the classification of the claim by the third party but rather the true nature of the claim when the underlying facts were examined, Morison J held that any action by the Government of Ghana against the assured would have involved two quite distinct contracts, one under Ghana I and one under Ghana II, so that there were two claims.

The case that has given rise to the most discussion is *Lloyds TSB General Insurance Holdings v Lloyds Bank Insurance Co Ltd*.[113] The claimants were companies which had provided personal pension plans to members of the public. The claimants were under a regulatory obligation to ensure that their representatives complied with a Code of Conduct, itself demanding that representatives gave 'best advice' to investors following a 'fact find'. The claimants employed Financial Services Consultants (FSCs), whose job was to sell personal pensions in place of occupational pensions. A large number of claims were made against the claimants by investors, based on allegations that FSCs had failed to give them 'best advice'. Most claims did not exceed £15,000, but there were a large number of them and the total amount was substantial. The assured's liability policy provided that the underwriters were liable for that part of each and every third party claim during the policy period which exceeded the deductible (which was £1 million for some claimants and £2 million for others). The Deductible Clause provided that:

> "The Deductible shall apply to each and every third party claim and shall be subject to no aggregate limitation.
>
> If a series of third party claims shall result from any single act or omission (or a related series of acts or omissions) then, irrespective of the total number of claims, all such third party claims shall be considered to be a single third party claim for the purposes of the application of the Deductible."

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112 [2003] Lloyd's Rep IR 724.

113 [2001] Lloyd's Rep IR 236 (Moore-Bick J), reversed in part [2002] Lloyd's Rep IR 113 (CA), reversed [2003] Lloyd's Rep IR 623 (HL).

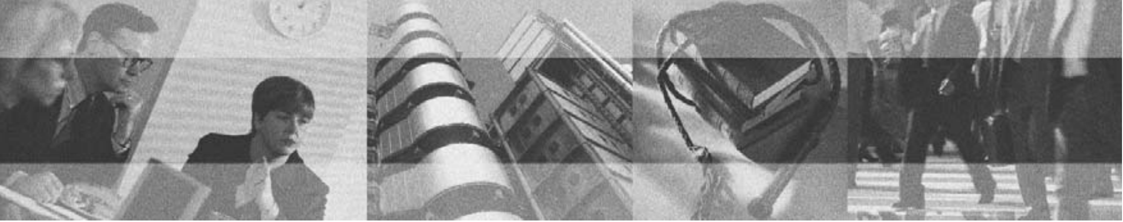
The assured submitted that the third party claims were a series of claims which all resulted from a single act or omission, namely, a failure on the part of management properly to train the FSCs so as to enable them to give investors 'best advice', so that only one deductible was to be borne. The insurers accepted that the failure of the FSCs to give proper advice was the result of management failure, and that the claims by investors could be a 'series of claims', but argued that the failure on the part of the FSC in each case was the cause of each claim so that, although there was a series of claims, those claims were not caused by a single act or omission on the part of the management. Accordingly, the deductible applied to each individual claim. The preliminary issue, in each case, was whether the third party claims were to be regarded as a single third party claim for the purposes of determining the number of deductibles to be borne. Moore-Bick J held that the claims resulted from a single act or omission of one of the claimants' officers or employees, or from a related series of acts or omissions of two or more of the claimants' officers or employees, and were therefore to be considered a single third party claim subject to a single deductible. This was so for a number of reasons.

(1) The phrase 'result from', in the Deductible Clause, posed the question whether the series of claims was the result of an act or omission, and did not require any causation inquiry as was the case in the insuring clause: the Deductible Clause, by contrast, contemplated that a unifying factor could unite a related series of acts or omissions. Here, all of the third party claims resulted from management failure in the provision of training, and it was irrelevant whether that failure was to be regarded as a single act or omission on the part of the assured or a related series of acts of omissions on the part of those engaged in the management of the business as, in either case, the insured was entitled to aggregate the claims for the purposes of the deductible.

(2) Even if this was wrong and a causation element had been imported into the Deductible Clause, management failure was the dominant cause of the losses, as they were the inevitable consequence of that failure.

(3) The words 'or a related series of [negligent] acts or omissions' in the Deductible Clauses were intended to extend the range of unifying factors beyond a single act or omission, providing that the acts or omissions were connected. Thus, even if there was a causation test, the claimants would still be entitled to aggregate third party claims on the basis that the policy covered a series of acts or omissions which were directly attributable to a single underlying cause of a kind itself within the scope of the cover provided by the policy.

Moore-Bick J's decision was upheld in the Court of Appeal, but only on point (3). The Court of Appeal ruled that the words "shall result from" clearly required the application of the proximate cause doctrine, and that it was necessary to read the deductible clause with the insuring clause. The insuring clause covered claims against the claimants, ie, individual claims by third party investors who had suffered losses. If that was the meaning of "claim" in that clause, then it was also the meaning of "claim" in the deductible clause. While it was arguable that management failure was a potent cause it its own right, it did not constitute the act or omission contemplated by the insuring clause: as the Court of Appeal pointed out, the duties of the assured to monitor and ensure the competence of their salesmen were no



more than regulatory duties which could not give rise to duties directly enforceable by action by a member of the public. As regards Moore-Bick J's point (3), the Court of Appeal agreed with his interpretation of the phrase in parentheses, "(related series of acts or omissions)". It was clear that a series of acts or omissions could be related by reason of having a single underlying cause or common origin. While it was not necessary that such underlying cause or common origin should itself be an act or omission as described in the insuring clause, this was a case where that cause or origin consisted of a failure to institute a system of training, supervision and monitoring of the very type which was required by the regulator. The word "related" was wholly apt to apply to a series of acts or omissions which were of an identical or very similar nature and which shared a common causal origin of that kind. Indeed, the Court of Appeal could find no other sensible meaning for the phrase, despite the suggestion that it might be referring to an individual loss caused by a number of contributory acts and omissions.

The appeal to the House of Lords by the insurers was successful. The House of Lords agreed with the Court of Appeal's view that the insuring clause and the deductible clause were to be read together. The insuring clause covered claims against the assured which were proximately caused by the assured's defaults, and in the same way the deductible clause aggregated those defaults which proximately caused loss to third parties. As it was the case that a default could amount to the proximate cause of a third party claim only if it was capable of giving rise to liability, it followed that management failure in training, and even breaches of the regulatory legislation were not of themselves aggregating events: what was required was something which proximately caused a loss, and accordingly the deductible was applicable to each individual claim made against the assured. Their Lordships were satisfied that, as a matter of the construction of the policy, the intention had been to exclude small losses, and it was for that reason that the deductible level had been set at £1 million. It will be noted that this conclusion matches the approach taken to defining "events" and "occurrences". It is apparent from the facts that management failure and breaches of statutory duty would not have qualified as an "event" or an "occurrence" but rather amounted to a "state of affairs". The House of Lords did, however, overturn the Court of Appeal on the construction to be given to the bracketed phrase "(or related series of acts or omissions)". Their Lordships were satisfied that this phrase was intended to be purely subsidiary to the main aggregating phrase "any single act or omission" and was not intended to lay down an entirely separate and wider basis for aggregation. The bracketed phrase was thus to be given merely an explanatory role, making it clear that where various defaults by one or more FSCs had given rise to a single loss, those defaults were to be treated as giving rise to a single third party claim. Their Lordships accepted that this was an unlikely scenario, and that in all probability the phrase would never actually have any effect.

DEFENCE COSTS

Nature of defence costs clauses

Insurers will provide or, in the alternative, fund, a director's defence where the claim against the director falls within the coverage of the policy.[114] The insurers typically agree either to conduct the defence or, if not, to indemnify the director against costs which may be or have been incurred in respect of the defence of claims against him. Some policies specify that a claim includes one made in civil, criminal and administrative proceedings , although if the policy is silent on the point the word "claim" is likely to be construed as covering all of these matters.[115] Australian market policies typically cover the following matters:

(a) defence costs – reasonable fees, costs and expenses incurred for the principal purpose of representing the assured

(b) investigation costs

(c) extradition costs

(d) bail bond and civil bond premiums

(e) prosecution costs, and asset and liberty expenses, ie, disqualification and confiscation proceedings

(f) public relations expenses

(g) travel costs.

The assured's overheads, such as staff time and resources, are irrecoverable.

Such costs may form a part of the overall limit of indemnity[116] or they may have their own limit of indemnity above and beyond the substantive cover. Where defence costs are treated separately in the policy, deductibles which apply to the policy itself will not extend to defence costs unless otherwise stated.[117] Separate causes of action against the insurers are vested in the assured in relation to the insuring clause and in relation to defence costs.[118]

A defence costs clause is triggered by the making of a claim against the assured within the policy period: insurers are not liable for costs incurred by the assured in anticipation of a claim[119] unless the assured has notified circumstances which may give rise to a claim and the wording permits such notification to be the trigger for costs coverage. Unless otherwise

114 *A & D Douglas Pty Ltd v Lawyers Private Mortgages Pty Ltd* 2006 FCA 691.

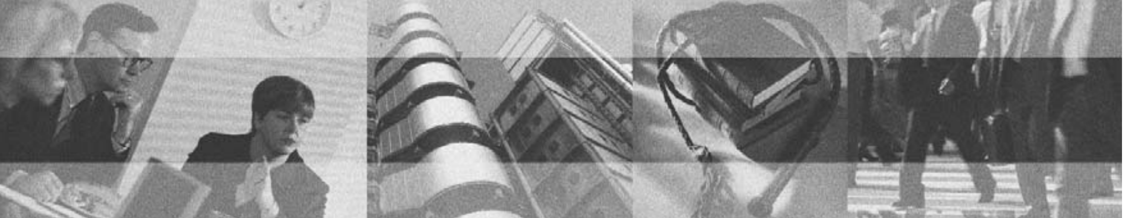
115 Conceded in *Porter v GIO* 2002 NSWSC.

116 See *Helfand v National Union Fire Insurance Co* 13 Cal Rptr 2d 295 (Cal CA, 1992); *Safeway v National Union Fire Insurance Co* 1992, ND Cal; *American Casualty Co v Rahn* 854 F Supp 494 (WD Mich, 1994).

117 *Kansa Insurance Co v Elbow Skiing Ltd* (1991) 6 CCLI (2d) 299; *Agra Foundations Ltd. v Commonwealth Insurance Co* (2001) 214 Sask R 255

118 *CGU Insurance Ltd v Watson* 2007 NSWCA 301. This must be the proper explanation of the Court of Appeal's otherwise curious assertion in *K/S Merc-Skandia XXXXII v Lloyd's Underwriters* [2001] Lloyd's Rep IR 802 that the assured under a liability policy does not have a claim against insurers unless and until the assured's liability to the third party is established and quantified by judgment, award or settlement.

119 *MWH International Inc v Lumbermens Mutual Casualty Co* [2007] BCJ No 559.



stated, defence costs are not payable in respect of claims which are outside the scope of the policy.[120] Thus if insurers have the right to rely on a defence to the substantive claim, they will also have the right to refuse to indemnify the assured for defence costs, or if the policy limits have been reached, there is no duty to defend further claims.[121] This has been held to be the position in two Australian cases, *Silbermann v CGU Insurance Ltd*[122] and *Wilkie v Gordian Run Off Ltd*,[123] both involving dishonesty which operated as a defence to substantive cover. There may nevertheless be exceptions. In *Poole Harbour Yacht Club Marina Ltd v Excess Insurance Co*[124] the defence costs clause was construed as providing an indemnity for any claim made against the assured in the course of the insured business, whether or not the substantive claim was covered: the insurers' protection was to be found in their discretion set out in the clause to refuse their consent to the incurring of defence costs.

Where the general rule is applicable, the trigger for payment of defence costs is not necessarily the same as the trigger for payment of liability claims. Assuming that the claim made is insured under the policy, then defence costs are presumed to be payable whether or not the claim is made out: "while the duty to indemnify only extends to claims which are actually covered by the policy, the duty to defend is much broader. It even applies to claims which are groundless, fraudulent or false."[125] It is possible to draft wording which confines recovery of defence costs to cases in which the assured is actually liable to the third party so that there is a substantive claim against the insurers, although that type of wording is relatively rare in liability insurance and even rarer in D&O policies.[126]

Advance funding of the defence

Defence costs clauses vary. Some state that insurers are not under any obligation to fund defence costs, and that the assured is entitled to a reimbursement of defence costs only if the assured is ultimately found to be liable on grounds which fall within the scope of the policy, in particular that the assured was not dishonest.[127] Others impose an obligation on the insurers, where a claim has been made against the assured, to defend the proceedings or in the alternative to pay defence costs on receipt of invoices. In the event that the claim against the assured is shown not to have been covered by the policy, the policy will generally provide that the insurers' expenditure – to the extent that there is no coverage[128] –is to be returned to them. Yet others do not impose an obligation but merely a discretion, so that insurers are simply empowered to fund a defence; sometimes this is expressed as requiring the assured to

120 *John Wyeth v Cigna* [2001] Lloyd's Rep IR 420.

121 *Boreal Insurance Inc v Lafarge Canada Inc* (2004) 70 OR (3d) 502, which holds that the costs of defending such claims are for excess layer insurers.

122 [2003] NSWCA 203.

123 [2003] NSWSC 109.

124 [2001] Lloyd's Rep IR 580.

125 *Cooper v Farmers' Mutual Insurance Society* [2001] OTC 652.

126 See *Thornton Springer v NEM Insurance Co Ltd* [2000] Lloyd's Rep IR 590 where the policy was construed in this fashion, although the assured was ultimately rescued by a special condition providing for payment of defence costs where the claim against the assured fell within the scope of the policy even though it was unsuccessful.

127 See: *Kenai Corporation v National Union Fire Insurance Co* 136 BR 59 (SDNY, 1992); *Harristown Development Corporation v International Insurance Co* 1988 MD Pa.

128 Allocation issues are discussed below.

seek the permission of the insurers to incur defence costs. The distinction between an obligation and a discretion may not always be obvious from the policy wording, although the English courts at least will construe any ambiguity in favour of compulsory cover.[129]

Let it be assumed that the policy imposes an obligation on the insurers to defend or pay defence costs, but there is a dispute as to whether the claim made against the assured, if substantiated, would fall wholly or partly within the scope of the substantive cover, or whether the insurers have some form of defence. Are insurers required to fund the defence and to seek repayment of some or all of their outlay after the trial, or are insurers entitled to raise coverage and defence issues immediately? The matter has been litigated in a number of jurisdictions, perhaps most extensively in Canada where liability policies, including D&O covers, are drafted on the basis of an obligation to defend or in the alternative to pay defence costs if a defence is refused. The cases make it clear that the duty to fund a defence and the obligation to provide indemnification against substantive liability are separate issues. The duty to defend is determined prospectively, and depends on the claim made against the insured. There are tens of cases on the point, but the root decision is *Nichols v American Home Assurance Co*,[130] from which, taken with later authorities, the following principles can be derived.[131]

First, the duty to defend arises where there is a "mere possibility" that the claim advanced against the insured is covered by the policy. It is incumbent upon the assured to establish that it is possible that the allegations made by the third party against the assured, if proved at trial, bring the claim within the four corners of the insurance policy.[132]

Secondly, if the pleadings in the third party's claim against the assured allege facts which, if true, could require the insurer to indemnify the assured for the claim, then the insurer is obliged to provide a defence.[133] This remains so even though the actual facts may differ from the allegations pleaded.[134] It is also settled law that "the widest latitude should be given to the allegations and the pleadings in the underlying actions, in determining whether they raise a claim within the policy".[135] The pleadings are to be read in a realistic way, so that it is not the labels used by the pleader, but the true nature of the claim that matters. The courts are to be aware of "manipulative pleading" which asserts claims that cannot be supported on the facts,

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129 *Glencore International AG v Ryan, The Beursgracht* [2001] 2 Lloyd's Rep 608.

130 [1990] 1 SCR 801.

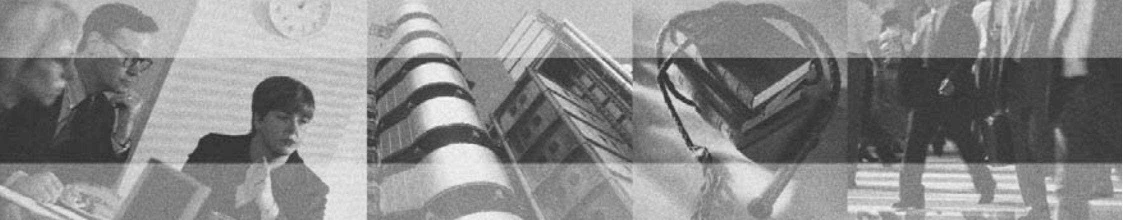
131 See the statements of principle in *Fermes Dionne ltée/Dionne Farms Ltd v Fermes Gervais ltée* (2002) 255 NBR (2d) 6 and *Conservation Council of New Brunswick Inc v Encon Group Inc* [2006] NBJ No 190.

132 *Kerr v Lawyers' Professional Indemnity Co* (1995) 25 OR (3d) 804; *Alie v Bertrand & Frere Construction Co* [2002] OJ No 4697; *Trafalgar Insurance Co of Canada v Imperial Oil Ltd* (2001) 57 OR (3d) 425); *Co-operator's Insurance Co v Ross* [2003] 65 OR (3d) 135; *Rotating Equipment Services Inc v Continental Insurance Co* [2004] AJ No 1340; *Scott v Optimum Frontier Insurance Ltd* [2006] OJ No 4204; *S v Gross* (2002) 100 Alta LR (3d) 310; *Conservation Council of New Brunswick Inc v Encon Group Inc* 2006 NBCA 51; *Portage La Prairie Mutual Insurance Co v Commission du District d'aménagement du Madawaska* [2006] NBJ No 454.

133 *Bacon v McBride* (1984) 5 CCLI 146; *Comeau v Roy* (1999) 217 NBR (2d) 242; *Russel Metals Inc v Ball Construction Inc* [2007] OJ No 4673.

134 *Palmieri v Misir [*2003] OJ No 3518; *Wi-Lan v St Paul Guarantee Insurance Co* [2005] AJ No 1416; *Monenco Ltd v Commonwealth Insurance Company* [2001] SCJ No 50.

135 *Hironaka v Co-operators' General Insurance Co* [2005] AJ No 1313; *Nash v R* (1995) 27 OR (3d) 1; *Hope v Dominion of Canada General Insurance Co* [2000] OTC 426.



eg, that there is negligence when the true allegation is fraud or deliberate conduct.[136] The term "pleadings" means allegations in the pleadings filed against the assured, and the court is not to look at anything other than the claim made against the assured. Extrinsic evidence explicitly referred to within the pleadings may be considered only for the purpose of determining the substance and true nature of the allegations made in the statement of claim and to appreciate the nature and scope of the insurer's duty to defend.[137] This approach has been adopted in England. In *Thornton Springer v NEM Insurance Co Ltd*[138] it was held that as long as a third party claim is in substance capable of falling within the policy then the obligation to fund arises, although the court recognised that the third party's pleadings could not be conclusive and that "it may be necessary to investigate what the basis of the claim really amounts to, as distinct from the manner in which it is expressed in the claimant's pleadings."[139]

Thirdly, once this rather low threshold is met, it then becomes incumbent upon the insurer to establish that the third party's claim actually falls outside the coverage provided by the policy or that the assured is in breach of a policy condition which precludes recovery.[140] Where it is clear that the allegations in the pleadings against the assured fall outside the insuring agreement or are excluded by an applicable exclusion, the duty to defend does not arise.[141] Importantly, if the insurers assert that they are not liable under the policy so that they are not liable for defence costs, and they lose at the hearing on defence costs, they are not estopped from relying on their substantive defence to liability under the policy at a later stage.[142] It would seem that there is nothing to prevent the insurers from seeking at this stage a final order that it is not under any obligation to indemnify the assured, by reason of a coverage or other defence to the substantive claim: this was so held in *Silbermann v CGU Insurance Ltd*.[143] English law would similarly entertain declaratory proceedings in such circumstances.

Fourthly, if some of the allegations in the pleadings appear to be insured, and a dispute arises

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136 *Non-Marine Underwriters, Lloyd's of London v Scalera* [2000] 1 SCR 551; *Godonoaga v Khatambakhsh* (2000) 132 OAC 391; *Randhawa v Da Rosa* [2000] OTC 738; *Joachin v Abel* [2001] OTC 299; *Unrau v Canadian Northern Shield Insurance Co* [2004] BCJ No 33; *Morrison v Co-operators' General Insurance Co* [2004] NBJ No 290; *O'Leary v AXA Pacific Insurance Co* 95 OR (3d) 315 (2009).

137 *Aiken v Harris* (1999) 45 OR (3d) 266; *Hamel Construction Inc v Lombard Canada Ltd* 2005 NSCA 65.

138 [2000] Lloyd's Rep IR 590.

139 Certain US jurisdictions adopt the same approach. In Texas, the principle is known as the "eight corners" rule, under which "the duty to defend does not depend upon the truth or falsity of the allegations ... a plaintiff's factual allegations that potentially support a covered claim is all that is needed to invoke the insurer's duty to defend": *Nautilus Insurance Co v Country Oaks Apartments Ltd* 566 F 3d 452, 454 (5th Cir 2009), applied in *Century Surety Co v Dewey Bellows Operating Co Ltd* 2009 BL 187750 (SD Tex Sept 2, 2009).

140 *Laughlin v Sharon High Voltage Inc* (1993) 12 OR (3d) 101.

141 *Slough Estates Canada Ltd v Federal Pioneer Ltd* (1994) 20 OR (3d) 329; *Picken v Guardian Assurance Co of Canada* (1993) 66 OAC 39; *Ross v American Home Assurance Co* 1999 OTC 360; *Non-Marine Underwriters, Lloyd's of London v Scalera* [2000] 1 SCR 551; *Mailet v Halifax Insurance ING Canada* [2003] NBJ No 5; *Hanis v University of Western Ontario* (2003) 67 OR (3d) 539; *Westridge Construction Ltd v Zurich Insurance Co* [2004] SJ No 43; *James v Lawyers' Professional Indemnity Co* [2006] OJ No 46.

142 *R v Kansa General Insurance Co* (1991) 2 OR (2d) 269.

143 [2003] NSWCA 203. There was no appeal against this ruling: see [2005] HCA 16, where an appeal against the lower court's ruling that the insurers were entitled to refuse coverage on the ground of dishonesty, on the basis that the claim against the assured should be determined before dishonesty could be adjudicated, was held to be hypothetical given the assured's acceptance of the right of the court to make such a ruling.

in respect of others, there is a duty to defend in full. The court is then to allocate the costs after the trial and not beforehand.[144] This is the case even where there are both insured and uninsured parties.[145] However, if it is clear that certain claims are not covered, in that the facts alleged in relation to the insured and uninsured claims are quite different, then there is no duty to defend the uninsured claim: the test is whether the two claims arise from the same actions and have caused the same harm so that the uninsured claim can be said to be derivative.[146]

Fifthly, if there are two policies which respond to the loss, the court may order the insurers to share the defence costs equally, subject to a subsequent apportionment based on actual liability after the trial,[147] and this remains the case even though one insurer asserts that it can be liable only for a small proportion of the loss.[148] This, however, is subject to express clauses, eg, rateable proportion provisions.[149] Equally, if an insurer is on risk for only a limited period during which the losses occurred, the insurer only has to provide defence costs in the relevant proportion.[150] The same apportionment principle applies as between primary and excess layer insurers.[151]

Finally, insuring agreements should be read broadly, exclusions narrowly and ambiguities resolved in favour of the assured. Ambiguities, however, should be apparent from a reasonable reading of the policy and not be judge-made.[152]

A discretion to defend

Most Australian D&O policies do not impose on the insurers an absolute obligation to fund the assured's defence. There is no obligation where the insurers have denied substantive cover at the outset, and funding will cease (and repayment of costs will be sought) during the course of the proceedings or thereafter if there proves to be no coverage. In particular, policies typically state that an allegation against the director of Corporations Act 2001, s 199A conduct (deliberate breach of duty, using company property or information for own benefit or to harm company) does not justify a refusal of defence costs unless and until the exclusion is established. In the absence of a denial of coverage, the insurers will advance

144 *St Paul Fire & Marine Insurance Co v Durabla Canada Ltd* (1996) 29 OR (3d) 737; *Daher v Economical Mutual Insurance Co* (1996) 31 OR (3d) 472; *Great West Development Marine Corporation v Canadian Surety Co* [2000] BCTC 339; *Conservation Council of New Brunswick Inc v Encon Group Inc* [2005] NBJ No 109; *Agresso Corp v Temple Insurance Co* [2007] BCJ No 21; *ING Insurance Co v SREIT (Park West Centre) Ltd* [2009] NSJ No 158.

145 *Continental Insurance Company v Dia Met Minerals Ltd* (1996) 20 BCLR (3d) 331.

146 *J A S v Gross* (1998) 231 AR 228; *Continental Insurance Co v Dia Met Minerals Ltd* (1996) 20 BCLR (3d) 331; *Sommerfield v Lombard Insurance Group* (2005) 74 OR (3d) 571.

147 *Prudential Life Insurance Co Ltd v Manitoba Public Insurance Corporation* (1976) 67 DLR (3d) 521; *General Accident Insurance Co of Canada v Ontario Provincial Police Force* (1988) 30 CCLI 178; *Royal Insurance Company v Coronation Insurance* (1993) 17 CCLI (2d) 13; *Skyline Gold Corporation v American Home Insurance* [1997] BCTC G22; *Incerto v Landry* (2000) 47 OR (2d) 622.

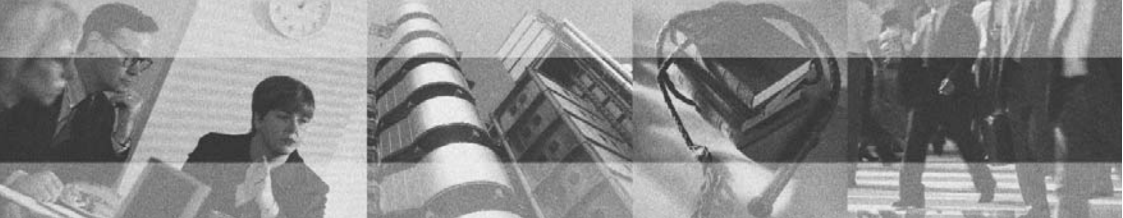
148 *Axa Pacific Insurance Co v Guildford Marquis Towers Ltd* [2000] BCTC 37.

149 *Family Insurance Corporation v Lombard Canada Ltd* (2000) BCTC 273.

150 *Royal and Sun Alliance Insurance Co of Canada v Fiberglass Canada Inc* (1999) 99 OTC 196.

151 *Broadhurst & Ball v American Home Insurance* (1990) 40 OAC 261; *American Assurance Co v Temple Insurance Co* 94 OR (3d) 534 (2007); *St Mary's Cement Company Inc v ACE INA Insurance* [2008] OJ No 2622.

152 *Opron Maritimes Constructions Ltd v Canadian Indemnity Co* [1987] 1 SCR 11; *Wilkinson v Security National Insurance Co* (1999) 249 AR 282; *Lanark Mutual Insurance Co v Economical Mutual Insurance Co* (2006) 81 OR (3d) 39; *Lombard General Insurance Co of Canada v Crosbie Industrial Services Ltd* [2006] NJ No 276.



defence costs promptly on receipt of invoices, providing that the costs have been incurred with their consent (such consent not to be unreasonably withheld). To that extent, therefore, there is a discretion whether or not to fund, tempered by a requirement on the insurers not to act unreasonably.

If the discretion has been exercised in favour of funding then, as noted above, the usual form of wording permits the insurers to withdraw funding once fraud is alleged or it becomes apparent that there is no substantive coverage under the policy. The wording may, however, be to the contrary. In *Wilkie v Gordian Run Off Ltd*,[153] the High Court held, on the policy terms before it, that fraud could not be relied upon as a defence until fraud had been established "in fact" in proceedings against the assured, so the insurers were under an obligation to fund the defence once they had given their consent to defence costs being incurred.

By contrast, if the discretion has not been exercised in favour of funding, a question arises as to whether the insurers' exercise of discretion can be challenged, particularly where the effect of refusal is to cut out any realistic possibility of the assured mounting a defence. In *Silbermann v CGU Insurance Ltd*[154] it was held that the insurers were entitled to refuse their consent to defence costs being incurred, by means of the insurers establishing that the assured had been dishonest: the wording of the policy was such that the discretion was an overriding one, even in respect of allegations of fraud. However, if matters have not proceeded to the point at which fraud or some other coverage defence has been established, the further issue is whether the courts will review the exercise of discretion. In Australia the matter is governed by s 13 of the Insurance Contracts Act 1984 (Cth), which makes the exercise of utmost good faith an implied contract term, so if insurers can be shown to have acted for improper motives then their decision may be regarded as giving rise to a breach of contract. As was said by Cullinan J in *Silbermann*: "Such a discretion could not be an unfettered one."[155] It is unlikely, however, that ordinary commercial judgements could be challenged.[156] The matter has been given consideration in a number of cases in England. The initial view taken by the English courts was that consent could not be withheld unreasonably,[157] but that test has now been abandoned in favour of a "rationality" test, ie, that used for judicial review: the question is not whether the insurers had acted unreasonably in denying funding, but rather whether they had reached their conclusion by taking into account considerations which were extraneous to the dispute itself (eg, for the purpose of asserting leverage in an entirely unrelated dispute).[158] The test has been laid down, but there is no case in England in which insurers have been found to have acted irrationally in their exercise of discretion.

If, as is usually the case, the policy requires the assured to obtain the consent of the insurers

153 2005 HCA 17.

154 [2003] NSWCA 203. This point did not arise on appeal, which was dismissed unanimously on procedural grounds, but by a 3:2 majority the High Court agreed with the lower court's analysis.

155 Para [60].

156 Lack of good faith was not alleged in *Silbermann*.

157 *Poole Harbour Yacht Club Marina Ltd v Excess Insurance Co* [2001] Lloyd's Rep IR 580.

158 *Thornton Springer v NEM Insurance Co Ltd* [2000] Lloyd's Rep IR 590; *Gan Insurance v Tai Ping Insurance* [2001] Lloyd's Rep IR 667; *Eagle Star v Cresswell* [2004] Lloyd's Rep IR 537.

before incurring defence costs or settling a claim, and the assured fails to do so, s 54(1) of the Insurance Contracts Act 1984is applicable and the assured's failure to seek consent may be excused.[159] That does not of course mean that the insurers are liable: if the criteria set out in the policy for giving consent are not fulfilled, or if there are no criteria and the insurers have acted in good faith in refusing consent, there will still not be any recovery.

Allocation between insured and uninsured claims[160]

Three separate issues arise here. The first is where some of the claims made against the assured are covered by the policy and some are not. In a D&O clause, typically the director will be accused of both negligent and fraudulent conduct, the former being covered but the latter not. As seen above, if the question is upfront funding, the Canadian courts have decided that the insurers are required to fund the entire defence and worry about the problem afterwards. However, once there has been a judgment finding that some parts of the claim are insured and some are not, the issue becomes whether costs are to be allocated between the two so that repayment is required. In the absence of express wording, there has to be an allocation, however difficult that may be,[161] although allocation is not required if the assured can show that the overall costs were not increased by the need to defend the fraud element of the claim.[162] In *McCarthy v St Paul International Insurance Co Ltd*[163] a number of claims were made against the assured, some in respect of fraud and some in respect of insured perils. The insurers asserted that the cause of defence costs being incurred was both insured and excluded perils, and in line with the general rule that an exception always trumps an insuring clause if there are concurrent proximate causes, there was no liability for defence costs. The court's response was that the claims were separable so that defence costs were payable in respect of the insured claims and, further, that to the extent that there were common costs the insurers were liable for them. The court noted that it might be possible to devise wording which produced a different result, eg, if the policy covered $X defence costs in any one year, excluding defence costs caused directly or indirectly by fraud: such wording might have the effect of preventing recovery of any defence costs even if the claims in question were not referable to fraud. Such language is not found in practice.

The second issue arises where there are both insured and uninsured defendants. There are various theories propounded in the US as to how this matter should be judged, but that which has been accepted in England is the "reasonably related" test. The effect of this is that if the assured would have incurred the same costs without our without the addition of an uninsured party,[164] the insurers are to pay the entire amount of the costs and they are not entitled to contribution from the uninsured party. The same approach has been adopted in

159 *Antico v Heath Fielding Australia Pty Ltd* (1997) 188 CLR 652.

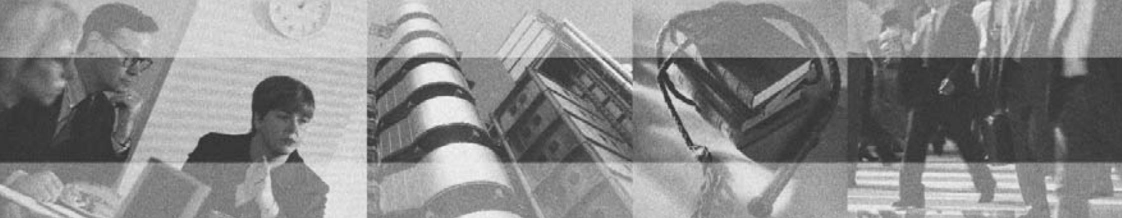
160 As seen earlier, there is often an allocation clause which applies to substantive claims. Such a clause may or may not be expressly extended to defence costs, but the cases indicate that there is to be an allocation in any event.

161 *Structural Polymer Systems Ltd v Brown* [2000] Lloyd's Rep IR 64; *Hanis v Teevan* 92 OR (3d) 594 (2008).

162 *John Wyeth v Cigna* [2001] Lloyd's Rep IR 420.

163 2007 FCAFC 28.

164 *New Zealand Insurance Co Ltd v New Zealand Forest Products Ltd* [1996] 2 NZLR 20; *Thornton Springer v NEM Insurance Co Ltd* [2000] Lloyd's Rep IR 590; *Coronation Insurance Co v Clearly Canadian Beverage Corp* (1999) 117 BCAC 22.



Australia, in *Vero Insurance Limited v Baycorp Advantage Ltd*,[165] where the defence costs were incurred on behalf of the insured directors and the uninsured company.

The third is where there are two or more insurers, each with a duty to defend. Ordinary contribution principles apply here. If one insurer has paid the full defence costs, that insurer is entitled to an appropriate contribution from the other representing its share of liability.[166]

Allocation may be governed by express provision. However, there is a risk that an allocation clause might be void for uncertainty if it does no more than say that the parties are to agree on an equitable allocation: such a clause was struck down by the trial judge in *Baycorp*, his reasoning being approved on appeal.[167]

Failure to insist upon repayment

A problem which has arisen in England, but which has not yet been litigated (although it has been arbitrated), becomes apparent where there is an aggregate limit of cover for defence costs and the sums available have been eroded. Included in the sums paid are sums forwarded to directors who, by reason of findings of fraud against them, are required to repay those sums to the insurers. If those sums are repaid, then the amount available to fund other defences is reinstated to that extent. But what is the situation if insurers fail to seek repayment, or are unsuccessful in obtaining repayment so that the policy limits are not eroded? Absent contrary policy wording, it is most unlikely that a court would conclude that there is some form of implied obligation on the insurers to pursue recovery to the full so that policy limits can be reinstated in respect of defence costs incurred by other directors.

ALLOCATION AND OUTWARDS REINSURANCE CLAIMS

The London reinsurance market is likely to face a series of claims from D&O insurers, particularly US carriers. Similar claims could conceivably arise from Australia. There are both procedural (notification) and substantive (coverage) issues arising from such claims.

Notification

The procedural issue is notification. Regrettably, reinsurances of D&O policies are not drafted as clearly as they might be, often because the notification clauses have been lifted from casualty covers where they make sense, and dropped into liability policies where they do not, and there have already been issues as to exactly when notification is to be given to reinsurers. The point has arisen in cases of claims by stockholders against directors for negligence in the running of the company which has led to a diminution in the value of their shares. Reinsurances typically require the reinsured to notify the reinsurers, within a limited period, once they obtain knowledge of any loss. The problem here is, whose loss is being referred to? In a D&O case, potential losses are those suffered by the stockholders

165 [2004] NSWCA 390 affirming the principles set out by Einstein J at first instance, *Baycorp Advantage Ltd v Royal and Sun Alliance Insurance Australia Ltd* 2003 NSWSC 941.

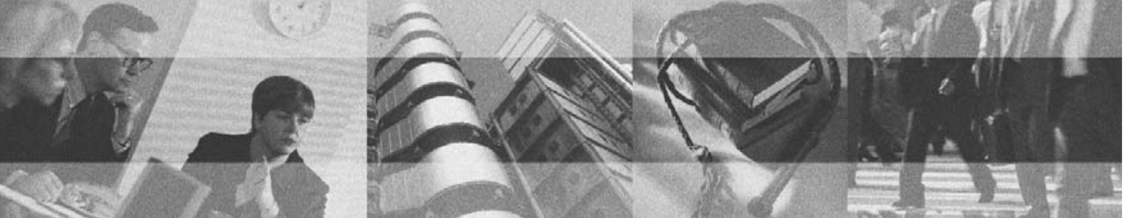
166 As in *Ing Insurance Co of Canada v Federated Insurance Co of Canada* 75 OR (3d) 457 (2005), where the dispute was between primary and excess layer insurers.

167 *Vero Insurance v Baycorp Advantage* [2004] NSWCA 390.

(when their shares plummet), the directors (when they are successfully sued or when they settle) and the reinsured (when the liability of the directors is established and quantified). The drafting gives no clue as to which is being referred to, and although the reinsurers plainly want to be notified at the earliest possible stage so that they can exercise rights relating to negotiation and settlement, the type of wording used is more consistent with casualty rather than liability coverage. In *Royal & Sun Alliance insurance Plc v Dornoch Ltd*[168] the reinsured was required "upon knowledge of any loss or losses which may give rise to claim under this policy, advise the Underwriters thereof by cable within 72 hours". The reinsured became aware of claims against the company and its directors at the end of December 2000, but the reinsurers were not notified of those claims until the middle of January 2001. The Court of Appeal nevertheless held that the notification was not out of time. Until the stockholders' claims against the company had been adjudicated, it could not be said that they had suffered any loss and the reinsured could not, therefore, have been aware of such losses.

The reasoning in *Dornoch* was followed but distinguished by the Court of Appeal in *AIG Europe (Ireland) Ltd v Faraday Capital Ltd*.[169] The policy here provided that "(a) The Reinsured shall upon knowledge of any loss or losses which may give rise to a claim, advise the Reinsurers thereof as soon as is reasonably practicable and in any event within 30 days …" and "(b) The Reinsured shall furnish the Reinsurers with all information available respecting such loss or losses, and shall co-operate with the Reinsurers in the adjustment and settlement thereof." On 19 November 2002 the assured informed the market that it intended to restate its financial statements for the preceding four years and to take into account only actual revenue rather than anticipated revenue. That led to a dramatic fall in the value of the assured's shares, at one point falling by one-third. A number of shareholders who had purchased shares in the period up to November 2002 commenced proceedings, which were notified to AIG in December 2002 and were subsequently consolidated into a class action in March 2003. The reinsured posted a substantial reserve in February 2004. The dispute between the assured and the insurers was referred to mediation, and the insurers were informed on 25 March 2004 that a settlement had been reached. The reinsurers were informed on 14 April 2004, and they pleaded breach of the notification clause. The Court of Appeal held that the notification was out of time. In its view, there was a crucial distinction between the two cases in that in *Faraday* the announcement of 19 November 2002 was a specific event which had led to almost immediate losses, and that to say that there was no coincidence between the announcement and the fall in share prices would have been, in the words of Longmore LJ, "to shut one's eyes to the obvious". As there had been an obvious loss to the shareholders, and as that loss considered at the time was clearly one which might have given rise to a claim (which indeed it did), notification was required within 30 days from AIG becoming aware of that loss. The Court of Appeal was satisfied that AIG knew of the relevant circumstances by late December 2002 when claims against the assured were notified to it, and the 30-day notification period commenced at that stage. The Court of Appeal noted that in *Faraday*, as in *Dornoch*, it was not immediately obvious that the assured faced any liability for the loss and that the insurers faced any liability to the assured, but the

168 [2005] Lloyd's Rep IR 544.
169 [2008] Lloyd's Rep IR 454.



notification obligation related to losses which may give rise to claims and not to losses in respect of which liability had been established. In *Dornoch* it was not obvious that shareholders had suffered losses, whereas in *Faraday* it was.

Coverage

The principles which govern the liability of a reinsurer are now well established in English law. In essence, a reinsured is able to make a successful claim if it can satisfy the two-limb test laid down by the Court of Appeal in *Insurance Co of Africa v Scor (UK) Reinsurance*:[170] (1) the reinsured must establish and quantify its own liability to the reinsured; and (2) the loss must fall within the terms of the reinsurance.

Each of these limbs gives rise to different issues. A reinsured can establish and quantify its own liability by: being sued to judgment by the assured; losing an arbitration; or entering into a settlement with the assured. Judgments and awards are more or less conclusive (subject to a "perversity" exception or the possibility that the reinsured has not defended the proceedings properly),[171] but a settlement is binding only if the reinsured can show that he was liable for at least the sum of the settlement.[172] That may have to be done in declaratory proceedings against the reinsurers following the settlement. In practice, however, most reinsurance agreements contain some form of follow the settlements (or follow the fortunes) provision, the effect of which – as established in the *Scor* case – is that the need to establish and quantify liability as a matter of law is replaced by an obligation on the reinsurers to accept the settlement unless they can prove that it was not made in a bona fide and businesslike fashion.

More problematic is the second limb, proof that the loss falls within the scope of the reinsurance. London market facultative policies normally contain one or other of the variations of the "full reinsurance" clause, which stripped to its basics provides "as original" (thereby incorporating the terms of the direct policy into the reinsurance)[173] and "follow the settlements". The use of identical wording in the insurance and reinsurance gives rise to a presumption of "back to back" cover, so that if the reinsured establishes that it faced liability under the direct policy on the claim, then the words of the reinsurance are not to be construed any differently and the reinsurers face the same liability.[174] This is so even if there has been some change in the law so that the liability under the direct policy was significantly more extensive than could have been predicted when the covers were taken out.[175] More problematic is the situation in which the direct insurance and the reinsurance are governed by different applicable laws. It might be thought that this is almost an inevitability where the insurance is placed in Australia, given the rules demanding the application of local law to most forms of insurance in s 8 of the Insurance Contracts Act 1984 (Cth), whereas reinsurance is outside the 1984 Act (so that different legal principles would apply) and in any

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170 [1985] 1 Lloyd's Rep 312.

171 *Commercial Union Assurance Co v NRG Victory Reinsurance Ltd* [1998] Lloyd's Rep IR 421.

172 *Commercial Union Assurance Co v NRG Victory Reinsurance Ltd* [1998] Lloyd's Rep IR 421.

173 See Lord Mance in *Wasa International Insurance Co Ltd v Lexington Insurance Co* [2009] UKHL 40.

174 *Assicurazioni Generali Spa v CGU International Insurance plc* [2004] Lloyd's Rep IR 457.

175 See Lord Collins in *Wasa International Insurance Co Ltd v Lexington Insurance Co* [2009] UKHL 40.

event – if placed in England – only exceptionally to be governed by anything other than English law. The problem of conflicting applicable laws was addressed in detail by the House of Lords in *Wasa v Lexington*, a case in which a three-year direct policy against property damage issued to Alcoa in the US was subject to a service of suit clause which permitted the assured to sue insurers in any court of competent jurisdiction in the US, that court to apply its own law to the dispute. Alcoa chose to sue in Washington, and that court applied its conflict of laws rules to come up with the law of Pennsylvania. Under Pennsylvania law, as construed by the Washington court, if damage occurred in the three year period, the insurers were liable for all property damage, including that occurring before and after the currency of the policy. On this reasoning the reinsured found itself saddled with claims for property damage extending for the best part of 50 years. The reinsurers pleaded that the reinsurance contract, which was for an identical 36-month period, was to be construed in accordance with English law, and in England 36 months does not mean 50 years so that coverage was only for damage occurring in the period of the reinsurance. The House of Lords agreed with the reinsurers. In their Lordships' view, if the law applicable to the direct policy cannot be predicted at the date the reinsurance is taken out, then it is not appropriate to construe all of the terms of the reinsurance in accordance with the law applicable to the direct policy. It is, in the words of Lord Collins. "almost inevitably" the case that a back to back interpretation will be adopted, but not for fundamental matters such as duration.

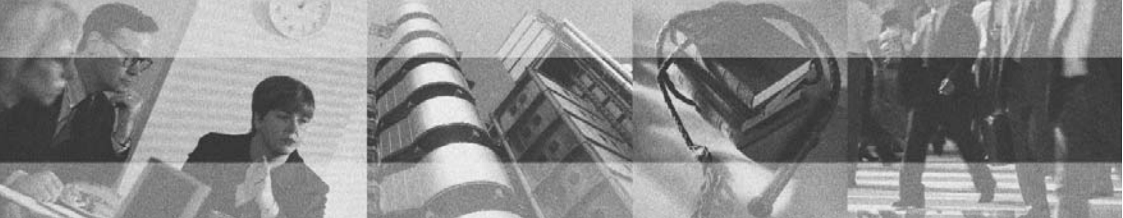
Post-settlement allocation

The ruling in *Wasa* gives rise to the problem of post-settlement allocation, ie, the way in which a claim is presented to reinsurers. Let it be supposed that circumstances which may give rise to a claim against a director are notified to insurers in year 1, and further related circumstances are notified year 2. Insurers decide to treat the assured's claim as confined to year 1, to take advantage of favourable policy limit provisions. The claim is the presented to reinsurers but on the basis that half the loss fell within year 1 and half the loss fell within year 2, thereby maximising their own recovery from reinsurers. To what extent are the reinsurers entitled to assert that the allocation is unreasonable? The alternative scenario could be that the insurers decide to allocate the losses equally between years 1 and 2, but make a claim against the reinsurers on the basis of a year 1 allocation in order to take advantage of favourable deductible provisions in the reinsurance. Once again, the question is whether the allocation can be challenged by reinsurers?

As far as English law is concerned, the reinsurers are entitled to insist upon a proper allocation of losses between policy years. Thus, in *Municipal Mutual Insurance v Sea Insurance*[176] petty thefts occurred over a period of 18 months and straddling three periods of reinsurance. The reinsured sought to allocate all of those losses to a single policy year for the purpose of recovery from reinsurers, but the Court of Appeal's view was that it was necessary to allocate the losses between the years, and to do so on an assumption of a consistent pattern of thefts to produce an appropriate proportionate allocation.

Some reinsurance contracts do give the reinsured the right to determine the allocation for

176 [1998] Lloyd's Rep IR 421.



itself, and in *Brown v GIO Insurance Ltd*[177] a clause which provided that "The reassured's definition of each and every loss and/or event shall be final and binding on the reinsurers hereon. The reassured shall be the sole judge as to what constitutes each and every loss and/or one event" was held to confer a discretion on the reinsured as to how to allocate losses, a discretion which could be overturned only if exercised mala fides or in a perverse fashion. These qualifications do not take the matter much further, however, because in every case the reinsured will be seeking to maximise recovery, necessarily to the detriment of reinsurers.

The problem of post-settlement allocation has been considered in a number of US cases.[178] The general position in the US is that "follow the settlements" or "follow the fortunes" clauses[179] extend into the allocation process and are not confined to the settlement process,[180] an issue which has never been discussed in England. That means that the reinsurers are required to follow the reinsured's allocation as against the original assured. The real problem arises where the allocation presented to reinsurers is not the same as that adopted for the settlement of the assured's claim. The standard adopted by the US courts that an allocation which does not match the basis of the original settlement is nevertheless to be followed unless it has been determined fraudulently, recklessly or with gross negligence. In *North River v ACE Insurance*[181] the reinsured sought to allocate 99% of its losses from asbestos claims to second-layer excess reinsurers even though the reinsured's own assessment of its liabilities had identified losses in higher layers. The Court ruled that, if the reinsurers were permitted to challenge the allocation, a detailed scrutiny of the facts would be required, a process which would undermine the obligation of the reinsurers to follow the good faith conduct of the reinsured. The protections of the reinsurers were thought to be the obligation of the reinsured to act in good faith and also the express coverage terms of the reinsurance. This approach was followed in *Travelers Insurance v Gerling Global*,[182] where the reinsured had settled thousands of asbestos claims without identifying the relevant number of occurrences, and presented reinsurance claims based on an equal spreading of loss amongst policy years so as to maximise the limits of indemnity in each reinsurance year. The court ruled that the reinsured had acted in good faith and reasonably, and that the losses fell within the scope of the reinsurance so that the reinsurers were liable.

The two qualifications have been applied in some cases. In *Allstate Insurance Co v American*

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177 [1998] Lloyd's Rep IR 201.

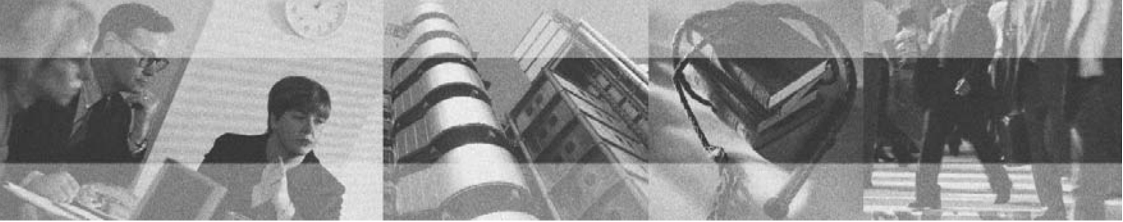
178 The author is indebted to Dr Ozlem Gurses for preliminary sight of her forthcoming work, *The Full Reinsurance Clause*, Informa, 2010. See also Hall and Wulf, "Allocation to Reinsurers and Follow the Settlements", *Mealey's Litigation Report: Reinsurance*, Vol 13, #19, February 6, 2003, p 26.

179 Despite the gallons of ink spilt on the distinction in journals and texts, it would seem that the US courts treat these concepts interchangeably, and that it is a matter of chance – depending on the pleadings – as to whether a follow clause receives one or the other nomenclature from the court.

180 *Commercial Union v Seven Provinces* 9 F Supp 2d 49 D Mass,1998; aff'd 217 F 3d 33 CA 1 (Mass), 2000. But contrast *Argonaut v Travelers* 2005 WL 66778 (NY Sup), 2005 and *Travelers Casualty and Surety Co v Certain Underwriters at Lloyd's of London* 96 NY 2d 583, 2001, decisions which have not been greeted uncritically: Rubenstein, "Follow the Settlements' and Allocation: Review of Recent Developments" Mealey's Litigation Report: Reinsurance, November 5, 2007, Vol 18 #13 p 29.

181 361 F 3d 134 CA 2 (NY), 2004.

182 419 F 3d 181 CA 2 (Conn), 2005. See also 441 F Supp 2d 646, SDNY, 2006.



Home Assurance Co,[183] a judgment was given against the reinsured to the effect that there were seven occurrences at the insured site. A claim was presented to the reinsurers on the basis of one occurrence, so that the reinsured bore only one deductible and not seven. This was held to be neither in good faith nor reasonable. These cases are not, with respect, easy to reconcile, and much presumably turns upon the impression gained by the judge of the reinsured's conduct. The point is that in each of them the reinsured was simply trying to maximise its own recovery. What presumably made *Allstate* different is that the court did not have to investigate any facts as to how the underlying settlement had been reached, because that matter had been determined by an earlier judgment. Reinsurers were also held not bound to follow the reinsured's allocation of pollution losses in *Travelers Insurance v Certain Underwriters*,[184] as in that case the reinsured's attempt to treat each contaminated site as a separate casualty was contrary to the definition of "casualty" in the reinsurance agreement.

The problem with the US approach is that it depends upon which end of the telescope is looked through. From the point of view of the reinsured, maximising recovery is a perfectly legitimate aspiration. From the point of view of reinsurers, such conduct is plainly bad faith, particularly where the reinsured has departed from the basis of its own settlement.

183 837 NYS 2d 138, 2007.

184 96 NY 2d 583, 2001. See also: *Hartford Acciccent and Indemnity Co v Ace American Reinsurance Co* 2005 WL Conn; *Affiliated FM Insurance Co v Employers Reinsurance Co* 369 F Supp 2d 217 DRI, 2005.