Insurance Matters

Sparke Helmore Lawyers

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If you have any questions or suggestions about *Insurance Matters* contact the editor, Grant Galvin, on +61 2 9373 3513 or grant.galvin@sparke.com.au

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Looking over the horizon

Following the tragic siege in Martin Place last December, Joe Hockey, Treasurer of Australia, declared the situation a "terrorist incident". In this issue, we consider some of the insurance implications of this decision for affected businesses and relevant insurers.

In 2012, the triennial review of the General Insurance Code of Practice was brought forward and Ian Enright, Senior Vice President and International Counsel at Reinsurance Group of America, was selected as the Independent Reviewer. We speak with Ian about the review and some of the key issues that were identified and addressed in the 2014 Code.

In *Dekker v Medical Board of Australia*, the Supreme Court of Western Australia decided that a medical practitioner did not owe a legal duty to rescue a person in an emergency situation while off duty. We explain why this decision, although encouraging for medical practitioners and their insurers, should be met with a degree of caution.

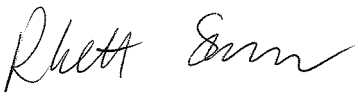
We also take a look at how the amended *Workers Compensation Act 1987* (NSW) will soon affect those claiming compensation benefits, and reflect on the duty that solicitors and barristers owe to the court when obtaining, tendering and relying on expert reports.

Finally, I'd like to congratulate Adrian Kemp on his promotion to partner and extend a warm welcome to the newest senior members of our team: Kevin Bartlett, Partner, and Helen Stavridis, Consultant, have joined our Professional Indemnity, D&O team and are based in Brisbane and Adelaide respectively.

If there are any other topics that you'd like us to explore, please send an email to me at rhett.slocombe@sparke.com.au

I hope you enjoy this issue of *Insurance Matters*.

Sincerely,



Rhett Slocombe
Insurance National Practice Group Leader
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Will insurance claims be paid in the aftermath of the Sydney Siege?

By Mark Doepel and Steven Canton

Holders of eligible insurance policies who were affected by the tragic siege in December 2014 at the Sydney Lindt Café may be entitled to be paid reinsurance after the Federal Treasurer declared the event a "terrorist incident" and for the first time activated the Australian Reinsurance Pool Corporation (ARPC).

Insurance policies usually give the insurer the right to exclude or cancel the insured's claim when there is a terrorist event. As a result, the ARPC was established by the Australian Government to make sure insured businesses are not left with an unfulfilled claim. The siege at the Lindt café provides an example of how this scheme operates.

When an incident is declared as a "terrorist incident", the ARPC operates to pay claims under eligible policies. However, there are limitations on what type of policy is reinsured in the event of a declared "terrorist incident". This article examines those limitations and how the reinsurance scheme operates.

How does the legislation operate?

Section 9 of the *Insurance Contracts Act 1984* (Cth) permits insurers to vary or cancel cover for risks related to terrorism. This usually results in insurers including terrorism as a "general exclusion" or an "excluded peril" within the insurance policy.

In the event of a terrorist incident, an insurer can rely on the exclusion to avoid making a payment on a claim. While some insurers do rely on the exclusion, others are sympathetic to the terrorism events and, as a matter of public policy, choose not to do so and pay out claims. This was exemplified in the events surrounding the Lindt Café where, as at 19 January 2015, three insurance companies had stated that they would not rely on terrorism exclusion clauses.

If an insurer does rely on the terrorism exclusion clause, this has the potential to leave the relevant insured without an avenue to make a claim or receive a payment. To counter this, in 2003 the Australian Parliament passed the *Terrorism Insurance Act 2003* (Cth) (TI Act); a move that was largely a response to the 9/11 terrorist attacks.

Section 6 of the TI Act provides that where a terrorist act occurs within Australia, the Treasurer can declare that event as a "terrorist incident". This declaration will mean that if the insurer has an eligible policy:

- a terrorist exclusion clause has no effect in an insurance policy
- a reduction percentage on claims may be applied as part of the declaration, and
- the insurer may be entitled to claim ARPC's reinsurance.

What kind of policy can be reinsured?

Generally, eligible insurance policies relating to loss or damage of the commercial property of the insured will be covered, as will business interruption and consequential loss. However other insurance policies, including home building insurance and many forms of travel-related insurance, are not covered under the reinsurance scheme.

What happens in the aftermath of a potential terrorist incident?

One problem with the operation of the scheme is the uncertainty, in the immediate aftermath of an incident, about whether the Government will declare an event a terrorist incident.

At this stage, insurers and their insured are left in limbo as to whether claims should be dealt with privately or with the assistance of the ARPC. Regardless, during this time, the ARPC requests that estimates of losses are provided to them by affected insurers, even though these may not be paid out.

This time delay is, to some extent, an unavoidable problem for the Government and the ARPC, as a process of consultation needs to occur with various stakeholders including the Attorney-General (as required by s 6(1) of the TI Act), and the Insurance Council of Australia.

Nonetheless, for insurers and their insured this creates a period of financial uncertainty as it is unclear how and if claims will be satisfied.

The process of a reinsurance claim

In effect, where an event is declared by the Treasurer as a "terrorist incident", a claim is made by an eligible policy holder to their insurance company, who may be entitled to claim reinsurance from the ARPC. This is demonstrated in the flow chart below.

Lindt Café – An example of the reinsurance scheme

The TI Act was relied on after the terrorist events at the Lindt Café in Martin Place. On 15 January 2015, the Treasurer, Joe Hockey, after consultation with the Attorney-General (as prescribed by s 6(1) the TI Act) and the Insurance Council of Australia, declared the hostage situation in Martin Place a "terrorist incident" with no applicable reduction percentage on claims.

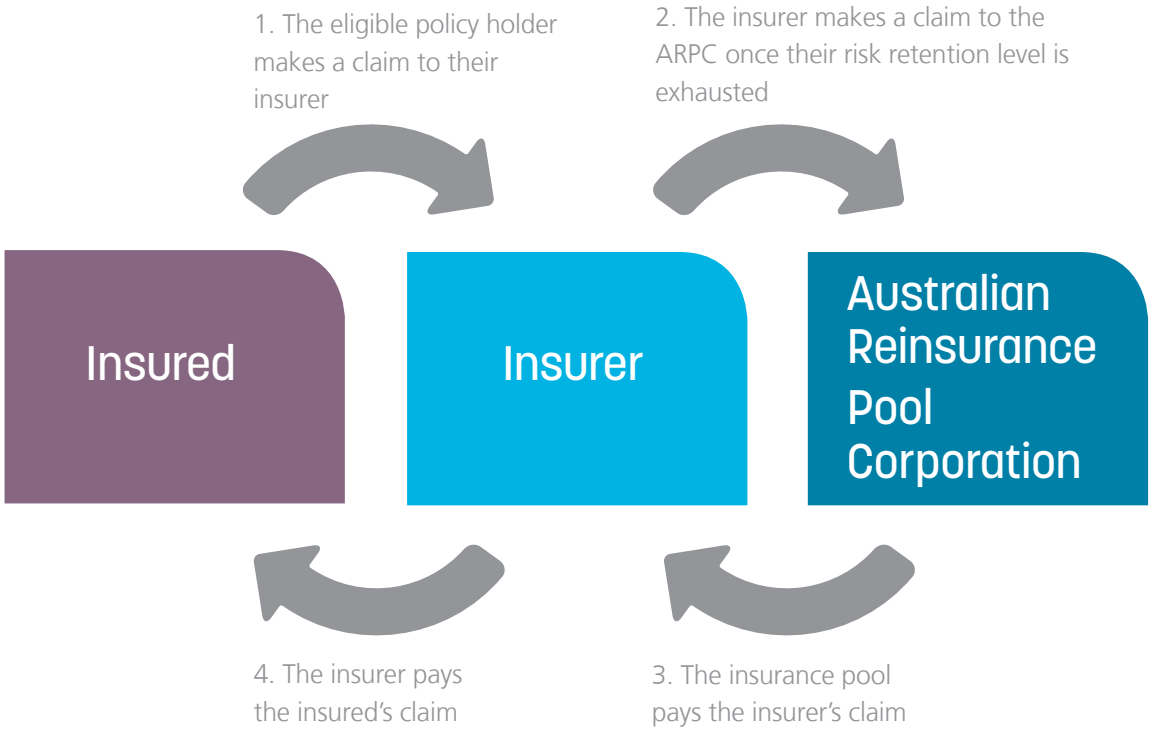
What is the position overseas?

The position overseas does not specifically impact on the ARPC. However, as more and more terrorist incidents occur that affect nationals from multiple countries, we may see governments work together to develop a standard reinsurance response to terrorist incidents.

In particular, it will be interesting to see how France's insurance industry responds to the Charlie Hebdo incident. France has a reinsurance scheme known as GAREAT. There are also notable terrorism reinsurance schemes in Austria, Belgium, Germany, South Africa, Spain, the United Kingdom, and the United States (which passed its *Terrorism Risk Insurance Act* in 2002).

Conclusion

In time, as affected businesses with eligible policies make claims against their insurance policies, the eligible insurers may be reinsured by the ARPC once the insurer's retention level is exhausted. This will ensure that the claims are paid out and that none of the relevant insureds are left with ineffective insurance policies.



A conversation with Ian Enright on the General Insurance Code of Practice

By Joanne Been

The General Insurance Code of Practice 2014 comes into effect on 1 July 2015. The new Code is the result of an independent review involving consultation with industry, customer groups, government, regulators and other stakeholders.

The Code is normally reviewed and revised every three years to ensure that it remains a living document that is quickly able to respond to changes in the market, products and customer needs. In 2012, the triennial review was brought forward and Ian Enright was selected as the independent reviewer.

With the end of the transitional period for the adoption of 2014 Code fast approaching, we talk to Ian about the review and some of the key issues that were identified and addressed in the new Code.

Why was the review brought forward?

The main impetus for the decision by the Insurance Council of Australia (ICA) Board to bring the review forward was to address concerns about the insurance industry's response to the impact of the 2010-12 natural disasters on the Australian community. There had been three summers in a row of unusually high levels of loss, damage and distress. These factors had highlighted the important role played by insurance companies in helping our communities to recover.

The speed and scale of legal and regulatory changes affecting the industry were also important factors.

What were some of the key issues highlighted by the review?

Code governance emerged as an important issue. Through the consultation process, we were given two very distinct narratives about how effectively allegations of breach of the Code had been dealt with and sanctions applied.

On the one hand, insurers felt that industry enthusiasm for the Code meant that they worked very well with the Code Compliance Committee (CCC) and with FOS (Financial Ombudsman Service) to ensure early detection and resolution of issues. And that where issues couldn't be resolved—there was still a very effective mechanism for the CCC to work with the insurer to understand and rectify the problem. Customers on the other hand, pointed to the fact that in its 20 year history only one sanction had been imposed under the Code, to support their view that the Code's model of self-regulation was not working effectively.

Another significant issue was how the industry had responded to claims following the natural disasters of 2010-12 and whether that response could be improved through changes to the Code.

Financial hardship was also rated as an important issue. Through the review process we discovered that, due to financial difficulties, many Australians had trouble maintaining their insurance policies and needed special arrangements to assist them at claim time.

How have these issues been addressed in the 2014 Code?

Overall, the Code governance arrangements have been made more independent and transparent. The CCC has been replaced by the Code Governance Body (CGB), which is an independent body made up of a consumer representative, an industry representative and an independent chair.

The CGB's powers are clearer and wider (it is now also involved in education and training and policy matters), and there is better coordination between the CGB and the FOS throughout the compliance monitoring and enforcement process.

Further, the Natural Disaster Declaration Guideline was incorporated as one of the Code guidelines. This is an important instrument to trigger the natural disaster provisions of the Code. The Code has also been amended to include a Natural Disaster Customer Response Guideline.

A new Financial Hardship Guideline was also adopted. This details a financial hardship assessment and notification process, as well as measures for assistance and mitigation.

The claims provisions are clearer and tighter and provide a more specific timetable.

And lastly, but importantly, the Code is now in plain language so that it is more understandable and accessible for customers.

Do you think more sanctions will be enforced under the Code's new governance structure?

History will tell its own story, but the evidence before the review was that there was quite a lot of activity around the monitoring compliance of the Code and a very high degree of self-reporting by the insurers. I would expect that to continue and indeed be higher if anything. With the CGB playing a greater role in how the audits and the monitoring is conducted, I think FOS and the CGB will be better able to see any instances of non-compliance.

But would I expect more sanctions in the future? That's very hard to say. I would be surprised if there were, simply because with the increased transparency and independence of the CGB, I think issues will be effectively dealt with before they move through to the ultimate sanction stage.

"The main impetus for the decision by the Insurance Council of Australia Board to bring the review forward was to address widespread concerns about the insurance industry's response to the impact of the 2010-12 natural disasters on the Australian community."

Do you think the Code may become mandatory in the future?

No, I think the industry and possibly other financial services industries will probably move in the other direction. Government regulation doesn't have a particularly good track record and is extremely expensive and resource intensive. Historically and even in modern times faulty regulation has had quite serious consequences. There's also now a greater realisation about how effective these voluntary codes of practice can be where you have a coherent, responsible industry that has customer service at its heart.

Consequently, I think we'll see more codes of practice covering wider ranges of regulation around the customer relationship. In light of the emerging concerns about the commission fees that life insurers offer financial planners, my prediction is that the life insurance industry will likely be the next to adopt a self-regulating code.

Do medical practitioners have a duty to rescue?

Mark Doepel and Verity Scandrett

Medical practitioners and their insurers breathed a sigh of relief in late 2014, after the Supreme Court of Western Australia handed down its unanimous decision in *Dekker v Medical Board of Australia* (2014) that the subject medical practitioner, who was off duty, did not owe a legal duty to rescue a person in an emergency situation.

However, the decision in *Dekker*, although encouraging for medical practitioners and their insurers, should be met with a degree of caution. There is still considerable potential for a medical practitioner to be exposed to claims while off duty, particularly if there is sufficient evidence that can establish a specific professional duty to rescue.

Background

In *Dekker*, the Medical Board of Australia commenced disciplinary proceedings against Dr Dekker for "improper" or "infamous" professional conduct after he failed to stop and provide medical assistance to a person following a "near miss" motor vehicle accident. Dr Dekker, who was a radiologist, had been involved in the accident and left the scene immediately after to notify police. The Medical Board claimed that Dr Dekker failed to discharge the professional duty owed by medical practitioners to provide medical assistance in circumstances where they are aware of the accident and potential for injury, and were physically able to give assistance.

As the law currently stands, there is still potential for a medical practitioner to be exposed to claims after they have clocked off for the day.

First instance decision

The State Administrative Tribunal agreed with the Medical Board and found Dr Dekker guilty of improper conduct. This decision purported to set an onerous precedent that no medical practitioner can leave the scene of a potentially injurious accident without the possibility of facing disciplinary consequences.

Supreme Court decision

On appeal, the Supreme Court overturned the Tribunal's decision, finding that no specific professional duty to rescue was owed by Dr Dekker.

The Court's ruling was made on the basis that:

- at the time of the accident, there was no evidence of a specific positive duty to rescue that was generally accepted by the medical profession
- the rules of natural justice precluded the Tribunal (half of whose members were non-medically trained) from drawing on its own knowledge and experience to decide on the existence of a specific professional duty, and
- there was no evidence that any duty to care for the injured was exercisable in the circumstances.

This decision is consistent with the common law position that, absent any prior relationship, there is no general duty imposed on an individual to rescue a stranger. It also marks a departure from the decision in *Lowns & Anor v Woods & Ors* (1996), where a NSW general practitioner was held liable in negligence for failing to attend to a person in an emergency who was not (nor had ever been) their patient.

What does this mean?

After two decades without any significant authorities addressing the obligations of medical practitioners in emergencies, the Supreme Court's decision to dismiss the

Medical Board's application against Dr Dekker for improper professional conduct is an encouraging result for medical practitioners and their insurers. This decision potentially narrows the scope for complaints by regulatory and disciplinary bodies against medical practitioners.

Proceed with caution

However, any relief should be tempered with caution. The Supreme Court's decision in Dekker cannot be regarded as binding authority that disciplinary action will not be taken if a medical practitioner fails to assist in an emergency.

The Court ultimately found that the evidence before the Tribunal was incapable of sustaining the Medical Board's claim against Dr Dekker, and absent such evidence, the Tribunal had erred in law. Had there been sufficient evidence that indicated Dr Dekker owed a specific professional duty to rescue, an adverse finding could have been made against her for failing to assist in the emergency.

There are also exceptions to the common law position that were not discussed in Dekker, but are relevant to medical practitioners. For example, medical practitioners in the Northern Territory are required, under s 155 of the *Criminal Code Act 1983* (NT), to provide medical assistance to a person who is in urgent need and whose life may be endangered if it is not provided. Callously failing to provide that assistance exposes medical practitioners to criminal charges and imprisonment for up to seven years.

In NSW, the adoption of the *Health Practitioner Regulation National Law Act 2009* (Cth) means that a medical practitioner in NSW may be found guilty of unsatisfactory professional conduct if they refuse or fail, without reasonable cause, to assist a person who is in need of urgent assistance–unless the practitioner has taken all reasonable steps to ensure that another medical practitioner will be there to assist within a reasonable time.

Conclusion

Despite the promise of immunity that the medical community hoped Dekker would bring, medical practitioners across Australia are no closer to having absolute protection from disciplinary proceedings for failing to render emergency assistance.

As the law currently stands, there is still potential for a medical practitioner to be exposed to claims after they have clocked off for the day. Consequently, although relatively small, providing assistance in an emergency remains an insurable risk for medical practitioners that warrants ongoing premium spend.

People with a disability: Who pays now?

By Colin Pausey

In June 2012, the NSW Government amended the *Workers Compensation Act 1987* (NSW) to require an injured worker to undergo a work capacity assessment after 130 weeks of receiving compensation benefits. In the coming months, a number of injured workers in NSW will be reaching the 130 week period.

If they don't meet the requirements of the work capacity assessment and workers' compensation benefits cease, who will pay the injured worker? And what other entitlements, if any, are available?

NSW workers' compensation: What is the threshold test?

The threshold test for NSW workers' compensation payments, which is determined by the insurer, is centred on capacity rather than incapacity. This change in emphasis aims to enhance the opportunity for injured workers to return to work—however, this hasn't been the case.

If the insurer determines that a worker has some work capacity and is not working 15 or more hours per week, then it is likely that the threshold will not be satisfied and the weekly compensation payments will cease.

Only those injured workers who can successfully demonstrate total incapacity or have no capacity to work will have ongoing workers' compensation entitlements.

Is TPD the answer?

Total and permanent disability insurance (TPD) is one of the few remaining lump sum benefits an injured worker may access. Most industry super funds have a default life insurance and TPD benefit available to members, and in recent years the number of claims being made to the funds and life insurers has increased.

The claim for a TPD benefit can be made whether or not the claimant is injured at work and whether or not they are still in receipt of workers' compensation benefits.

However, the threshold for payment of a TPD benefit is significantly different to the threshold for payment of benefits under the Workers Compensation Act.

A person is entitled to receive a TPD benefit, if they establish (generally) that after their injury or sickness they are "unlikely to ever" or "unable to" work in a position for which

they are qualified by education, training and experience.

Generally, the time for determining that threshold for entitlement is six months after the commencement of the claimant's disability. If a claimant meets that threshold, the disablement is considered to be both total and permanent.

Will the potential for a number of NSW workers to lose their weekly workers' compensation benefits cause another spike in TPD claims? The likely answer is yes. However, the contested nature of the threshold test for TPD will probably result in an increase in the number of disputed claims and associated costs, rather than in the number of accepted TPD claims and payouts.

In light of this, TPD is not the solution to the problem of workers' compensation benefits ceasing after 130 weeks.

Does the Disability Support Pension help?

Unlike TPD, the threshold test for the Commonwealth Disability Support Pension (DSP) is not total and permanent disablement. Rather, the disablement must only be likely to continue for at least two years.

The Workers Compensation Act amendments were initially seen as a shifting of the burden, so that people who had previously received benefits under the workers' compensation system, would be entitled to Commonwealth benefits, such as a DSP.

However, recent changes to the criteria to qualify for a DSP, has meant that the anticipated flood of recipients has not happened.

This is in large part due to changes that have been introduced by both the Labor and Liberal Commonwealth Governments. Most recently, in 2014, the Liberal Government reduced the threshold number of hours that a person in receipt of a DSP could work, from 30 to 15 hours.

Each time a person claims a benefit, a different test or series of tests apply and there are a number of gaps through which claimants can fall.

This change has made it harder for individuals to make a claim, as the reality is that many employers can more easily provide work for persons with a disability for up to 30 hours per week, rather than the more restrictive threshold of 15 hours.

The 2014 amendments make it particularly hard for people under 35 to receive the DSP. To remain eligible for DSP payments, recipients under 35 with some capacity to work will also be required to attend regular participation interviews with Centrelink and to develop participation plans, to help build their capacity and overcome barriers to work.

The DSP and the tightening of the threshold test to obtain its benefits doesn't seem to be the answer.

Where does that leave us?

Unfortunately, as the number of people with a disability or with a restricted capacity to work continues to rise, Australians are starting to realise that this may not be the lucky country for people with a disability.

The threshold tests for ongoing workers' compensation benefits, a TPD payment or the DSP benefit are different and bear little or no relationship to each other. Each time a person claims a benefit, a different test or series of tests apply and there are a number of gaps through which claimants can fall. The consequence is that many workers in NSW, who may lose their entitlement to benefits after 130 weeks, are unsure or uncertain of their future. We will continue to watch this space and keep you updated on any developments.

Expert evidence – failure to comply with duties to the court could be costly

By Brooke Grealy

The recent decisions of the Victorian Supreme Court in *Hudspeth v Scholastic Cleaning and Consultancy Services Pty Ltd & Ors* (Hudspeth) are a timely reminder of the paramount duty that experts, solicitors and barristers owe to the Court when obtaining, tendering and relying on expert reports—and the consequences of breaching this duty.

The expert reports

During the trial it became apparent that three different versions of the plaintiff's expert report were floating around:

- First Report: A report dated 9 April 2010, which Mark Dohrmann (the expert) had signed and sent to the plaintiff's solicitors, Clark, Toop & Taylor Lawyers, before the trial. The First Report was served on the defendant.
- Second Report: A report dated 9 April 2010, which was an amended version of the First Report. The Second Report included changes made by the expert's assistant at the request of the plaintiff's solicitors, without the expert's knowledge or approval of those changes or of the existence of the Second Report.
- Third Report: A report dated 12 November 2010, which was a further amended version of the First Report. The Third Report included changes made by the expert's assistant at the request of the plaintiff's barrister, John Richards SC, when it became apparent that the assumed facts in the First Report were inconsistent with the evidence given by the plaintiff during the trial. The expert signed the Third Report and provided it to the plaintiff's barrister, but it was not provided to the plaintiff's solicitors, nor was it served.

The inquiry

When giving evidence in chief, the expert was asked to read the assumed facts contained in his report. Unaware of the Second Report, he read from the First Report, while the plaintiff's barrister referred to the Second Report. Due to the inconsistencies between the two versions, it wasn't long before it was discovered that each was referring to a different report.

During cross-examination, the expert was questioned on the inconsistencies between the two reports. In his response, the expert disclosed that there was a Third Report, which had not been served on the other parties. The expert tried to explain this on the basis that the Third Report was a draft report he had prepared to assist with trial preparation, but the Court didn't accept this explanation.

Dixon J started an inquiry into the conduct of the plaintiff's solicitors, barrister and expert pursuant to s 29(2)(b) of the *Civil Procedure Act* (Vic) (the Act), to establish whether any of them had contravened their obligations to the Court.

The findings

Dixon J made the following findings about the conduct of the plaintiff's solicitors, barrister and expert as it related to the Third Report:

- The plaintiff's barrister breached his paramount duty to the Court, in particular the overarching obligation to disclose the existence of documents (s 26 of the Act) and not to engage in misleading or deceptive conduct in a civil proceeding (s 21 of the Act), as he:
  - led the Court into the error of assuming that the expert had not prepared and adopted a supplementary report

- misled the court in his submissions that the Second Report was relevant and admissible and the assumed facts would ultimately be established by evidence in chief from the expert
- led evidence from the expert as to the assumed facts, which arose out of the Third Report, when it had not been served nor had he sought leave from the Court, and
- went beyond proper conduct in dealing with an expert witness when he dictated changes to the expert's assistant, which effectively directed the expert away from observing the Expert Code of Conduct.

- The plaintiff's expert:
  - breached his overarching obligation not to engage in misleading or deceptive conduct by failing to disclose the Third Report (in circumstances where it was materially different from his previous versions) and therefore leading the Court to the wrong assumption that it had not been prepared or adopted, and
  - failed to adhere to the Expert Code of Conduct when giving his evidence in chief by not mentioning the existence of the Third Report.
- The plaintiff's solicitors breached the overarching obligation to disclose the existence of the Third Report under s 26 of the Act.

In his subsequent judgment handed down on 16 December 2014, Dixon J ordered:

- the expert to indemnify each of the plaintiff's solicitors and barrister for 13.333% respectively, for their liability to pay the costs arising out of the successful appeal lodged by the plaintiff after her initial action was dismissed, and
- the plaintiff's expert, solicitors and barrister each pay one-ninth of the defendant's costs, including reserved costs, of and incidental to the inquiry.

Lessons learned

Two important lessons can be taken from *Hudspeth*.

First, the role of a legal practitioner is to transparently instruct an expert, not to write or amend his report. It's then up to the expert to determine how a report should be amended, if at all, following a variation in instruction.

Second, where an expert has provided a supplementary report to a party, it must be served on all of the other parties as soon as possible. Failure to do so will prevent the parties from relying on the earlier and supplementary reports at trial and will be a breach of the overarching obligations. This breach entitles the court to make a number of orders under s 29 of the Act, including undertaking a costly inquiry and ordering that the perpetrator compensate a wronged party and/or pay their costs and expenses.

Recent developments

There have been a range of recent legal developments that affect decision-makers in insurance organisations, self-insureds and reinsurers. Click on the links below to read these articles.

Important amendments to the Seafarers Act introduced into House of Representatives

The *Seafarers Rehabilitation and Compensation and Other Legislation Amendment Bill 2015* proposes important amendments to the *Seafarers Rehabilitation and Compensation Act 1992* (Seafarers Act). The Bill proposes to repeal ss 19(2)-(5) of the Seafarers Act and introduce a "directly and substantially" test into the overseas/interstate trade or commerce requirement. If passed, the effect will be to reverse the impact of the Full Federal Court decision in *Samson Maritime Pty Ltd v Aucote* and the original Administrative Appeals Tribunal decision of *Aucote and Samson Maritime Pty Ltd.* *Click here to read more...*

NSW Court of Appeal highlights importance of properly assessing conflicting witness evidence

In a significant decision, the NSW Court of Appeal has set aside a District Court judgment on the grounds that the trial judge inadequately assessed crucial elements of witness evidence. Consequently, the appellant was found not to be liable for the respondent's motor accident injuries. This decision brings an end to a long running dispute and emphasises the delicate task a trial judge must perform in assessing conflicting witness evidence. *Click here to read more...*

Queensland Supreme Court decision opens door to shift liability from insurers to WorkCover

In *Byrne v People Resourcing (Qld) Pty Ltd & Anor* the Queensland Supreme Court held that WorkCover is required to extend indemnity to an employer for liability in contract to a co-tortfeasor. This decision is significant for its potential to shift the burden for such claims from public liability insurers to WorkCover, at least in the short term. Further, WorkCover may now be required to indemnify an employer for a contractual indemnity claim absent any liability to pay damages to the injured worker. *Click here to read more...*

Related entity exclusion ineffective where insured is a beneficiary of discretionary trust

The Supreme Court of Queensland has found that a related entity exclusion in a professional indemnity policy does not apply to a claim on behalf of a discretionary trust of which an insured was a beneficiary. The decision offers guidance on the Court's approach to the question of whether a claim is brought "on behalf of" an insured and in what circumstances an insured has a "financial interest" in the entity bringing the claim. *Click here to read more...*

Sparkes welcomes Lloyd's Chairman, John Nelson, to Australia

In February, we had the pleasure of hosting Lloyd's Chairman, John Nelson, at an event in our Sydney office. Our firm has had a strong association with the Lloyd's market for a long time, so we were very pleased to be able to welcome John on his first official visit to Australia since his appointment as Chairman in 2011. John was greeted by guests including representatives from cover holders and syndicate service companies. *Click here to read more...*

John Nelson, Lloyd's Chairman, speaks at Sparke Helmore

About the contributors

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Mark has extensive experience in professional indemnity litigation, directors' and officers' liability and reinsurance. He has practised in these areas for more than 17 years in London and Sydney.

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Colin works with life insurers and accident and health underwriters, advising on claims issues, policy wordings and compliance related issues. He has operational management experience and has acted on behalf of insurers, reinsurers and brokers.

Brooke Grealy, Senior Associate

Brooke has more than 13 years' experience in the area of directors' and officers' insurance. She has extensive experience as a defence lawyer and in advising Australian and international insurers on coverage issues from small claims through to large, multi-party litigated matters.

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Steven is a lawyer in our insurance team. He is primarily involved in professional indemnity, directors' and officers' liability, and reinsurance matters. He routinely assists clients in resolving a variety of professional, corporate and financial disputes.

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Joanne has worked in communications for professional services firms for three years, after a previous life as a commercial lawyer at a top tier international law firm. She specialises in corporate communications and social media.

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