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When Will An Individual Have The Right To Sue A Business For Mishandling Personal Information

The widespread use of digital platforms to interact with consumers, market and sell products and services and provide online services ensures that data is now seen as a valuable commodity.

Businesses collect data for its intrinsic value and businesses are often prepared to pay for data collected by others.

The collection of user data is fundamental in the business model of advertiser funded platforms.

Businesses that understand the value of data and how to leverage it are changing the way they think about the data they collect and the way it is managed however the tides of change may be approaching as the Government looks for ways to better protect consumers from harm caused by those that mishandle personal information.

In Australia individuals have limited recourse against digital platforms or those that collect data to seek compensation for mishandling their user data or personal information.

There is no statutory right for an individual to bring a civil claim for breach of privacy nor does Australian law recognise a cause of action for breach of privacy.

The *Privacy Act* has been in play for some 30 years in Australia however consumers do not have a cause of action against a company that breaches the Australian privacy principles or the *Privacy Act*. A consumer's only recourse is to complain directly to the business that has mishandled their information and then to make a complaint to the Office of the Australian Information Commissioner.

However that position may change with the recommendations of the Australian Competition and Consumer Commission's ("ACCC") following its recent inquiry into digital platforms. The ACCC's final report was published at the end of June 2019 advocating the introduction of a private right to bring a claim for compensation where personal information is mishandled.

This is not the first time in Australia that the Government's advisors have advocated the creation of a statutory cause of action for individuals against those that mishandle personal information.

In 2014 the Australian Law Reform Commission ("ALRC") advocated the introduction of a statutory cause of action in the form of a tort of serious invasion of privacy.

The ACCC in its inquiry revisited the ALRC's recommendations and has recommended the adoption of the ALRC's 2014 recommendations concerning the creation of a statutory cause of action against those that mishandle personal information.

If the ACCC recommendations are accepted individuals will be entitled to bring an action against those that mishandle information for serious invasion of privacy. The protections found in the Privacy Act will continue however the creation of a statutory cause of action will be an added deterrence against harmful data practices.

The ACCC by the adoption of the recommendations of the ALRC support the creation of a statutory cause in the form of a tort of breach of privacy be made available for either "intrusion into seclusion or misuse of private information".

The statutory tort of invasion of privacy would have the following elements:

- the person who brings a claim must provide they had a reasonable expectation of privacy in the circumstances;
- the invasion of privacy must have been committed intentionally or recklessly;
- the invasion of privacy must be serious;
- the invasion need not cause actual damage and damages for emotional stress may be awarded;
- a Court must be satisfied the public interest in privacy outweighs any countervailing public interest.

As for remedies Courts should be empowered to:

- award damages for economic loss or emotional distress;
- in some circumstances award exemplary damages to punish and or deter;
- order an account of any profits made from the invasion of privacy;
- impose injunctions;
- order companies to deliver up and destroy or remove material.

Consumers in the UK, New Zealand and certain provinces in Canada have the ability to bring an action against a party that has misused their personal data or breached their privacy.

Class actions arising out of data breaches are common in the US.

The introduction in Australia of a statutory cause of action for a breach of privacy would have wide ranging ramifications for all businesses.

And now the ACCC in its June 2019 report arising from its inquiry into Digital Platforms recommended that the Government adopt the ALRC's recommendations concerning the creation of a statutory cause of action against those that mishandle personal information.

Treasury launched a consultation seeking stakeholder comments on the ACCC's findings and recommendations in August 2019 and that consultation closed on 12 September 2019. We are waiting to see what transpires.

However it seems that in the future individuals may be entitled to bring an action for serious invasion of privacy and or mishandling personal information and businesses will need to look at risk strategies for the new potential liability. Insurance will no doubt feature in those considerations and we will watch with interest to see whether insurers seek to manage any new liability by developing bespoke privacy breach insurance policies, adding it to cyber insurance products, or management liability products, or providing cover under general liability insurance policies.

Challenges lay ahead.

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Shake up for Add On Insurance in Australia

On 9 September 2019 the Government published a proposal paper on reforms to the sale of add-on insurance products in Australia and gave 21 days to stakeholders to comment on the proposals. Time to make submissions closed on 30 September. The Governments Roadmap for Reforms identifies 30 June 2020 as the target date for introduction of these reforms.

Add-on insurance is sold or offered at the same time as an associate primary product.

The Royal Commission into Misconduct in the Financial Services Industry recommended an industry wide deferred sales model for the sale of add-on insurance products except for comprehensive motor insurance.

Over the last few years ASIC has focused attention to on add-on insurance products and associated sales practices including pressure selling and more that $130 million is being returned to consumers for the sale of car-yard add-on insurance which ASIC viewed had little or no value to over.

The Government's proposal paper makes it plain that the Government's main concerns about add-on insurance and sales practices which have developed

are poor claims ratios, low level of consumer engagement and pressure selling.

The Government's concerns include that add on insurance as sold through intermediaries or external sellers that are not subject to the strict licensing obligations and enforcement requirements that insurers operate under and are generally sold under a general advised model in which the seller is under no obligation to take into account the personal financial circumstances of the consumer.

Not all add on insurance will be treated the same.

The General Insurance Code of Practice Committee has observed that as at June 2018 there were 28 different types of add-on insurance products sold in the Australian market. Details of the types of add on insurance were published by the Committee in its report which we have replicated below:

Accidental damage cover for mobile electronic devices	Covers accidental damage to mobile electronic devices such as mobile phones and tablets.
Cargo insurance	Covers cargo as it is transported from one location to another location.
Consumer credit insurance (CCI)	Sold with credit cards, personal loans, home loans and car loans, CCI insures the debtor's capacity to make repayments under the credit contract if they become sick, injured or disabled; lose their employment or die.
Home contents insurance	Covers cost of repairing or replacing household property such as jewellery, furniture and electrical appliances and devices.
Guaranteed asset protection insurance (GAP)	Sold with assets, GAP insurance covers the difference between what a consumer owes on a loan and any amount received under a separate insurance policy if the asset is a total loss.
Jewellery insurance	Covers cost of repairing or replacing jewellery.
Loan termination insurance	Sold with assets, loan termination insurance covers the difference between what a consumer owes on a loan and the value of the asset if they are unable to make a repayment and the asset is sold.
Mechanical breakdown insurance	Also known as an 'extended warranty', mechanical breakdown insurance covers the repair or replacement of specific parts where unexpected mechanical failure occurs. It typically applies after a manufacturer's or dealer's warranty has expired.
Motorcycle insurance	Three types of cover: damage to an insured's motorcycle (comprehensive) and other people's property; damage to other people's property (third party property); same as third party property with fire and theft cover for the insured's motorcycle.
Motor vehicle – cover for vehicles under a finance contract (CCI insurance)	Covers a borrower's shortfall under a finance contract when they and the financial institution agree to return the vehicle and terminate the finance contract (for instance due to illness or bankruptcy) or relieves the borrower of repayment obligations if certain defined events occur (for instance due to involuntary unemployment).
Motor vehicle – excess insurance	Covers an insured's excess payment on a claim under a separate motor vehicle insurance policy.
Motor vehicle – GAP insurance	When a vehicle is deemed a total loss, covers shortfall between the original purchase price of the vehicle and the total loss payment under a separate motor vehicle insurance policy.
Motor vehicle – hybrid GAP insurance	When a vehicle is a total loss, pays an insured the greater of: the original purchase price of the vehicle (if owned outright) less the total loss payment, or the replacement vehicle value less the total loss payment and/or the loan settlement amount due to the financial institution less the total loss payment.
Motor vehicle insurance	Three types of cover: damage to an insured's vehicle (comprehensive) and other people's property; damage to other people's property (third party property); same as third party property with fire and theft cover for the insured's vehicle.
Motor vehicle – loss of personal effects	Covers loss of personal effects that were in a vehicle deemed a total loss under a separate motor vehicle insurance policy due to accident, fire or theft.
Motor vehicle – scratch and dent insurance	Covers the cost of repairing minor accidental scratches and dents to an insured's motor vehicle.

Motor vehicle – novated motor vehicle lease insurance (CCI)	Covers an insured's novated lease repayments if unable to continue them due to involuntary unemployment.
Pet injury insurance	Covers injuries sustained by pets.
Pleasurecraft insurance	Covers vessels used for pleasure or recreation such as boats and personal watercraft.
Pleasurecraft – mechanical breakdown insurance	Covers repair or replacement of specific mechanical parts if an unexpected mechanical failure occurs.
Rental bond insurance	Covers a renter for accidental damage to the rented premises and extra cleaning costs due to an estate agent's final inspection.
Rental vehicle – accidental death, disablement & baggage insurance	Covers accidental death, disablement and damage/loss of baggage/personal effects during the hire period.
Rental vehicle insurance – excess	Covers excess that is payable when a rental vehicle is damaged while in the possession of the hirer.
Ticket event/ticket cancellation insurance	Ticket cover: covers an insured's ticket cost when they cannot attend the event due to for example illness or airline delays. Event cover: covers the insured's loss of costs or expenses or income due to for example cancellation or postponement of the event.
Transit insurance	Covers an insured's possessions when being transported by road, rail, sea, air or post.
Transport package	Package contains several covers including liability, carrier's cargo and business interruption cover.
Travel insurance	Covers an insured for financial losses caused by certain defined events that can affect travel – such as trip cancellation, medical expenses or theft of luggage.
Tyre and rim insurance	This insurance covers the cost of repairing and replacing damaged tyres and rims.

The Government intends to introduce a tiered approach, categorising add-on insurance into three categories as follows:

- Tier 1 - products causing significant consumer detriment;
- Tier 2 –all add-on insurance products other than Tier 1 and Tier 3;
- Tier 3 – case by case exemptions for products that meet relevant criteria.

The Government proposes to regulate products causing significant consumer detriment (Tier 1) through ASIC's product intervention powers. These powers are available where ASIC is satisfied that a product has resulted or will result or is likely to result in significant consumer detriment. ASIC has intervention powers permitting it to ban or impose conditions on the offering of financial products to retail clients.

Intervention orders can include a requirement that a product must not be issued to a retail client unless the retail client has received personal advice. ASIC can also make intervention orders that persons must not engage in specified conduct in relation to a class of products.

In relation to Tier 2 products it is proposed there will be a deferred sales model prescribing information that must be provided at the time the product is offered and specifying when the product can be purchased.

The prescribed information that will need to be provided when add-on insurance is offered includes:

- the total premium of the add on insurance contract including options for different cover levels within a particular product;
- the significant features of benefits, significant and unusual exclusions or limitations and cross references to the relevant policy document provisions;
- the duration of the policy;
- when the consumer can initiate completion of sale;
- the product claims ratio;
- notification that the add on insurance product is sold by other distributors;
- a link to ASIC money smart website on the particular add on insurance product (if available); and
- the date the above information is provided to the consumer.

This information can be delivered by hard copy disclosure or online.

The deferral period proposed is four days for Tier 2 products.

Deferred sales models can inconvenience consumers and there will be mechanisms for consumers to shorten the deferral period and products will be able to be purchased by the consumer the day after they are offered where the customer initiates the completion of the sale.

In addition, at the conclusion of the deferral period the seller will only be able to contact the consumer once after the deferral period in respect of their offer of the product.

As for Tier 3 ad-on insurance products ASIC will create a list of products which will be exempt from any deferred sales requirements and ASIC intervention on the terms that the products are offered. The exempt products will be those that historically have shown to be good value for money and there is strong competition in the market and the products are well understood by consumers, and there is a high risk of under insurance.

Moving forward ASIC will be responsible for supervision of add-on insurance and will manage the products dealing with exemptions for Tier 3 products and intervention orders for Tier 1 products.

The proposed reforms will not apply to the comprehensive motor insurance market.

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No Duty of Care When Involved in Joint Illegal Enterprises

The NSW Court of Appeal has recently considered whether or not a driver of a motor vehicle should be liable to his passenger who sustained serious injuries when the car left the road and collided with a telegraph pole at Wallsend in Newcastle (*Bevan v Coolahan*) whilst being used to drive to a location to pick up illegal narcotics.

Chloe Bevan was injured in a motor vehicle accident on 9 August 2014. There were four occupants of the car at the time of the accident, all of whom had consumed Cannabis and Crystal Methamphetamine (ice).

Ordinarily there would be no issue with liability if negligent driving occurred. The complication here was that the driver and passengers were arguably involved in a joint illegal enterprise at the time of the collision.

The matter proceeded to hearing in the District Court before her Honour Judge Gibson who dismissed the claim on the basis the driver and passengers, including Bevan, were involved in a joint illegal enterprise which prevented Bevan from recovering damages from someone else involved in the same enterprise.

In her judgment the trial judge described the joint illegal enterprise as:

- conspiring to travel to procure ice from the home of a drug dealer, "Crystal";
- using the vehicle illegally for this purpose as none of the people in the vehicle could have driven the vehicle lawfully, as all of them had consumed significant quantities of drugs;
- procured the ice in exchange for an iPod that was illegally obtained by Bevan from her brother and jointly taking the drugs in the vehicle using an ice pipe;
- storing the remaining ice and ice pipe in the vehicle to travel to 'Crystal's' house for further drug consumption.

The Court of Appeal by a 2-1 majority dismissed the appeal.

The majority were of the opinion that Bevan was engaged in a joint illegal enterprise and so was not owed a duty of care by the driver.

Basten JA in his judgment stated:

> *"There was, as the amended defence alleged, a joint illegal enterprise involving the purchase, consumption and possession of Crystal Methamphetamine. The use of the car to travel to the place of purchase and back home, carrying some of the purchased drugs, having consumed the rest, was an essential element in the enterprise. The possibility that the driver would, after consuming drugs, drive negligently or dangerously, and thereby commit further offences, must have been foreseen in circumstances where the very act of driving under the influence of drugs was illegal. Accordingly, it fell within the scope of a joint criminal enterprise as identified in Miller v The Queen; just as there was incongruity in the law applying a duty of care with respect to the participants in the theft and illegal use of a motor vehicle, similarly there is an incongruity in conceding an enforceable duty of care between participants in a joint enterprise involving the taking of illicit drugs and the use of a motor vehicle. The principle of joint liability meant that the plaintiff was equally responsible with the driver for his conduct in the driving of the vehicle."*

As well as considering the common law principle of joint illegal enterprise, Justice Leeming in his judgment undertook a lengthy consideration of Section 54 of the *Civil Liability Act* 2002 which applies to motor accidents. That section provides:

> *"54 Criminals not to be awarded damages*
>
> *1. A Court is not to award damages in respect of liability to which this Part applies if the Court is satisfied that:*
>
> *(a) the death of or the injury or damage to, the person that is the subject of the proceedings occurred at the time of, or following, conduct of that person that, on the balance of probabilities, constitutes a serious offence, and*
>
> *(b) that conduct contributed materially to the death, injury or damage to the risk of death, injury or damage.*
>
> *2. This section does not apply to an award of damages against a defendant if the conduct of the defendant that caused the death, injury or damage concerned constitutes an offence*

(whether or not a serious offence)."

This section was not pleaded by the defendant and in fact the defendant argued that Section 54 had no application in this case.

Nevertheless, Justice Leeming noted the difficulty with the operation of Section 54 where there was a joint illegal enterprise. Further, Justice Leeming noted Section 54 only becomes applicable as a prohibition on the award of damages, which only comes into play after duty, breach and causation have been established. If an argument of joint illegal enterprise is successful then no duty of care is owed.

Justice Leeming also formed the view Bevan was prohibited from recovering damages as a consequence of joint illegal enterprise. Bevan had committed offences contrary to the *Drug Misuse and Trafficking Act* and the *Road Transport Act a*nd her claim must therefore fail.

Justice McCallum was in dissent. In Justice McCallum's view, on the defences pleaded the illegality was not such as to deny the existence of a duty of care. The plaintiff's conduct in being a passenger in the car was not unlawful.

Justice McCallum stated:

"The fact that she remained a passenger knowing that the driver had consumed drugs sounds in contributory negligence or assumption of risk but, not being unlawful, is not incongruent with the existence of a duty of care owed to her as a passenger. Assuming the parties were engaged in a joint criminal enterprise to possess prohibited drugs and administer those drugs to themselves, the use of the car was an incident of that enterprise but was not in itself unlawful. On the defence as pleaded, I would allow the appeal for those reasons."

However Bevan's case ultimately failed. The majority of the Court of Appeal were of the opinion Bevan could not recover damages given her involvement in the joint illegal enterprise.

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Statutory Benefits and the Motor Accident Injuries Act 2017

In December 2017 the Motor Accident Injuries Act 2017 ("MAIA 2017") came into effect in New South Wales.

That legislation resulted in a complete overhaul of the previous system and provided for a system where statutory benefits are payable to a person injured in a motor vehicle accident regardless of who was at fault.

The first judicial determination involving this legislation was recently handed down by His Honour Justice Fagan in the Supreme Court (AAI Limited v Singh).

On 29 April 2019 a prime mover driven by Singh, and it's attached trailer, rolled over on a street in Mascot. Shortly prior to the accident occurring the container had been loaded onto a trailer by QUBE. Singh was subcontracted to Simer Transport Pty Limited who had a contract with QUBE for the transport of containers.

When the accident occurred Singh was making a right hand turn at less than 10kph. The vehicle rolled as the contents had not been secured within the container, resulting in them shifting when the truck made the right hand turn. Singh was not involved in the loading.

Following the accident Singh made a claim pursuant to the MAIA 2017. For a period of 26 weeks after the accident he received from GIO weekly payments along with medical expenses. After the 26 weeks GIO ceased payment of the statutory benefits.

GIO argued that as a consequence of the provisions the accident was deemed to be wholly Singh's fault and so Section 3.11 as well as 3.28(1)(a) were engaged and Singh was no longer entitled to the benefits.

Singh disputed this was the case.

An internal review of the decision was undertaken at Singh's request. GIO upheld its decision and Singh subsequently applied to the Dispute Resolution Service for determination of his claim.

The matter proceeded to assessment and on 13 February 2019 Belinda Cassidy, the assessor, issued a certificate stating her findings that for the purpose of Sections 3.11 and 3.28 the accident was not caused by the fault of Singh.

GIO appealed. The matter was heard by His Honour Justice Fagan.

His Honour Justice Fagan discussed the provisions of the legislation including Clause 3.11 which provides that:

"1. An injured person is not entitled to weekly payments of statutory benefits under this Division for any period of loss of earnings or earning capacity that occurs more than 26 weeks after the motor accident concerned if:

(a) the motor accident was caused wholly or mostly by the fault of the person; or
(b) the person's only injuries resulting from the motor accident were minor injuries.

2. A motor accident was caused mostly by the fault of a person if the contributory negligence of the person in relation to the motor accident ... was greater than 61%."

In contrast section 5.2 Liability in case of no-fault motor accident provides:

(1) The death of or injury to a person that results from

a no-fault motor accident involving a motor vehicle that has motor accident insurance cover for the accident (within the meaning of section 1.10) is, for the purposes of and in connection with any claim for damages or statutory benefits in respect of the death or injury, deemed to have been caused by the fault of the owner or driver of the motor vehicle in the use or operation of the vehicle.

(2) If the no-fault motor accident involved more than one motor vehicle that has motor accident insurance cover for the accident (within the meaning of section 1.10), the death or injury is deemed to have been caused by the fault of the owner or driver of each of those motor vehicles in the use or operation of the vehicle

Justice Fagan undertook a detailed analysis of the legislation including Part 5 of the legislation that relates to no fault motor accidents. Justice Fagan stated:

"An aspect of the Scheme of Pt 3 is that fault in causing the accident is the criterion for terminating statutory benefits at 26 weeks. That Scheme would be subverted if a section located in Pt 5 (dealing with accidents not caused by anyone's fault) should operate to deem fault in the causation of the accident for the purposes of the limit on statutory benefits. In my view S5.2(1) does not so operate. Section 5.8 reinforces this conclusion. Pt 5 has no bearing upon Mr Singh's entitlement to statutory benefits. It provides no basis for them being terminated after 26 weeks."

After consideration of the legislation as a whole Justice Fagan noted there were a number of problems with the legislation. His Honour concluded:

"Notwithstanding that a path through the labyrinth of Pts 3 and 5 of the Motor Accident Injuries Act has been found for the purposes of resolving this proceeding, it is apparent that these provisions, Pt 5 in particular, require careful and detailed reconsideration. Amendment will be necessary if a spate of litigation generated by the obscurities of these provisions is to be avoided. At the very least, the conflict between Sections 5.1 and 5.6 should be addressed by amendment. If the interpretation adopted in these reasons accords with Parliament's intention then 5.6 should be repealed. If not, the definition of "no fault motor accident" in Section 5.1 will require adjustment in some respect, adopting a qualification to the concept of "any other person" that I cannot presently envisage."

"The width of Section 3.1(2) is such that statutory benefits are payable by the insurer of a vehicle involved in a motor accident even if the accident was not caused by the fault of any person, including the owner or driver of a motor vehicle or the injured party. Section 3.2(1) provides the rule for determining which insurer must pay the statutory benefits. Thus Pt 3 is sufficient to provide for entitlement to statutory benefits and to identify the insurer responsible for them in the case of any motor accident that would fall within the definition of a "no fault motor accident" in Section 5.1. There is no need for the provisions of Pt 5 to deal with statutory benefits, at all."

It remains to be seen whether or not following this decision there will be amendment to the legislation.

This judicial determination has identified issues that may need to be addressed. However what is clear as the law now stands in NSW a persons entitlement to weekly compensation does not end at 26 weeks if a person is injured in a motor accident that is not caused by anyone's fault.

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The Operation of an Insolvency Exclusion in a D & O Policy

Directors of companies have both statutory and fiduciary duties to shareholders and others to ensure the company operates within the law and trades while solvent.

A company director can be exposed to personal liability for breaches of insolvent trading provisions of the *Corporations Act 2001* (Cth) including law suits brought against him / her by receivers or liquidators of the company.

To that end, companies will often take out insurance policies that provide cover to its directors and officers for "management liabilities" that arise during the course of the director's or officer's duties. This usually means a director is covered for liability arising from any actual or alleged act, error or omission or breach of duty arising from the person's status as a director, subject to policy exclusions.

One such exclusion involves the company's insolvency. If the director's acts, errors or omissions led to the company becoming insolvent, and the company suffered losses, is the director covered for liabilities arising from those losses or does the policy exclusion apply?

This issue arose for consideration in the recent decision of the Full Federal Court of Australia in *AIG Australia Limited v Kaboko Mining Limited*.

Kaboko entered into agreements with Noble Resources Limited ("Noble") which provided for Noble to buy from Kaboko a large quantity of manganese ore from mines in Zambia in exchange for Noble agreeing to advance US$10m to Kaboko in two tranches.

The advances were to be treated as provisional payment for the managanese. The delivery of manganese to Noble was to be treated as repayment of the advances.

Under the agreements, Kaboko undertook not to sell manganese from the mines to a third party without Noble's prior written consent.

Noble claimed that Kaboko was in default of its undertaking by allegedly selling manganese to a third party without Noble's consent.

Noble made a demand for payment of US$6.3m on the basis that Kaboko's liability to repay the amount had been accelerated by reason of unremedied default. Noble then issued a statutory demand to Kaboko for US$5.95m.

Some months after these events transpired, AIG issued a policy to Kaboko which contained management liability cover for directors and officers of the company.

After the policy was issued, Noble sent letters to three directors of Kaboko giving them notice of insolvent trading claims under *Corporations Act,* s588G(1).

Noble's statutory demand was then set aside upon an application by Kaboko. Noble subsequently made a demand for repayment by Kaboko of the first tranche. When payment was not forthcoming Noble appointed receivers to Kaboko.

Kaboko then appointed administrators which led to a deed of company arrangement being entered into.

The administrator then brought proceedings in the Federal Court, funded by Noble, making claims against the former company directors.

The claims involved allegations the company director failed to use the advances made by Noble to Kaboko for the mining operations specified in the agreements including the sale of manganese to third parties without Noble's consent.

It was also pleaded in general terms that in the absence of these failures by the company directors, Kaboko would have had the commercial opportunity to develop the mines and realise a profit.

The directors made a claim under the AIG policy and sought indemnity with respect to the claims by Kaboko in the Federal Court proceedings.

AIG declined to indemnify the directors in reliance upon an insolvency exclusion clause.

This led to AIG being joined as a respondent to the proceedings. The issue concerning whether or not AIG was liable to indemnify the directors; specifically, whether or not the insolvency exclusion clause applied, was heard as a separate question by Justice McKerracher.

At the hearing of the preliminary question the parties relied upon an agreed set of facts. The primary judge found in favour of the company directors.

AIG appealed to the Full Federal Court. By a unanimous decision, the Full Court (Allsop CJ, Derrington & Colvin JJ) dismissed the appeal.

The Full Court noted the wording of the exclusion clause in the following terms:

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

Each of the emboldened words were separately defined in the policy which the Court also considered in the context of the appeal.

AIG argued the exclusion clause applied if there was the requisite insolvency connection with either the bringing of the Claim or the nature of the Loss for which indemnity was sought.

The insurer also contended that the bringing of the proceedings arose out of, was based upon or was attributable to the insolvency of Kaboko or its inability to pay its debts. It was submitted there would have been no proceedings if Kaboko had repaid Noble the first tranche advances when they were due and reason the proceedings were brought was due to the insolvency of Kaboko.

The directors argued the exclusion clause only applied if insolvency was one of the underlying facts that, if established, would justify the claim or the loss claimed. In other words, for the exclusion to apply, the merits of the claim itself or the causal pathway for the loss claimed in the proceedings must be shown to depend upon demonstrating the insolvency of Kaboko or its inability to pay any or all of its debts.

The Full Court observed the wording of the exclusion clause used both "Loss" and "Claim" in circumstances where the definition of Loss itself incorporated the term "Claim".

Second, the definition of "Claim" was concerned with the occurrence of an event, not the reasons why that event occurred.

Further, the Full Court noted the exclusion clause could have been expressed as applying to any Loss arising out of or based upon or attributable to Kaboko's insolvency or inability to pay its debts.

It did not.

Alternatively, it could have been expressed as applying to any Claim, without any reference to Loss.

It did not.

Here, the Full Court stated the key question was whether it can be said the Claim arises out of, is based upon or is attributable to the actual or alleged insolvency of Kaboko or its inability to pay its debts when due.

The Full Court held that a Claim does not so arise in this instance unless the subject matter of the Claim has that character. The exclusion was not to be read as applying where the insolvency of Kaboko, or its

inability to pay its debts, might be said to have motivated or led to the Claim being brought.

The Full Court highlighted there was no language in the definition of Claim nor in the terms of the insolvency exclusion, that directs attention to the reasons why the Claim was brought. Further, the definition of Claim refers to demands and proceedings for a specified act, error or omission, thereby focusing on the character of the Claim not the reasons for it.

The Full Court observed:

> *"…if the scope of the exclusion depended upon an inquiry into the reason for bringing a claim then there would need to be an objective or subjective inquiry into the state of mind of those bringing the Claim. In this case, the Claim is brought by the administrator, but AIG seeks to rely upon the motivations of Noble as the party funding the proceedings. In a different case, there could be a third party funder supporting a claim that is being brought in the interests of a few creditors who have not been paid. It can be seen that there would be complexity in an inquiry as to whether the proceedings were in some way said to be ultimately the result of an effort to recover amounts that a creditor could not pay and for that reason they had the specified insolvency link."*

Kaboko's claims against the company directors, so the Full Court held, were not founded upon any allegation of insolvency or insolvent trading. They were founded upon alleged failures by the directors to ensure Kaboko complied with the terms of the agreements with Noble to fulfil the company's obligations with respect to the manganese ore which resulted in a lost commercial opportunity that affected Noble.

Accordingly, the appeal was dismissed.

This interesting decision illustrates the principles applied by Courts when interpreting the wording of an insurance policy by inserting definitions into clauses to give them their full meaning and effect.

Here, the Court held the insolvency link qualified the types of Claims for which indemnity for Loss must be provided. As such, the exclusion clause was only enlivened if the Loss was in connection with any Claim with the specified insolvency link.

As the Claim was held not to have the specified insolvency link, the exclusion did not apply.

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When Can a Life Insurer Pay a Death Benefit into Court?

One feature of life insurance policies is that they provide for the payment of a benefit upon the death of the insured to the insured's estate or legal personal representative.

What if no-one comes forward to claim the death benefit or if the life insurer cannot, after reasonable enquiries, locate a legal personal representative or someone to whom the benefit can be paid to discharge the life insurer's obligation under the policy?

This interesting question was recently considered by Justice Thawley of the Federal Court of Australia in *Westpac Life Insurance Services Ltd v Estate of the Late Graham Brian Ugle*.

Ugle took out a life insurance policy with Westpac in 2003. Under the policy, Ugle was entitled to a lump sum benefit of $50,000 if he died in an accident.

In December 2004, Westpac received notice of Ugle's death which, after investigations, Westpac ascertained was the result of accidental drowning.

The life insurer also determined that Ugle did not, at the time of his death, leave a valid will. Further, the deceased had no wife, no *de facto* partner or any children.

He did, however, have four sisters and one brother.

In what has been almost 15 years since notice of Ugle's death came to Westpac's attention, the life insurer has been unable to discharge its obligation to pay the death benefit under the policy.

Accordingly, Westpac commenced proceedings in the Federal Court seeking orders under *Life Insurance Act 1995* (Cth), s215 which creates a statutory right for a life insurer to pay into the Court any money payable by the life insurer in respect of a policy for which, in the life insurer's opinion, no sufficient discharge can otherwise be obtained.

The proceedings were brought under rule 9.24 of the *Federal Court Rules 2011* (Cth) which provides:

> ***Deceased Persons***
>
> *(1) If:*
>
> *(a) A deceased person was interested in, or the estate of a deceased person is interested in, any matter or question in a proceeding; and*
>
> *(b) The deceased person has no personal representative;*
>
> *a party may apply to the Court for an order:*
>
> *(c) That the proceeding continue in the absence of a person representing the deceased person; or*
>
> *(d) That a person who has consented in writing represent the deceased person's estate for the purpose of the proceeding.*
>
> *(2) An order under subrule (1) and any subsequent order made in the proceeding binds the estate of the deceased person as the estate would have been bound if the deceased person's personal representative had been a party to the proceeding."*

Thawley J noted the evidence before the Court, at the first case management hearing, indicated Westpac had been attempting to pay the death benefit since March 2006 but it has been unable to do so.

The evidence also confirmed there was no personal representative of Ugle as no-one had applied for letters of administration.

There was, however, some evidence of Westpac having established contact with one of Ugle's surviving sisters.

Westpac had given written notice to lawyers who acted for the sister that the Federal Court application was listed for a case management hearing and that the life insurer intended to seek appropriate orders to pay the death benefit into Court.

The lawyers for Ugle's sister responded by letter stating they wished to be kept informed of the outcome, without their client seeking to actively participate.

In those circumstances, Justice Thawley was satisfied the elements of rule 9.24 of the Rules had been established by Westpac and accordingly it was appropriate for the life insurer to apply to the Court for orders in the absence of any person representing the estate of the deceased.

His Honour then proceeded to make orders under s215 of the Act requiring Westpac to pay into Court the amount of the death benefit (which had increased to $51,500 as at August 2019) with Westpac's costs of the application to be assessed on the papers with the assistance of a registrar of the Court and deducted from the moneys paid into Court.

Further, the Court ordered that notice of the orders be served on the solicitors acting for Ugle's sister and granted liberty to any personal representative or family member of Ugle to apply in relation to the balance of the proceeds remaining after payment of Westpac's costs.

The Court also declared that upon payment of the death benefit into Court, Westpac will be discharged from any further liability under the policy in relation to the death benefit.

A life insurer therefore has the option of bringing a Court application to discharge its obligation under a life policy to pay a death benefit into Court, even where many years have passed since the death, which created an entitlement to the benefit, occurred.

It is interesting that the insurer waited nearly 15 years to do so in this case but the Court adopted a sensible approach to make the orders at the first available opportunity to keep the costs of the application to a minimum and not whittle away the moneys paid into Court.

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TPD Claim – Member's Appeal Dismissed - Insurer not in Breach of Duty to Act Reasonably & Fairly

In our October 2018 edition of GD News we reported on the NSW Supreme Court decision in *Newling v FSS Trustee Corporation (No 2)* in which his Honour Justice Parker dismissed a claim by a group member for payment of a total and permanent disablement benefit under a life insurance policy issued by Metlife Insurance Limited ("Metlife") to FSS Trustee Corporation ("FSS").

The NSW Court of Appeal recently dismissed the member's appeal by a unanimous decision (per Emmett AJA, Bell P & Leeming JA concurring).

To recap the case at first instance, Kim Newling, a former officer of the NSW Police Force, performed desk work after sustaining a back injury in 1997.

In 2011, Newling ceased work and in May 2012 she was discharged from the Force on medical grounds.

In April 2012, Newling lodged a TPD Claim as a member of FSS which had obtained a group life insurance policy with MetLife.

The MetLife policy provided benefits to FSS members, including a TPD benefit.

The relevant policy wording stated that MetLife was not required to pay the TPD benefit unless proof to its satisfaction had been presented that the claim was valid.

MetLife considered all of the evidence provided on behalf of Newling which included several medical reports.

In addition, MetLife obtained its own medical evidence from a psychiatrist, orthopaedic surgeon and vocational practitioners.

MetLife also obtained surveillance footage of Newling.

MetLife wrote to Newling's solicitors inviting them to make submissions to confirm why Newling was entitled to the TPD benefit.

MetLife provided a summary of the evidence with comments expressing some scepticism of various medical opinions or inconsistencies between Newling's stated disabilities and medical evidence.

Newling's solicitors responded to one of MetLife's letters stating the insurer was wrong to rely on the opinions of its own medico-legal experts rather than Newling's treating specialists.

In particular, Newling's treating psychiatrist had made comments being critical of some of MetLife's doctors that tended to stray beyond his expertise.

MetLife declined the claim.

Newling's solicitor asked MetLife to reconsider its

decision but MetLife maintained its earlier position.

MetLife relied on the following:

- the surveillance footage contradicted Newling's claims that she was unable to walk and stand for extensive periods;
- MetLife was not obliged to accept everything Newling said.
- MetLife was entitled to be sceptical of the opinions of Newling's doctors.

Newling instituted proceedings at the NSW Supreme Court against FSS and MetLife but FSS took no active part in the proceedings.

The matter proceeded to hearing before Justice Parker limited to separate questions concerning whether MetLife:

- Breached its duties to Newling;
- Formed an opinion that was not open to Metlife.

Parker J found in favour of MetLife and dismissed Newling's claim.

The focus of our October 2018 article was upon Justice Parker's analysis of the circumstances in which a Court may intervene to determine a TPD Claim.

His Honour's analysis included references to the life insurer's duty to act reasonably and fairly.

On that issue, Parker J made the following key findings that led his Honour to dismiss Newling's claim:

- The Court must consider whether "an insurer" acting reasonably would have made the same decision, not whether MetLife itself had acted reasonably.
- MetLife was entitled to be sceptical of the opinions of Newling's treating doctors, one of whom went beyond his expertise.
- MetLife was entitled to rely upon the opinion of reputable medical practitioners and was not obliged to accept the opinions of Newling's treating specialists over MetLife's doctors.
- The relevant question, according to his Honour, was whether it was reasonably open to MetLife to proceed as it did by obtaining its own independent expert opinion, which his Honour held it was.

In her appeal to the NSW Court of Appeal, the focus of Newling's appeal grounds was an assertion that the primary judge erred in failing to find MetLife had breached its duty to act reasonably and fairly.

Further, it was contended on behalf of Newling that the duty of good faith owed to a claimant by an insurer under a group life policy gives rise to an obligation on the part of an insurer to give reasons for declining the claim.

Newling argued that, in the absence of evidence of the reasons and process, the only option available to a claimant is to start with the denial of the claim, examine the material given to the insurer, and then speculate as to how the particular insurer arrived at that result.

Justice Emmett wrote the leading judgment in the appeal. His Honour observed that a trustee is not required to give reasons for the exercise of a discretion imposed by the relevant trust instrument and it may therefore be arguable that a member of FSS would not be in any different position so as to be entitled to require the Trustee to give reasons simply because FSS had arranged to insure against any liability that it might have to a member.

In any event, his Honour held that MetLife had provided adequate reasons for its decision.

On the question of whether MetLife acted reasonably and fairly, Justice Emmett held it was not unreasonable for MetLife to prefer the opinions of doctors it had retained over those of Newling's treating doctors, and that this did not constitute a breach of MetLife's duty, particularly in circumstances where much of the opinion evidence of the treating doctors was dependent upon the history provided by Newling.

Emmett AJA observed that a significant part of Newling's approach was that MetLife preferred the opinions of the doctors it engaged rather than the opinions of Newling's treating doctors. However, his Honour remarked:

> *"Had the member been able to demonstrate that the analysis of the material reached by MetLife was so wrong and defective, such that the conclusion reached was simply not open to it, that might be a basis for concluding that MetLife's decision should not stand. However, the Member fell well short of doing so. It could not be suggested that the only conclusion that could reasonably be reached was one favourable to the Member. Even if the Member were able to demonstrate that a different conclusion was preferable, that of itself would not suffice. The most that she has been able to demonstrate, both before the primary judge and in this Court, is that there are contrary arguments."*

Justice Emmett emphasised that Newling at all times bore the onus of establishing an entitlement to the TPD benefit. Simply establishing there were competing views on whether the available medical evidence satisfied the TPD definition was not sufficient to discharge that onus.

It was also contended on behalf of Newling that the primary judge impermissibly conducted a merits review of MetLife's decision. However, according to Emmett AJA, a fair reading of Parker J's reasons indicated that his Honour was not endeavouring to stand in the shoes of MetLife and make a decision on the merits:

"Rather, his Honour was doing no more than considering the complaints made by the Member about MetLife's reasoning in order to determine whether or not that reasoning could be characterised as going

beyond what an insurer, acting reasonably and fairly, could adopt."

Bell P and Leeming JA agreed with the reasons of Emmett AJA and therefore dismissed the appeal.

The Court of Appeal has therefore confirmed that a member claiming TPD benefits under a life insurance policy:

- At all times bears the onus of establishing, to the life insurer's satisfaction, the available evidence has established an entitlement to the benefit;
- A life insurer is entitled to obtain its own independent medical evidence;
- The life insurer will not breach its duty to act reasonably and fairly by simply preferring medical opinion of consultants over the opinions of treating doctors, provided the insurer has taken all of the material into account when arriving at its decision;
- The real question is always whether the decision was open to "an insurer" acting reasonably and fairly.

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CONSTRUCTION ROUNDUP

Importance of Precision When Preparing Construction Contracts

In our newsletters we have occasionally discussed the importance of being careful and precise when preparing the contract documents for a building project. This is something which (unfortunately) is too often overlooked by participants in the construction industry - particularly when they view the written contract as just unwelcome paperwork. However, a mistake can have a significant impact on the parties' rights and ultimately the time and cost required to resolve a dispute that arses as a consequence of a mistake

This issue was considered recently by the Supreme Court of NSW in *BH Australia Constructions Pty Ltd v Kapeller [2019] NSWSC 1086*.

In May 2015 BH Australia had been incorporated with the name "Blissful Constructions Pty Ltd". On 26 June 2017, its name was changed to "SSDR Pty Ltd" "for operational reasons". A week later, on 11 July 2017, the company changed its name again, to "BH Australia Constructions Pty Ltd".

A related company had been incorporated in January 2015 under the name "Prospective Developments (Aust) Pty Ltd". It acquired ownership of a business name "Blissful Homes" in January 2015 and in July 2015 its name was changed to "Blissful Developments Pty Ltd". On 24 March 2018, its name changed to "Prospective Developments (Aust) Pty Ltd", but then changed again three days later to "ACN 603 550 867 Pty Ltd".

In the meantime, in September 2015, Mr Kapeller and Ms Cesnik had approached "Blissful Homes" via its website to arrange the construction of a house. After negotiation with a Mr Daniel Roberts who used an email from "blissfulhomes.com.au", they entered into a standard form home building contract which noted "Blissful Developments Pty Ltd" (together with its ABN) as the builder.

However Blissful Developments was neither licensed nor insured for home building works under the Home Building Act 1989 (NSW). Instead, the contract gave the licence number and insurance details of Blissful Constructions.

A dispute arose between the parties with respect to the quality of the work and the builder's entitlement to payment. The lawyer acting for the homeowners asserted that since Blissful Developments did not hold a contractor licence, the HBA provided that it was not entitled to pursue a claim for breach of contract for non-payment. In response, the builder's lawyer stated that the naming of the builder as Blissful Developments had been a mistake and that the builder offered to novate the contract to Blissful Constructions. (This offer was not accepted.)

On 16 April 2018 Blissful Developments went into liquidation. Meanwhile, the dispute had escalated to the NSW Civil & Administrative Tribunal. In the Tribunal proceedings, the homeowners now asserted that the correct contracting entity was Blissful Constructions rather than the insolvent Blissful Developments in order to have better prospects of recovering damages. However, NCAT held that the homeowners had contracted with Blissful Developments not Blissful Constructions for the following reasons:

- the named builder on the contract was Blissful Developments;
- Blissful Developments owned and traded under the business name "Blissful Homes";
- Mr Roberts was a director of Blissful Developments (although also employed by Blissful Constructions);
- the lawyers' correspondence showed that at the time the dispute had first arisen both parties appeared to have accepted that the contract was with Blilssful Developments rather than Blissful Constructions;
- the homeowners had commenced proceedings against Blissful Developments rather than Blissful Constructions;
- little weight could be given to the evidence of Mr Roberts that the naming of the builder as Blissful Developments was a mistake, particularly since

Mr Roberts had not been available for cross examination even though a summons for his attendance had been issued;

- Blissful Developments had claimed and received payments under the contract for the building work;
- the assertion by the homeowners that the contract was with Blissful Constructions was "convenient" in circumstances where Blissful Developments was in liquidation.

The homeowners appealed to NCAT's Appeal Panel, who reversed the initial decision, finding that the correct contracting party was Blissful Constructions. In reaching this decision, the Appeal Panel applied the legal principles espoused in Harold R Finger & Co Pty Ltd v Karellas Investments Pty Ltd [2015] NSWSC 354.

- The identity of the contracting party is to be determined by looking at the matter objectively against the factual matrix;
- the identification of the parties to a contract must be in accordance with the objective theory of contract (which considers what a reasonable person, with the knowledge of the words and actions of the parties communicated to each other, and the knowledge that the parties had of the surrounding circumstances, would conclude that the parties had intended);
- the conduct of the parties after the date of the contract is largely equivocal to identify the intended parties unless it included any admissions in this regard;
- similarly, the conduct of the parties after the contract was entered into is admissible only to answer the question of whether a contract had been formed, but not as an aid to the construction of the contract;
- however, in some cases it had been accepted that it was legitimate to take into account the conduct of the parties after the contract had been entered into in order to identify the correct parties.

The builder appealed to the Supreme Court of NSW, where Leeming JA considered the complex factual background and the different approaches of NCAT and the Appeal Panel.

Leeming JA noted that in *Tokio Marine & Nichido Fire Insurance Co Ltd v Hans Bo Kristian Holgersson trading as Holgerssons Complete Home Service [2019] WASCA 114* at [76] the Western Australian Court of Appeal had stated that "[T]here is no doubt that, in the process of construction of an instrument, a court may correct an obvious error" and (as stated by the High Court in Fitzgeralt v Masters) "[w]ords may generally be supplied, omitted or correct, in an instrument, where it is clearly necessary in order to avoid absurdity or inconsistency'."

His Honour stated that the test for correcting obviously incorrect contractual language was stated in a passage from *Seymour Whyte Constructions Pty ltd v Ostwald Bros Pty ltd (in liquidation) [2019] NSCCA11; 365 ALR 345* at [8] – [9] as follows:

> *"Two conditions are necessary in order to correct the contractual language in this manner: (a) that the literal meaning of the contractual words is an absurdity and (b) that it is self-evident what the objective intention is to be taken to have been".*

Leeming JA concluded that the parties must be taken to have intended that Blissful Constructions was to be the builder for the following reasons:

- The builder must be taken to have sought to comply with the law. Builders must not do residential building work under a contract unless insurance is in place: HBA s. 92(1);
- Builders must not demand to be paid for work done without insurance: HBA s. 92(2). Further, if the contract of insurance is not in force, the contractor is not entitled to damages, nor to recover money under any other right of action, including quantum meruit: HBA s. 94;
- There is every reason to impute an intention to the homeowners to enter into a lawful contract in which it was lawful for the builder to require payment for work done;
- The contract was a contract for the construction of a home. Given the different roles of a development and builder, the fact that Blissful Constructions was licensed and insured as a builder and Blissful Developments was not was not unrelated to those companies' names;
- The date of council approval of the DA (December 2018) suggested that at the time of contract, a DA was pending (or perhaps had not even been lodged) with the local council. It seemed likely that Blissful Developments played a role in propounding that application, with the homeowners having provided their consent to it. But that did not detract from Blissful Constructions being the party which must be taken to have been intended to be the builder.

Accordingly Leeming JA dismissed the builder's appeal.

This dispute would most likely have been resolved a lot more quickly in NCAT if the contract had correctly identified the builder. Furthermore, since the HBA provides strict limitations on the builder's right to payment in the absence of the required licence and insurance, the builder would have been in a stronger position to pursue payment for its work at the beginning. Instead, the dispute travelled through several forums and the parties were required to incur significant legal costs (and in the homeowners' case, their own time since they were unrepresented in the Appeal proceedings).

It is also worth noting that an ultimate finding by a court or tribunal based on the various objective principles

espoused may not actually be consistent with one or more of the parties' intentions at the time the contract was entered into.

At Gillis Delaney Lawyers we have expert construction lawyers who can prepare contract documents (or review and check contract documents that have already been prepares) to ensure the precision that is necessary to avoid this type of dispute.

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Payment Claims Must Sufficiently Identify The Work Claimed To Have Been Performed

In the construction industry it is common for building contractors to submit progress claims which break down the work under the contract into categories, and to identify the percentage of each category of work claimed to have been completed to date. Ordinarily, such an approach is sufficient for the principal to be able to understand what work is being claimed to have been completed and to be able to provide a payment schedule or certificate in response.

However, the level of detail in the progress claim is relevant to whether it meets the criteria set out in the security of payment legislation so that it becomes a valid payment claim under that legislation.

This was an issue examined recently by the Supreme Court of Queensland in *KDV-Sport Pty Limited v. Muggeridge Constructions Pty Limited & Ors* [2019] QSC 178.

In August 2017 KDV had engaged Muggeridge to construct student accommodation consisting of a three storey accommodation complex and outdoor facilities. The contract was a lump sum contract for approximately $10.6 million. The work included 50 trade packages, but the overall price was agreed as a lump sum.

Included with the contract documents was a "Trade Breakdown Schedule" which had been required to be provided as part of the tender. The Trade Breakdown Schedule set out the various categories of work required under the contract and attributed a part of the contract price to each category.

On around 20 August 2018 Muggeridge submitted a progress claim for $2,365,432 (including GST), which it said was a payment claim for the purposes of the (now repealed) *Building and Construction Industry Payments Act 2004* (Qld). This progress claim was a one page document which utilised the format of the Trade Breakdown Schedule. It contained six columns. The first was headed "Trade Breakdown", the second "Total Amount", the third "Total Paid to Date", the fourth "Total Claim % to Date", the fifth "Total Claimed Trade to Date" and the sixth "Progress Claim".

KDV wrote to Muggeridge saying that the purported payment claim was not valid for the purposes of the Qld Act since it did not sufficiently identify the work said to have been performed. Reserving their primary position, they also served a payment schedule proposing nil payment, adopting a certificate provided by their superintendent, WT Partnership.

Muggeridge applied for adjudication of its payment claim, and the adjudicator delivered a determination that it was entitled to payment of $802,198.59 with interest.

KDV applied to the Queensland Supreme Court for an order that (amongst other things) the payment claim was invalid because it did not sufficiently identify the work claimed to have been performed, as required by section 17(2) of the Qld Act.

It was common ground between the parties that if the payment claim was invalid, then the adjudicator lacked the jurisdiction to deliver his determination, which should then be declared void.

Section 17(2) of the Qld Act (which was in relevantly identical terms to section 13(2) of the NSW Act) provided:

"*A payment claim —*

(a) must identify the construction work or related goods and services to which the progress payment relates; and

(b) must state the amount of the progress payment that the claimant claims to be payable (the ***claimed amount****); and*

(c) must state that it is made under this Act."

Brown J noted that the test to determine whether the payment claim sufficiently identified the construction work was an objective one. Such an assessment not only was of the claim itself; the evaluation of whether the work had been sufficiently identified took into account the background knowledge of each of the parties derived from their past dealings and exchanges of information: *Neumann Contractors Pty Limited v. Peet Beachton Syndicate Limited* [2011] 1 Qd R 17 at [25] per White J.

However, the focus needed to remain on the objective circumstances, not on the subjective intentions of the parties, although it was not wrong to examine the issue from the vantage point of the parties to the contract: *Clarence Street Pty Limited v. Isis Projects Pty Limited* (2005) 64 NSWLR 448 at [39] per Mason P.

In this regard, a document did not fail to be a payment claim merely because it did not successfully identify all the construction work for which payment was claimed – the test was whether "*the claim purports in a reasonable way to identify the particular work in respect of which the claim is made*": *T&M Buckley P/L v. 57 Moss Road P/L* [2010] QCA381 per Philippides J.

Above all, however, it was important to remember that

the overall purpose of the Act was "*to provide a speedy and effective means of ensuring that progress payments are made during the course of the administration of a construction contract, without undue formality or resort to the law*": *Coordinated Construction Co Pty Limited v. Climatech (Canberra) Pty Limited* [2005] NSWCA 229 at [45] per Basten JA.

KDV submitted to the Court that for the 51 items referred to as the "trade breakdown" in the first half of the one page claim (of which 26 items were claimed for in the progress claim), the only descriptions provided were extremely general and offered no meaningful information about the actual work performed from time to time. It said that while it may be accepted that KDV was aware of the content of the Trade Breakdown Schedule, where there were some 51 categories of work in a sizeable contract with a number of components in the work to be undertaken, merely referring to the category of work did not identify the construction work itself to which the claim related.

Similarly, KDV had contended that out of the variations claimed, many of the variations did not identify the work to which they related. Further, KDV pointed to errors in the calculations of the percentages and dollars claimed in the progress claim which (it contended) further contributed to the claim not being reasonably comprehensible.

Muggeridge submitted that the information contained in the payment claim was sufficient, particularly if the background knowledge of each of the parties was taken into account. It also submitted that because it had already submitted variation claims that would have set out the work which was the subject of the claim, the information in those prior claims was known to the parties and should be taken into account in considering whether the payment claim identifies the work.

Brown J noted that the court had not been taken to anything in the trade breakdown from which the parties with background knowledge could identify the actual construction work that was the subject of the claim (apart from common sense about the order in which the work was likely to have been carried out).

Brown J also accepted KDV's submission that merely providing the percentage of the work carried out in total was insufficient to reasonably identify the construction work in respect of the claim.

This, his Honour pointed out, was exacerbated in the present case by the inaccuracies in the figures, and the inability to reconcile the percentages claimed with the dollars claimed.

Brown J stated that the lack of description of the work and the inability to reconcile the figures to the amount claimed support the fact that the construction work the subject of the claim could not be identified with any certainty and the claim did not purport in a reasonable way to identify the work.

Muggeridge had submitted that that since the superintendent had been able to respond to the payment claim, this demonstrated that it was reasonably comprehensible to KDV.

However, Brown J did not agree with this submission. His Honour stated that it was KDV as principal (not its superintendent, who was not its agent) who was required by the Act to respond to a payment claim. In order to respond to the current claim, KDV would have had to reconstruct all the previous claims to try to determine what had been paid for and the work that had been done, so as to identify the balance of the work that was the subject of the claim. This was unreasonable within the time constraint of 10 days allowed by the Act.

Muggeridge had also submitted that the payment claim was in a similar format to the claim examined by the NSW Court of Appeal in *Clarence Street v. Isis* (which had been approved by the Queensland Supreme Court), and in that case the payment claim was held to have been valid for the purposes of the Act. However, on closer examination, Brown J pointed out that the categories of work in the payment claim in that case were each supplemented by a single line item description of the work – which was absent in the present case.

Brown J stated that the matters that had been identified by KDV did not simply relate to the interpretation of the payment claim and its scope and nature, but rather to its [lack of] comprehensibility. There was no description of the work that was the subject of the claim. While KDV may have been able to determine what part of the work was being claimed out of the total percentage identified in the claim by engaging in a process of reconstruction based on previous claims and amounts paid, this would be contrary to the purpose and timings of the Qld Act.

In addition, the mathematical errors created further uncertainty as to the identification of the work. Given that the figures could not be reconciled, the bases for the claimed percentages were uncertain.

Accordingly, Brown J held that the payment claim did not satisfy the requirement of section 17 to identify the work that was the subject of the claim, and thus the payment claim was not valid for the purposes of the Qld Act. Therefore, the adjudicator lacked jurisdiction in the matter and the consequential determination must be declared void.

This case demonstrates how important it is to properly prepare a payment claim if it is to be accepted as valid for the purpose of the security of payment legislation.

At Gillis Delaney Lawyers we have expert construction lawyers who can assist claimants in preparing or reviewing payment claims to ensure that they satisfy the requirements of the Act.

If you have been served with a purported payment claim, we can provide advice as to whether the claim is likely to be held to be a valid claim.

Similarly, we can advise and assist with adjudication applications and responses where the validity of the payment claim is an issue.

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EMPLOYMENT ROUNDUP

Digital Scanning – Privacy Act Implications

The implications of technological advances on workplace relations are profound. There has been much recent media coverage of issues connected with the use of social media by employees, and whether that can affect their employment.

Another simmering issue is the growing reliance on biometric data as a means of identification. A recent decision of the Full Bench of the Fair Work Commission highlights some of the primary principles which come into play in this area.

The employer operated two sawmills in Queensland. There were approximately 150 employees in total. The applicant was employed as a casual general hand and had a total period of service of a little over 3 years.

On 12 February 2018, the applicant was dismissed because he did not comply with the employer's Site Attendance Policy (***the Policy***) by refusing to use newly introduced fingerprint scanners to sign on and off for work at the site.

He brought an unfair dismissal action, asserting a claim of ownership of the biometric data contained within his fingerprint. He submitted that biometric data is sensitive personal information under the *Privacy Act 1988* (***Privacy Act***); and that the employer was not entitled to require that information from him.

He claimed that his refusal to give the information to his employer was not a valid reason for his dismissal. Initially, a Commissioner dismissed his application for an unfair dismissal remedy on the basis that his dismissal was not harsh, unjust or unreasonable, and therefore not unfair, for the purposes of section 387 of the *Fair Work Act 2009* (***the Act***).

The Full Bench overturned that decision. It considered that the direction to comply with the Policy was inconsistent with the employer's obligations under the Privacy Act.

The critical factor which the Full Bench had to consider was whether there was a valid reason for dismissal, in accordance with section 387(a) of the Act.

In assessing this question, the Commission noted that the Policy did not form a term of the applicant's contract of employment – it was introduced after he commenced work, and his contract did not have a term adequately incorporating later policies or amendments to existing policies.

There was evidence that a series of meetings and information sessions had taken place to alert employees of the impending introduction of digital scanning prior to the publication of the Policy.

The Policy itself was in these terms:

> ***Site Attendance Policy***
>
> *Due to company Workplace Health and Safety and Payroll requirements it is imperative all employees are accounted for on site.*
>
> *Therefore as at the 2nd January 2018 it is policy that all employees must use the biometric scanners to record attendance on site.*
>
> *It is reinforced that the biometric scanners do not take a finger print. The algorithm data used to record attendance cannot be used to generate a fingerprint.*
>
> *Please ensure you scan in when arriving on site and leaving site at the end of your shift. If you are having issues with scanning please see your supervisor. If you fail to use or attempt to use the biometric scanner then disciplinary action may be taken. Signing the attendance sheets alone is no longer acceptable.*

To comply with the Policy, employees were required to first register their fingerprint for use with the scanners and then use their fingerprint to scan in and out of work each day.

The terms of the *Privacy Act* require consent to the collection of employee biometric information by the employer to be used for the purpose of automated biometric verification or biometric identification.

Section 13 of the *Privacy Act* deals with interferences with privacy. Relevantly, an act or practice of an 'APP entity' is an interference with the privacy of an individual if it breaches an Australian Privacy Principle in relation to personal information about the individual.

By reason of section 15, acts and practices that breach an Australian Privacy Principle are prohibited.

The *Privacy Act* does not make paramount the protection of individual privacy. What it does, or seeks to do, is to protect individual privacy from arbitrary or unlawful interference.

<u>The Australian Privacy Principles</u>

The Australian Privacy Principles are found in Schedule 1 to the *Privacy Act*.

Principle 1 provides for open and transparent management of personal information. Among other things, it requires (at 1.3) that entities have a clearly expressed and up to date policy about their management of personal information.

Principle 3 deals with the collection of solicited personal information that is solicited by an APP entity.

It prohibits the collection of sensitive information about an individual, unless that person consents to the collection of the information, and the information is reasonably necessary for one or more of the entity's functions or activities (at 3.3). 'Sensitive information' includes biometric information that is to be used for the purpose of automated biometric verification or biometric identification. It was not in dispute that the collection of fingerprint data by the scanners meets the description of sensitive information. Collection of personal information may only occur by lawful and fair means (at 3.5).

Principle 5 deals with notification of the collection of personal information. It provides that, at, before or (if that is not practicable) as soon as practicable after the time that an APP entity collects personal information, it must take reasonable steps to notify the individual of certain specified matters, or to otherwise ensure the individual is aware of those matters. That which must be notified to an individual depends on what is reasonable in the circumstances. The specified list of matters includes:

- The identity and contact details of the APP entity;
- If personal information is collected from someone other than the individual, or the person may not be aware that the organisation has collected the personal information, the fact that the APP entity does, or has, collected the information and the circumstances of that collection;
- The purposes for which the APP entity collects the personal information;
- The main consequences for the individual if all or some of the personal information is not collected by the APP entity;
- Any other entity or type of entity to which the APP entity usually discloses personal information of the kind collected;
- That the APP entity's privacy policy has information about how to access one's personal information and seek its correction; and
- That the APP entity's privacy policy has information about how to make complaints about breaches of the Australian Privacy Principles and how complaints will be dealt with by the APP entity.

Section 7B(3) of the *Privacy Act* also contains an exemption in relation to employee records. An act done, or a practice engaged in, by an employer that is directly related to a current or former employment relationship between the employer and the individual and an employee record held by the organisation and relating to the individual, is exempt from the obligation to comply with the Australian Privacy Principles.

"Employee record" is a defined term and in relation to an employee, means a record of personal information relating to the employment of the employee.

Was the direction to scan a lawful one?

The Full Bench held it was not.

First, at the relevant time the employer did not have in place a privacy policy, contrary to Principle 1 of the APP.

Second, Principle 3 applies both to the solicitation and collection of sensitive information. It necessarily operates at a time before collection, because an APP entity 'must not' collect sensitive information 'unless' the individual consents to that collection. Any collection that occurs without first having obtained consent to that collection would be contrary to Principle 3.

Third, the employer also had not issued a privacy collection notice to the applicant Mr Lee (or any other employee) in accordance with Principle 5.

Although it had given some information required by Principle 5, it would also have been reasonable to notify the applicant of some of the additional matters set out in Principle 5. That included information about the range of other entities that were likely to have access to his sensitive information, including parent entities and technology service providers. It should also have included information about the employer's privacy policy (which it was required to have) and information in relation to privacy complaints and how to access his personal information.

In addition, the Full Bench made it clear that the employee records exemption only applies to records already held by an employer that relate to a particular individual. The exemption didn't apply in relation to the applicant because his biometric data hadn't been collected. This meant that, without the applicant's consent, the direction to provide the biometric data wasn't lawful. Further, any consent given after being told he would likely be dismissed wouldn't have been genuine.

The takeaway

This is clearly a complex area for employers.

As the pressure to move forward – digitally – increase, employers will need to ensure that their understanding of the relevant rules and regulations is accurate, and that they have in place policies and procedures which will ensure that problems like these do no arise.

Breaches of the APP constitute civil penalty offences, leading to exposure to prosecution, on top of industrial disharmony.

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WORKERS COMPENSATION ROUNDUP

PIAWE Reforms

The PIAWE reforms that were introduced in NSW as part of the *Workers Compensation Legislation Amendment Act 2018* commenced on 21 October 2019 and apply claims of workers injured after that date.

An injured worker's pre-injury average weekly earnings (PIAWE) will now be easier to calculate.

The guiding principles are found in the *Workers Compensation Legislation Amendment Act 2018* and the *Workers Compensation Amendment (Pre-Injury Average Weekly Earnings) Regulation 2019.*

The new method for calculating PIAWE will enable both injured workers and employers to agree on the PIAWE amount to be applied as an alternative to a scheme agent or self insurer making a work capacity decision.

The reforms were developed to:

- improve transparency in the process of calculating PIAWE;
- ensure workers, employers and scheme agents focus on return to work and improved outcomes for workers as opposed to spending time on calculating PIAWE; and
- reduce PIAWE related disputes.

New NSW Workers Compensation Guidelines which accompany the reforms and replace the December 2018 Guidelines also apply to all claims from 21 October 2019 and Part 10 of the Guidelines on PIAWE will apply only to workers injured on or after 21 October 2019.

The key changes include:

- a new PIAWE definition – reference to ordinary earnings, shift and overtime will be removed. PIAWE will simply mean the weekly average of the gross pre-injury earnings received by the worker in all employment at the time of injury;
- a simpler calculation – PIAWE will be calculated as gross earnings divided by the relevant earning period which is the 52 weeks before injury unless an adjustment applies. Gross earnings include income from all employment at the time of injury and the cash value of non monetary benefits that have been withdrawn after injury but excludes compulsory superannuation, workers compensation and/or other compensation benefits;
- a simpler calculation of the amount of weekly payments – deductions will no longer be considered;
- a new agreement – in the circumstances a scheme agent will be allowed to give effect to an agreement between a worker and employer about a worker's PIAWE.

Special provisions have been introduced for workers, apprentices, trainees and young people that have been employed for short terms.

In circumstances where there is an agreement as to PIAWE, the worker or the employer may apply for the approval by the scheme agent of a PIAWE agreement and the application is to be made within five days of the initial notification to the scheme agent of the injury.

The application is to be in writing and is to include each of the following:

- the agreed amount of PIAWE;
- the date of the agreement;
- the date of injury and claim number;
- the name of the worker and employer;
- the name and contact details of any person authorised by the employer to enter into the agreement;
- details of any other employment in which the worker is engaged;
- any supporting information;
- any other information the worker or the employer considers was taken into account in reaching the agreement;
- acknowledgement of the consent of the parties to the agreement.

The worker or the employer may withdraw an application by giving notice in writing to the scheme agent.

After receiving an application for approval of a PIAWE amount the scheme agent is to determine whether to approve or refuse the agreement. The scheme agent must determine the application within seven days of receiving it. The scheme agent must approve a PIAWE agreement if satisfied the agreed amount reasonably reflects the worker's PIAWE and that the agreement is otherwise fair and reasonable. The scheme agent must not approve a PIAWE agreement relating to a worker who is under a legal incapacity.

The scheme agent may decide to make weekly payments of compensation on the basis of the agreed amount of PIAWE until the application for approval of the agreement is determined.

The scheme agent must not however approve any PIAWE agreement if it has made a work capacity decision about the amount of the worker's PIAWE before the application was made to the scheme agent to approve the agreement. Balancing that, the scheme agent must not make a work capacity decision about the amount of the worker's PIAWE before any

application for approval of the PIAWE agreement is determined.

Whilst a PIAWE agreement is in play the scheme agent can approve a variation of the PIAWE agreement on the application of the worker or the employer if the worker's entitlement to the use of a non monetary benefit has been withdrawn on or after the date of the injury.

The reforms will make the calculation of PIAWE simpler and quicker and will eliminate disputes which previously arose over the calculation of PIAWE.

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"Reasonably Necessary" under Section 60

Section 60 of the Workers Compensation Act 1987 (NSW) provides that a worker's employer is liable to pay the cost of medical or hospital treatment that is "reasonably necessary" as a result of an injury received by a worker.

In relation to interpretation of the phrase "reasonably necessary" the starting point is usually the statement by Burke J in *Bartolo v Western Sydney Area Health Service* (1997) 15 NSWCCR 233 which indicates the issue should be approached on the basis of "*Should the patient have this treatment or not? If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said the patient should not do without this treatment, then it satisfied the test of being reasonably necessary."*

In subsequent decisions of *Pelama Pty Limited v Blake* (1998) 4 NSWCCR 264 and *Rose v Health Commission (NSW)* (1995) 2 NSWCCR 32 the appropriateness of the treatment, the alternatives to it, its cost effectiveness and acceptance by the medical profession, were all identified as relevant factors.

The issue is most prevalent in cases where surgery is proposed by a treating specialist which is often disputed as reasonably necessary treatment on the insurer's behalf.

The relevant factors pertaining to whether surgery was "reasonably necessary" were recently considered in the decision of His Honour President Judge Phillips in *Broad Spectrum Australia Pty Limited v Skiadas* [2019] NSWWCCPD 31.

The worker sustained an injury to her neck after using a vacuum cleaner in the course of her employment. In earlier proceedings the employer was ordered to pay the costs of anterior cervical discectomy and fusion and this was performed in April 2016. Eighteen months later after a period of conservative treatment the worker's neck, arm and shoulder pain remained and consequently the worker's treating surgeon recommended supplementing the anterior fusion with a posterior fusion. The treatment was recommended on the basis it may relieve the worker's symptoms. The treating surgeon also noted the significant risks associated with the surgery. The worker advised that notwithstanding the risks she would like to try the surgery because she was experiencing unbearable pain and lack of mobility.

The employer declined approval for the surgery on the basis it was not reasonably necessary.

Proceedings in the Workers Compensation Commission ensued.

The worker relied upon independent medical evidence ("IME") supporting the procedure as an extremely useful approach to improve stability of the fusion with a significant overall improved outcome. It was noted the treating surgeon was competent and not one to carry out surgical procedures unnecessarily. The IME believed the proposed surgery gave the worker the best chance towards optimal outcome.

The employer relied upon a series of medico-legal reports from an orthopaedic surgeon disputing the necessity for surgery to deal with neck pain in the absence of objective radiculopathy. The doctor advised there was a 10% chance of improving the worker's symptoms and a 90% chance of not improving them, such that there were good odds to make her worse. It was only if non-union of the fusion was established that the surgery would become reasonable.

The treating surgeon commented on the forensic reports advising whilst it may appear the fusion was solid, the patient still had "micro movement" and if the fusion was very solid the symptoms should disappear.

Although the treating surgeon could not guarantee the surgery would make any difference the worker believed she could not continue to live the way she was and wished to take the chance which the surgeon thought was reasonable, although she may end up having more treatment and pain management in the future.

At first instance the arbitrator determined the posterior cervical fusion proposed by the treating surgeon was reasonably necessary treatment.

The arbitrator referred to the decision in *Diab v NRMA Limited* which referred to the decision in *Rose*, setting out the test for determining if medical treatment was reasonably necessary as a result of a work injury where Burke CCJ stated:

"Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.

It is reasonably necessary such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to,

should be afforded to, and should not be forborne by, the worker. ... (with) regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual potential effectiveness of the treatment and its place in the usual medical armoury of treatments for this particular condition."

The arbitrator considered the primary difference in medical opinion related to whether there was a solid fusion as a result of the initial surgery and whether the further surgery proposed was appropriate treatment as a result.

Ultimately the arbitrator accepted the opinions of the treating surgeon and the worker's IME noting their explanations were "clear and consistent with the worker's complaints of pain".

Balancing the range of considerations outlined in the legal authorities, the arbitrator was satisfied the surgery proposed was reasonably necessary.

The employer lodged an appeal alleging error in both fact and law in the arbitrator's conclusion that the proposed medical treatment was "potentially effective".

His Honour Judge Phillips noted the arbitrator was faced with competing medical opinions. As he read the medical evidence the doctors all agreed with what the scans showed however their opinions differed in the interpretation. The worker's doctors reviewed the scans in the context of her ongoing complaints of pain and disability and considered the surgery gave the best chance of an optimal outcome. The employer's doctor acted on a lack of objective signs on the scans to support a view that notwithstanding the ongoing complaints of pain there was no objective indication for the surgery which had prospects of a poor outcome.

The effect of the opinion of both of the worker's doctors was that the surgery was "potentially effective," which was one of the relevant matters to consider in terms of reasonableness. Even the employer's doctor's estimation of a 10% chance of success suggested the proposed procedure was potentially effective, albeit that it had a low prospect of success. There was therefore evidence available to substantiate the findings by the arbitrator that the surgery was "potentially effective".

Consequently The President determined none of the grounds of appeal were made out.

Whilst each case must be approached on its own facts and medical evidence, the decision highlights the relative ease for workers to succeed in establishing that proposed surgery is reasonably necessary. If there is cogent medical evidence from treating medical practitioners supporting the potential effectiveness of treatment the Commission is likely to be inclined to find that the treatment is reasonable and necessary.

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