HERBERT SMITH
FREEHILLS
KRAMER

AUSTRALIAN POLICYHOLDER HIGHLIGHTS

11TH EDITION

In this issue

Introduction

We are delighted to bring you the the 11th edition of Herbert Smith Freehills Kramer's Australian Policyholder Highlights, which pulls together the key takeaways for insurance policyholders, their brokers and claims advisors from the most relevant insurance cases and market developments over the last 12 months.

This year, as well as looking at some key decisions on important issues for policyholder claims such as notification, limitation periods in underlying claims and interest on claims, we have included a series of spotlight articles on topics which have been a particular focus for us and our clients namely:

- Warranty and indemnity insurance – we explore the background to this increasingly used product, and canvas the reported decisions on claims and coverage in Australia and the UK
- Physical damage under property insurance policies – we summarise the historical position on the meaning of "physical damage" and look at a series of Australian and UK decisions which suggest a trend towards a broadened meaning which will benefit policyholders
- Director liability and insurance – we look at key evolving liability risks for directors as well as developments for their personal insurance position
- Class actions and insurance – we look at the key trends from shareholder class actions, and two decisions dealing with the application of policy deductibles in the context of a shareholder class action, and the use of ATE insurance as a form of security for costs

A huge thanks to the policyholder insurance team here at Herbert Smith Freehills Kramer Australia for their contributions in putting this edition of Policyholder Highlights together, as well as our colleagues across the broader firm with whom we frequently work on insurance issues, and who have kindly contributed perspectives from their practice areas.

Thank you also to our clients and contacts for your continued support and for entrusting us with your most significant matters.

We hope that you find this year's edition of Policyholder Insurance Highlights insightful. Please contact a member of our Insurance team (details at the back of this publication) if you would like to discuss any of the cases or trends and how they may impact your business.

Anne Hoffmann
Partner
T +61 2 9225 5561
M +61 418 906 447
anne.hoffmann@hsfkramer.com

Guy Narburgh
Special Counsel
T +61 2 9322 4473
M +61 447 393 645
guy.narburgh@hsfkramer.com

BAND 1 INSURANCE: POLICYHOLDER AND BAND 1 DISPUTE RESOLUTION **CHAMBERS & PARTNERS ASIA PACIFIC, AUSTRALIA 2026**

TIER 1 INSURANCE, TIER 1 DISPUTE RESOLUTION **LEGAL 500 ASIA PACIFIC, AUSTRALIA 2026**

Warranty and indemnity insurance – where are we at?

Warranty and Indemnity insurance has been around for a number of years. It is often an essential part of a M&A transaction, in particular where the buyer cannot or does not want to rely on warranties from the seller post transaction, for example if that seller has ceased to exist or does not have the funds to meet a breach of warranty claim.

Despite their importance, it is only in the last few years that we are seeing judicial commentary on the operation of these policies. In this segment, we set out, that judicial guidance including by reference to a case decided in 2025.

What is warranty and indemnity insurance?

A warranty and indemnity insurance policy is a tool for reallocating the risk during the sale of a company. On the sale of a company, the owner will typically provide a series of warranties about the state of the business. For example, it will warrant that it has disclosed all material contracts and that the books of account it has provided are accurate. The seller will also often give certain indemnities in support of the warranties and in relation to tax liabilities.

Where a warranty and indemnity policy is obtained, the insurer will bear the risk of those warranties being false (or of the risk of the tax liability). If the buyer would otherwise have a claim against the seller for a breach of warranty, that liability is instead covered by the insurer(s). The policy can either insure the buyer (insuring the amount the buyer could have claimed from the seller) or the seller (insuring the seller's liability). It is also common for a policy insuring the buyer to be arranged in part by the seller and then flip to the buyer to finalise the arrangement before completion.

Importantly, the insurance claims essentially involve a two-stage inquiry:

1. what liability would the seller have had to the buyer under the underlying sale agreement (disapplying provisions putting that risk onto the insurer); and
2. what liability does the insurer have given the overlay of the insurance policy?

Overarching observations

There are now a number of different Australian and English decisions in relation to warranty and indemnity insurance, and it is worth taking stock to consider what lessons can be learnt from them.

Taking them together, a few overarching observations can be made.

First, courts have adopted the two-stage inquiry described above. While policyholders have not always been successful in their claims, that course shows that the policies are conceptually working as intended.

Mia Harrison-Kelf
Partner, Corporate (Sydney)

"While W&I insurance has been a feature in private equity deals for some time, offering certainty of clear exit for investors, it is an increasingly common feature in corporate M&A transactions where it is being used to simplify negotiation of transaction documents and bridge gaps in risk appetite. We are even seeing W&I insurance gaining more traction in public M&A deals where representations and warranties have historically been reserved for termination events rather than a compensatory regime and we expect this trend to continue."

Second, there is inherent complexity in warranty and indemnity claims. This is essentially because of four main issues:

(a) it is often complex to identify and then demonstrate that there has been a breach of warranty. For example, it may require expert accounting analysis to identify and explain issues in the company's accounts giving rise to a breach of an accounting warranty;

(b) a number of different methods for quantifying the seller's liability may be available. A typical measure is the

difference in value of the company between the as warranted position (the "warranty true" position) and the true position (the "warranty false" position). This can require expert valuation evidence;

(c) in addition to the above (which relate to the buyer's warranty claim against the seller), an additional layer of complexity is introduced by the terms of the insurance policy itself, which may modify what is claimable; and

(d) the quantum of the claims can be significant. Take, for example, a multiplier method of calculating the target's value by reference to the target's expected revenue. A breach of warranty can affect both the expected revenue and the multiplier, with the effect that a comparatively small warranty breach can result in a significant difference to the valuation of the company, and therefore a large claim.

In short, there are potentially significant claims under policies of this kind, but there is a real danger of the complexity in the underlying breach (eg accounting complexities), the two layers of contractual documents (ie legal complexities), and the valuation methodology (ie valuation complexities) obscuring, or discouraging policyholders from exploring these potentially significant claims.

Our key takeaway in relation to warranty and indemnity insurance is that when a breach of warranty is suspected – engage early with the right experts. While this may involve an initial investment – it can lead to significant insurance recoveries.

In what follows, we provide a high-level summary of Australian and English warranty and indemnity decisions to date:

Decisions from the Australian courts

Australian Federal Court: *Aftermarket v Lloyd's* (2016)[1]

This case relates to a policyholder purchasing a franchised automotive service business.

A change of control clause in the underlying share sale agreement specified that the liability of the seller to the policyholder would be extinguished to the extent that the policyholder ceased to own or control shares in the acquired company. A year after the sale, the policyholder on-sold the target company to a third party.

The policyholder notified two claims to the warranty and indemnity policy, alleging separate breaches of warranty. One was notified before the on-sale and one after. The insurer denied both on the basis of the change of control clause.

The Court upheld the insurer's denial of the claim. The change of control extinguished the seller's liability to the policyholder. The insurance policy only insured that liability – as it had been extinguished, there was no liability to insure and therefore no insurance claim. The timing of the notifications to the insurer made no difference to the extinguishment of the seller's liability to the policyholder.

Victorian Supreme Court: *UDP v Ironshore* (2019)[2]

This case related to a policyholder purchasing a milk distributing company. In breach of warranty, the seller had failed to disclose that it had been overcharging one of its main customers and was in worse financial position than had been believed.

The issue was not one of breach of warranty, but rather, the quantum of the insurance claim. The case provided a detailed (over 100 pages) analysis on the quantum issues. The key points are:

- The Court concluded that it was appropriate to value the company by reference to the company's future maintainable earnings multiplied by an earnings multiple. The breach reduced both the future maintainable earnings and the multiple, with the result that the claim exceeded the policy limit.
- The policyholder's evidence was that it would not have proceeded with the sale had it known the true position. Nonetheless, the difference in value was the correct measure of damages. The Court reached this conclusion on the basis that the relevant warranty did not give rise to a right to terminate the sale.
- The warranties were given both on signing the share sale agreement and on completion of the share sale agreement. The policyholder could choose either date as the date for measuring the value of the company.
- The definition of loss in the policy excluded amounts recovered from the

1. *Aftermarket Network Australia Pty Ltd v Certain underwriters at Lloyd's subscribing to Policy No 6482/13(C)-13087* [2016] FCA 1402.
2. *UDP Holdings Pty Ltd (Subject to Deed of Co Arrangement) (Recs and Mgrs Apptd) v Ironshore Corporate Capital Ltd (No 2)* [2019] VSC 645.

seller. The insurers argued that there was therefore no loss until claims against the seller had been resolved. The Court rejected this argument. The policy required the policyholder to reimburse the insurer in the case of third-party recoveries and that was ample protection for the insurer.

NSW Supreme Court: *DTZ Worldwide v AIG* (2025)[3]

This case related to a policyholder purchasing a property services company for AU$1.215 billion.

The policyholder alleged a number of breaches of warranty in relation to a significant facilities management agreement in Singapore (the **FM Contract**). Specifically, it alleged a number of accounting warranty breaches:

- the accounting warranties had been breached as certain future payments should not have been accounted for in the current year and due to the method for accounting certain mobilisation costs; and
- the FM Contract was an onerous contract and should have been accounted for differently.

The above breaches were said to lead to a difference in purchase price of AU$213 million. The Court concluded that there had been no breach, but went on to consider the quantum issues. In doing so, the Court confirmed a number of principles in valuing the breach:

- the Court accepted that the measure of damages was the difference between the "warranty true" and "warranty false" values;
- the "warranty true" value was not necessarily the purchase price (though it is often used as a proxy for it on the basis that it is reasonable to infer that the price paid represents fair warranty true value);
- the assessment of damages is objective – ascertaining what the value difference would be for a reasonable purchaser and seller engaging in an arm's length transaction;
- the method of valuation adopted by the actual buyer and seller during the purchase is not determinative of the method the Court will adopt, but is a method the Court may use;
- the value is to be determined at the date of the breach, but the Court will have regard to all matters known at the trial that shed light on the value as at the date of the breach; and
- it was appropriate to value the company by reference to a discounted cash flow analysis (estimating future cashflows and applying a discount rate). While this was the method proposed by the policyholder, the Court rejected that the alleged breaches justified any adjustment to either the estimated future cashflows or the discount rate.

In the alternative to the primary breach arguments, the policyholder argued that the warranties were breached by failing to disclose certain problems with the FM Contract. Had those problems been disclosed, the policyholder (and a reasonable hypothetical purchaser) would have made further enquiries into the facts relevant to the FM Contract. Those enquiries would have revealed further problems which would have resulted in a reasonable purchaser discounting the purchase price by AU$247 million.

While the Court accepted that there had been a failure to disclose certain cleaning costs, the loss flowing from that was minimal. It rejected the alternative basis for measuring damages based on further enquiries. It considered that the damages assessment for a breach of warranty involved only the facts that were warranted. It does not invite an enquiry into what the parties would or might have done had the true position been known to them.

Decisions from the English courts

There have also been a number of decisions coming out of England.

Ageas v Kwik-Fit [2014][4]

This case related to the purchase of an insurance broker. Errors in the business' disclosed accounts led to a significant over-valuation of the business. This decision was focused on similar quantum issues as were discussed in the Australian decisions.

Of note is that the decision considered that damages are assessed as the value of the company at the date of the breach and will only take account of the performance of the company after the breach where this is shown to be necessary to give effect to the compensatory principle.

Finbsury Foods v Axis (2023)[5]

This case related to the purchase of a gluten-free bakery. The alleged warranty breaches related to a trading conditions warranty and a price reduction warranty, but the Court ultimately held that there had been no breach of either warranty and (even if there had been) any breach was excluded under the insurance policy on account of the deal team having actual knowledge (as defined in the policy) of the breaches.

The case is of note as it adopted an unusual approach to the question of causation and valuation (in obiter). Namely, it found that the seller was not enthusiastic about the sale and would not have accepted a lesser sale amount. The policyholder buyer would have done all it could to keep the seller interested and would not have walked away from the deal. On that basis the Court concluded that the breach (had it been established) caused no loss.

We flag this as unusual as the judgment appears to apply simultaneously a subjective test for causation (what would the specific parties have done) as well as an objective test for valuation (what would reasonable buyers/sellers have done). Respectfully, we anticipate it is unlikely that this rationale will be adopted in Australia, as it is clear in Australia that valuation is to be done objectively (and bounding that assessment by first applying a subjective causation test defeats that principle).

Project Angel Bidco (2024)[6]

This case related to the purchase of a civil engineering and construction company. The decision ultimately turned on the specific issue of interpretation of the insurance policy. That is, the covering spreadsheet of the policy identified an anti-bribery and corruption warranty as "covered" but a general exclusion excluded bribery and corruption risks. The Court held that the warranty was excluded. It rejected an argument of "rectification by interpretation" – that is, reading the policy differently from its express words – on the basis of an obvious error. It acknowledged that the clauses were in conflict, but held that there was neither an obvious error nor an obvious solution to the error.

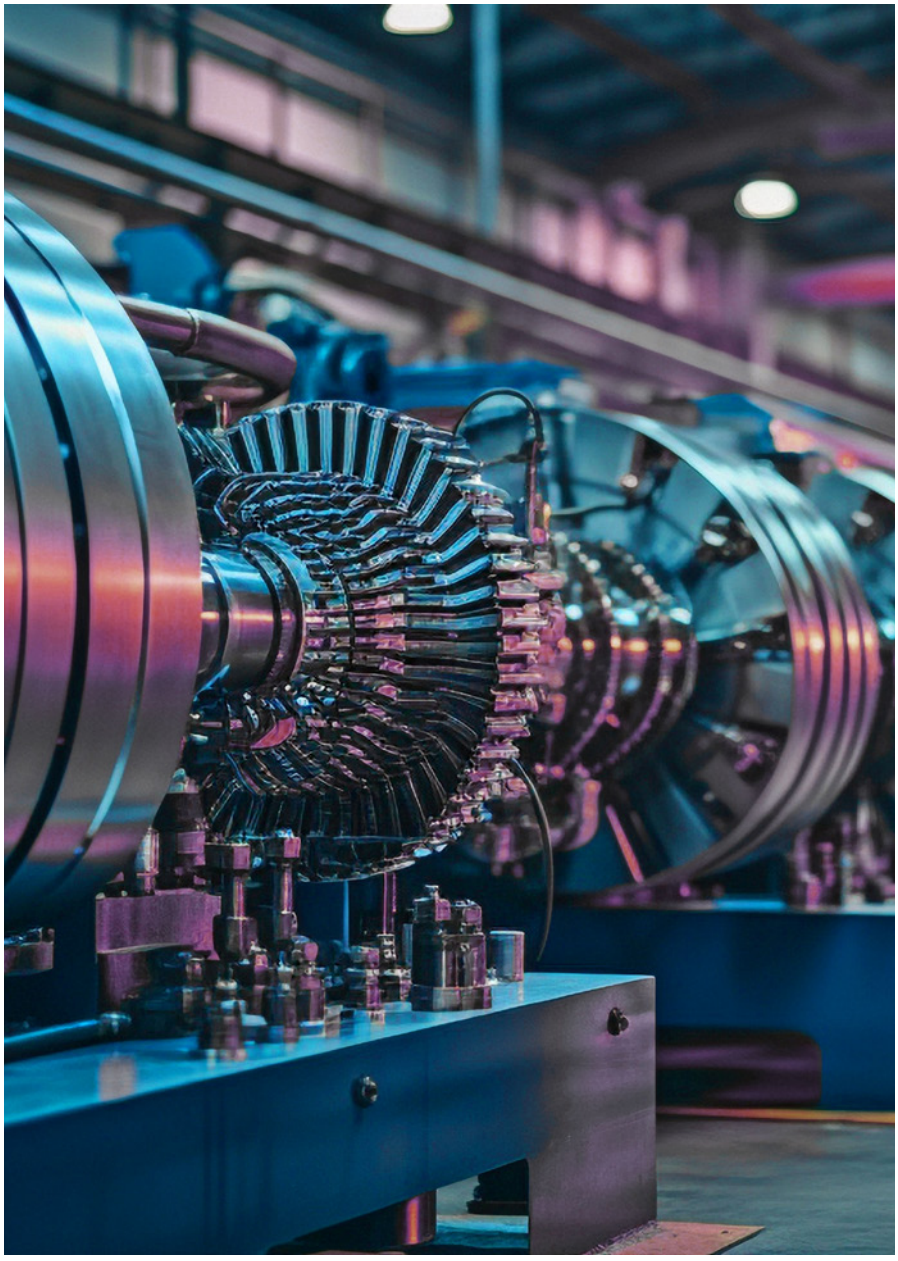
3. *DTZ Worldwide Limited v AIG Australia Limited [2025]* NSWSC 12.
4. *Ageas (UK) Ltd v Kwik-Fit (GB) Ltd* [2014] EWHC 2178 (QB).
5. *Finsbury Food Group plc v Axis Corporate Capital UK Ltd and Others* [2023] EWHC 1559 (Comm).
6. *Project Angel Bidco Ltd (in administration) v Axis Managing Agency Ltd (as representative of Syndicate 1686 at Lloyd's of London) and other companies* [2024] EWCA Civ 446.

What's the "damage"?

Damage is the cornerstone of many insurance claims. It is an important trigger for cover under an operational all risks policy, a construction all risks policy, and under public liability insurance.

In Australia, the meaning of property damage was given its initial definition in *Ranicar v Frigmobile*[7] and requires that there is a physical alteration to the insured property impairing its value or usefulness. For example, in *Ranicar*, scallops were stored at a higher temperature than permitted by certain export laws. They were still edible, but could no longer be exported. As a result of the high temperature, the scallops underwent microscopic changes that would not have been present at different temperatures. This was a change resulting in the loss of exportability and therefore constituted damage (as required by the policy). Other examples range from the obvious, for example, the collapse of a warehouse (*Mobis Parts Australia Pty Ltd v XL Insurance Company SE*[8]), to more challenging cases such as where the breaking of a fuse (property designed to break) was held to be damage (*Mainstream Aquaculture Pty Ltd v Calliden Insurance Ltd*[9]). In contrast, a defect is a static state of affairs or circumstances whereby the insured property (or design, workmanship etc) falls short in some way.

For there to be cover under the above policies, there must be damage. A defect alone will not trigger the insuring clause. Where there is both damage and a defect, a defect exclusion may apply. One of the key issues that consistently arises in claims is untangling whether something is defective or damaged, or what cover is available when there is both.

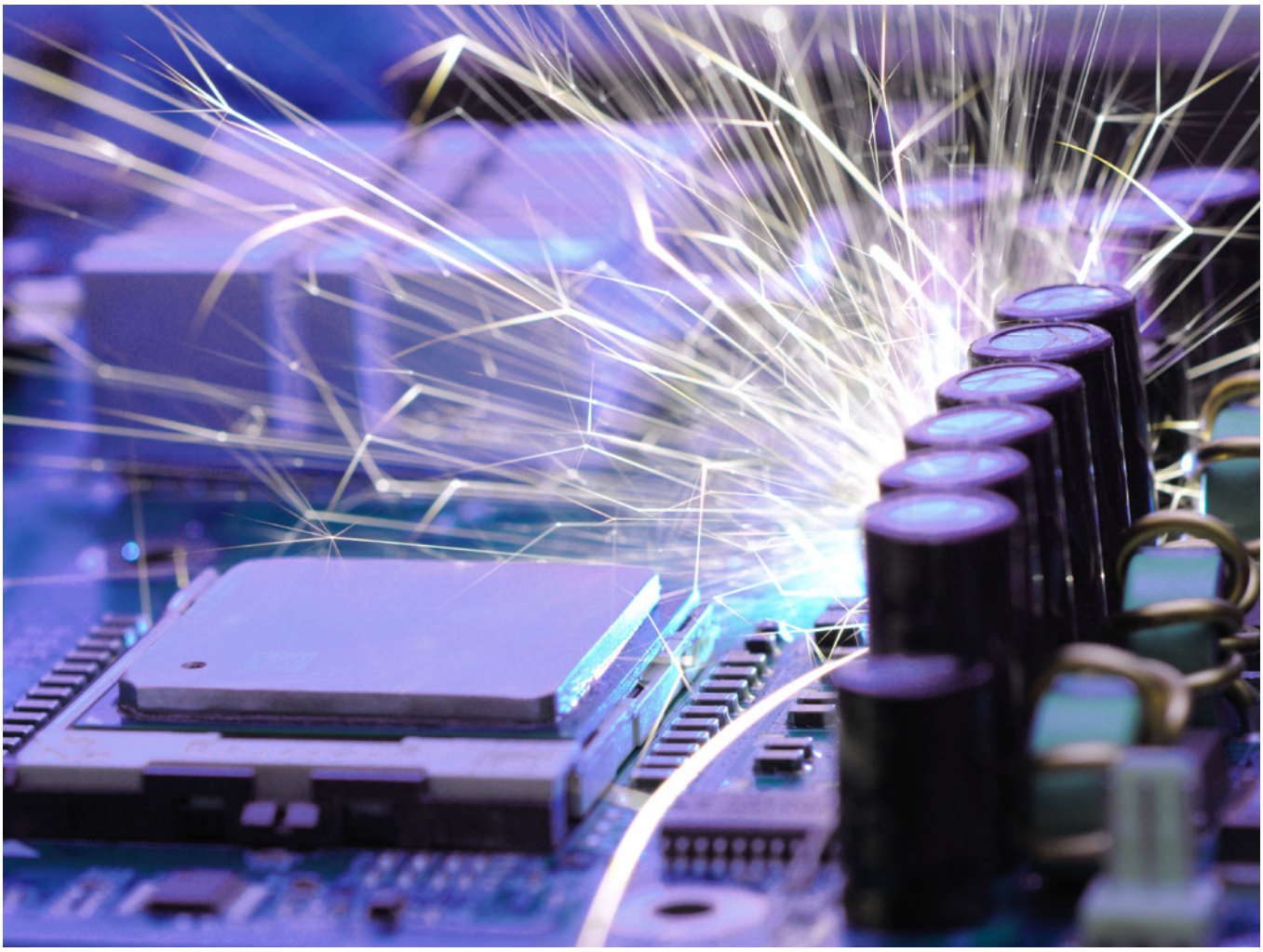


7. [1983] Tas R 113.
8. (2018) 363 ALR 730.
9. [2011] VSC 286.

The last 12 months have seen several decisions which grapple with the damage/defect distinction in different circumstances. We discuss three of these cases in the three articles that follow. Here, we set out the key takeaways in summary:

- A recent English decision, *Sky UK Limited v Riverstone Managing Agency Ltd*[10] (***Sky v Riverstone***), held that a policy will insure not just the damage which occurs during the policy period, but also the damage which continues developing after the policy period as long as it has begun developing during the policy period. This decision fits neatly with the Federal Court of Australia's decision in *Baralaba Coal Company Pty Ltd v AAI Ltd (t/as Vero Insurance)*[11] on which we reported last year (see our Policyholder Highlights article here). In *Baralaba*, the Court found that damage after the policy period which was "relevantly connected" to an obligation to indemnify damage occurring during the policy period was insured.

  Collectively, these cases demonstrate that there are a range of circumstances wherein damage occurring outside the policy period will be insured. Accordingly, policyholders should carefully consider whether property damage is covered, despite some or all of it occurring after the policy period.
- The decisions suggest a general trend that courts are interpreting "damage" more broadly. Namely, *Sky v Riverstone* confirms that temporary damage is damage (which is also important to trigger business interruption cover). Further, the Australian decision of *Insurance Australia Limited T/as CGU Insurance v Capral Limited*[12] supports the proposition that while an impairment of "value" or "usefulness" is relevant, the "real point" is that the alteration to property must involve some (negative) consequence to the property.
- In the property construction context, a common suggestion made by insurers is that "damage" and "defect" must be considered by reference to the end product. This is superficially appealing, as a claim against the contractor will generally be on the basis that they have delivered a defective final product. But the insurance claim is not bound by the deliverables of the contractor. For the insurance claim, the question of whether property is damaged or defective arises during the course of construction. Unfinished work can be damaged. As one of the Australian decisions shows, the incorporation of a defective part into non-defective property, can constitute damage.
- Finally, the decisions serve as a reminder of the importance of onus of proof. The insurer bears the onus of proving that exclusions apply.



10. [2024] EWCA Civ 1567.
11. [2024] FCA 532.
12. (2025) 309 FCR 385.

Painting over the cracks

Helicopter Aerial Surveys Pty ltd v Insurance Australia Limited (No 2) [2025] FCA 1360

This case highlights how coverage disputes can hinge on the distinction between correcting defective works and repairing resulting damage – an issue that can significantly impact policyholders facing claims under liability policies. This decision underscores the critical importance of understanding how liability policies apply when defective work leads to subsequent damage.

Facts

The policyholder painted the claimant's ship, the Mishima, in 2015. The claimant subsequently discovered that areas of the Mishima had not been satisfactorily treated before painting. The result was that corrosion began to develop through the paintwork.

The claimant engaged a contractor to perform works to the paintwork in both 2016 (costing ~$90,000) and 2019 (costing ~$148,000). It was accepted that both sets of work related to the faulty paintwork in 2015, but there was limited information about precisely what works were undertaken.

The policyholder was found liable for the faulty work in separate court proceedings in 2020, but was subsequently deregistered. The claimant therefore brought a claim directly against the policyholder's public liability insurer pursuant to s 601AG of the *Corporations Act 2001* (Cth). That section provides that a person may directly recover from an insurer of a deregistered company if the insurance contract covered that liability.

The insurance policy covered liability for property damage, but excluded liability for "the cost of performing, completing, correcting or improving any work". The insurers alleged that, as a result of s 601AG, the onus was on the claimant to prove the claim was covered and that this exclusion did not apply to the works.

Decision

The Federal Court quickly rejected the suggestion that the claimant bore the onus of proving the defects exclusion did not apply. Insurers typically bear the onus of proving an exclusion applies and s 601AG did not evince an intention to reverse that onus.

The Court accepted that the exclusion would exclude the costs of correcting the defective paintwork, but held that damage (ie the corrosion) resulting from that defective work would be covered.

In light of the lack of evidence around what precise works were done in 2016 and 2019, the Court concluded:

- it was more likely than not that the work done in 2016, done shortly after the original work and before significant corrosion had time to develop, was to correct the work done by the policyholder; but
- the corrosion would have worsened by 2019 and the insurer had not proven that the work done in 2019 was to correct the work done by the policyholder.

Therefore, the work done in 2016 was excluded, but the work done in 2019 was not.

Lessons for Policyholders

Fundamentally, this is a case about managing an information deficit. While the deficit ultimately worked (largely) in the claimant's favour, the case is a good demonstration of the importance of being mindful of a defendant's insurance arrangements when litigating.

While it is tempting to think of the defendant's insurance arrangements as the defendant's problem, this case serves as a good example of why a claimant should be actively considering the likely insurance issues when conducting its claim. Had the underlying proceedings demonstrated the nature of the works being done in 2016 and 2019, then it may have been possible to avoid (or at least shorten) the four years of litigation between the original decision and the insurance decision.

Shipshape or ship wrecked?

Insurance Australia Limited T/as CGU Insurance v Capral Limited (2025) 309 FCR 385

This case is a valuable reminder for policyholders in the construction and manufacturing sectors about how courts will distinguish between defective products and resultant property damage – an issue that can determine whether liability coverage applies. The Court of Appeal confirmed that welding defective aluminium plates onto ships constituted property damage.

Facts

The policyholder manufactured and supplied aluminium plates for incorporation into ships.

In late 2020, it discovered that some of the plate it had manufactured did not comply with corrosion resistance standards. Ships that incorporated the plate could still be used, but their long-term service life was compromised. The policyholder therefore recalled the plate.

For ten customers, the plate had been welded to their ships. They elected to remove the plate and install compliant material. The customers brought a claim against the policyholder for this cost. The policyholder settled those claims, and the settlement deeds referred to the settlements being in relation to property damage, among other things.

The policyholder sought indemnity under its products and public liability policy. The insurer refused the claim on the basis that:

- the policyholder's liability was for defective goods, not for property damage; and
- the policy expressly excluded "damages claimed in relation to the… loss of use… of Products… if such Products are withdrawn from the market… because of any known or suspected defect."

At first instance the trial judge found in favour of the policyholder, holding that the welding of the defective product onto the ships was damage and that the exclusion only applied to losses of use occurring after the withdrawal of the product (whereas the welding damage occurred prior to the recall).

Decision

The Court of Appeal upheld the trial court's decision.

The meaning of property damage was stated in *Ranicar v Frigmobile*[13] as requiring that there is a physical alteration to the insured property impairing its value or usefulness.

Insurers essentially argued that there had not been damage, rather the ships had simply been defectively constructed due to the incorporation of a defective component. In particular, they argued that:

- the *Ranicar* test applies to fully formed property, not property in construction;
- without the plate, the ship was not seaworthy – incorporating the defective plate improved the ship (just not as much as it should have); and
- the shipowner's claims were "for" the defective plate, not damage to the ship.

13. [1983] Tas R 113.

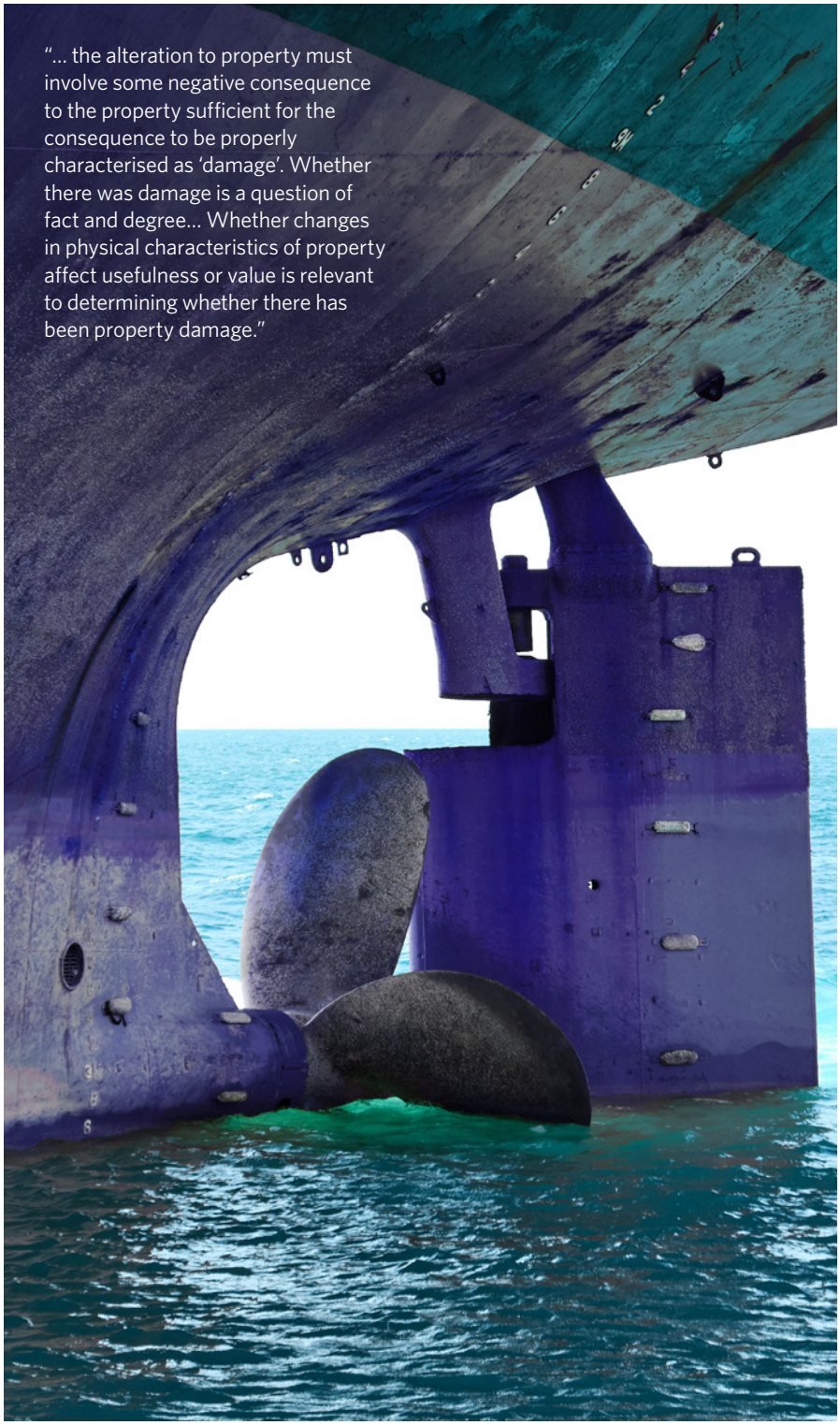
The Court rejected each of these arguments. The Court stated that the "real point" of test for damage is that:

"... the alteration to property must involve some negative consequence to the property sufficient for the consequence to be properly characterised as 'damage'. Whether there was damage is a question of fact and degree... Whether changes in physical characteristics of property affect usefulness or value is relevant to determining whether there has been property damage."

Here, the welding of the plate to the vessel caused a physical change to the vessel. Although it would not be known for some time, from the moment the plate was welded to the vessel it needed to be removed. The welding of the plate onto the vessel was therefore a detrimental change to the vessel and was damage. It did not matter that the plate did not immediately corrode.

The Court also accepted the claims were "for" property damage. The claims were in respect of defective products but were more directly for the damage to property caused by incorporating the defective product.

The recall exclusion required a causal link between the recall and the loss. Here the loss occurred at the moment of welding – even if it was not known at the time. The act of recalling the plate did not cause the loss and therefore the exclusion did not apply.



Lessons for Policyholders

Real care needs to be taken in distinguishing between damage and defects, particularly in the construction context. A common trap is to think of "damage" and "defect" by reference to the end product. This may be because the claim against the contractor will generally be on the basis that they have delivered a defective final product.

But the insurance claim is not bound by the deliverables of the contractor. Insured damage can occur to property that is not yet complete or, in this case, through the incorporation of defective property. It is important to work through the precise sequence of events to determine whether there had been damage during the construction.

Damage that develops

Sky UK Limited v Riverstone Managing Agency Ltd [2024] EWCA Civ 1567

A recent decision in the UK, *Sky v Riverstone,* covers a range of issues in relation to Contract All Risks Insurance. In particular, this includes a circumstance in which damage may be covered despite occurring after the policy period. We focus here on the issue of damage. The London team has published a more detailed article on a number of interesting points of law here.

Background

The case concerned a claim under a CAR insurance policy for damage arising out of the construction of the policyholder's flagship building.

The roof of the building comprised 472 wooden cassettes. These cassettes became wet during construction, leading to the irreversible swelling and structural decay of the cassettes. It was not clear if *all* cassettes had been affected. In order to determine if they had been damaged, each cassette had to be opened (at significant cost). The work required to identify and rectify the damage, or prevent further ongoing damage, would take a number of years.

Insurers accepted that some of the cassettes had been damaged during the policy period, but argued that as the swelling and structural decay largely occurred after the policy period, it was therefore not covered.

Decision

Meaning of damage

In the first instance decision, the Court held that "damage" within a property insurance policy included the presence of water which, if left unattended, would affect the structural stability, strength, functionality or usable life of insured property during the period of insurance.

The English Court of Appeal held that damage means any physical change to tangible property which impairs its value or usefulness, and that damage can be minor or transient, such as the soaking of a blanket, even if capable of remediation. The Court considered this definition was consistent with the natural and ordinary meaning of the word.

It follows that the mere wetting of the timber was itself damage.

Was damage occurring after the policy period insured?

It was held at first instance that recovery was confined to damage which was physically present on the day the policy period ended. Such an interpretation would pose a significant risk for policyholders, as there is the potential for a gap in policy coverage if damage begins during one policy year and continues into the next policy year:

- the first year may not respond because the damage was not physically present in the policy year; and
- the second year may not respond because of either non-disclosure of the damage (or disclosure resulting in an exclusion being added to the policy) or because in the second year the event has already occurred and the damage is inevitable (and therefore not covered).

The English Court of Appeal overturned the first instance decision on this issue and held that the developing damage was insured despite some of it occurring after the end of the policy period. To reach this conclusion the Court considered that an indemnity is a promise that the policyholder will be held harmless from the loss resulting from insured damage. As a result, when the insured damage occurs, the insurer is in breach of that obligation and is obliged to pay the foreseeable losses caused by the breach. Subject to the usual principles of causation and mitigation, that includes the costs of remedying the foreseeable deterioration and development damage occurring after the period of insurance.

Lessons for Policyholders

The decision suggests courts (at least in England) are interpreting "damage" more broadly than previously – including transient damage. While transient damage may not reduce the property's value or require repair, this qualification is important as "damage" is generally the trigger for business interruption cover.

Further, damage starting in the policy period but developing/continuing after the policy period can be insured under the same policy (though it is important to bear in mind that the policyholder will be obliged to mitigate its loss if able). The case is in line with the Australian decision of *Baralaba Coal Company v Vero*[14] in 2024 (on which we reported here). That decision held that once an insurer's obligation to indemnify has been enlivened under a policy covering damage to insured property, subsequent damage occurring after the expiry of the policy period may still be covered depending on the circumstances. Together, these cases demonstrate that the end of the policy period is not always the end of coverage for a property damage claim.

Sky v Riverstone addresses a range of other issues. It is worth reading in detail for anyone involved in the construction insurance industry.

14. [2024] FCA 532.

Timing is everything

The Owners - Strata Plan No. 81376 v Dyldam Developments Pty Ltd [2025] NSWSC 438

This case clarifies how policy wording and limitation periods interact under the *Home Building Act 1989* (NSW) (**HBA**), particularly where coverage depends on multiple future events such as insolvency. It is important for policyholders as it reinforces the importance of remaining on top of limitation periods where there is a possibility for claims to arise.

Facts

The policyholder was an owners corporation which owned a development in Parklea. Building work on the development was performed by Dyldam Developments Pty Ltd (the **Builder**) and, according to an occupation certificate, was completed on 4 September 2008. The Builder went into administration in 2022.

On 21 February 2012, 25 January 2022 and 28 June 2022, solicitors for the owners corporation sent letters to insurers regarding alleged defective works in the development. Proceedings were commenced against the Builder and a developer, and insurers were joined to determine whether the owners corporation was entitled to indemnity under a residential building insurance policy (the **Policy**).

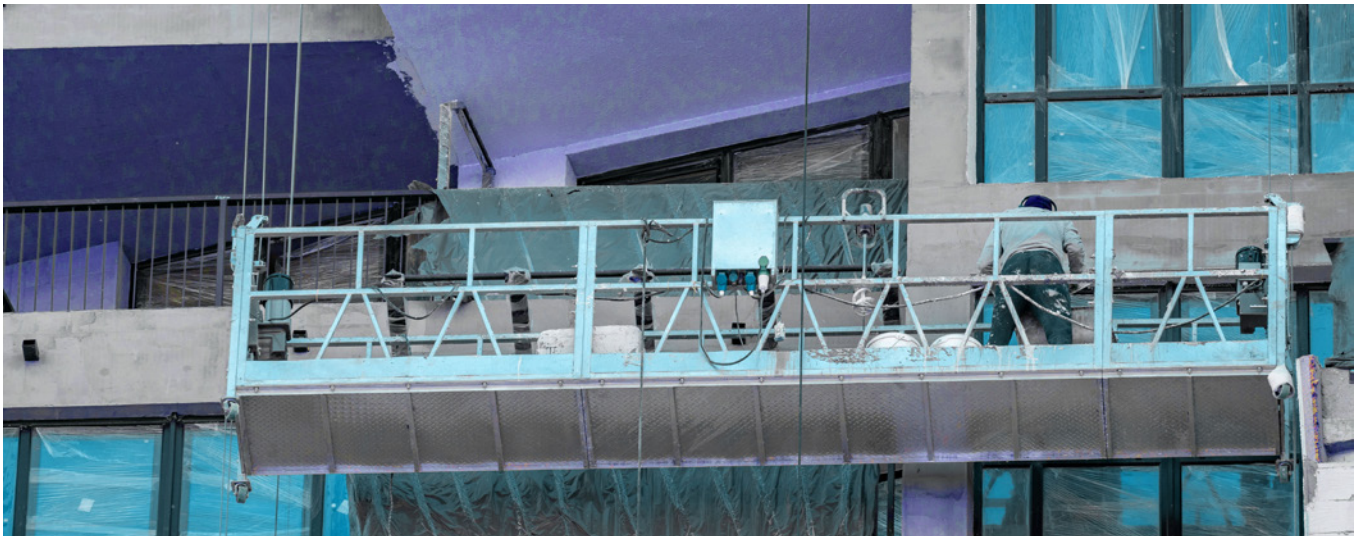
Decision

The Court was asked to determine, as separate questions, whether each of the letters were claims under the Policy made within the ten year "long stop" limitation period in s 103BC(1) of the Home Building Act (**HBA**). This in turn required consideration of what was required to trigger cover, and whether s 92(5) of the HBA – which extends the force of a contract of insurance in relation to residential building work to include any rectification of the original works - operated to extend the long stop period.

A condition precedent to cover – irrecoverable third-party claim

The Court commenced its analysis with the insuring clause, which indemnified "Insured Loss which results from an Insured Event which occurs during the Period of Insurance". This incorporated:

- the definition of "Insured Event", being "... any event referred to in Section 2.1 of this Policy which occurs during the Period of Insurance";
- Section 2.1, which included "a breach of a Statutory Warranty, being loss or damage in respect of which the Insured cannot recover compensation from the Contractor or have the Contractor rectify because of the Insolvency, death or Disappearance of the Contractor"; and
- Section 3.1, which provided that "[t]he indemnities referred to and contained in Section 2.1 shall apply only if the Insurer suffers loss or damage because of the Insolvency...of the Contractor".



The combined effect of these clauses led the Court to find that the inability to recover the loss from the contractor due to insolvency of the contractor, and therefore the relevant "loss" for the purpose of the policy, would both have to occur before the Policy responded. That is, the insolvency of the contractor (in this case, the Builder) was a condition precedent to cover under the residential building insurance policy.

The letters – the limitations issue

Turning to the limitation issue, the Court considered whether each of the letters constituted a claim and, if so, whether that claim had been made within the period set down in the HBA. At the time of the 21 February 2012 letter, the Builder was not yet insolvent. Accordingly, the Court found that the condition precedent had not been met, and the 21 February 2012 letter could not therefore constitute a claim under the Policy.

The Court was satisfied that the 2022 letters constituted claims. Whether those claims had been made within time depended on two things.

First, was the occupation certificate determinative of when the works were completed, such that the "long stop" date ran from 4 September 2008? The Court found that it was, rejecting an argument from the owners corporation that the fact the certificate had been issued in breach of a statutory provision rendered it invalid. Consequently, the "long stop" date ran until 4 September 2018.

This gave rise to the second issue, namely whether that date was extended by operation of s 92(5) of the HBA. The Court found that it was not, because:

- an extension to the "long stop" period would extend the period for which insurers were on risk indefinitely, which was contrary to the intention behind enacting s 103BC(1); and
- s 92(5) applies only to policies which are "in force" and, due to the "long stop" period, the Policy ceased to be in force on 4 September 2018.

To put that latter point differently, the Court found that s 92(5) extended the subject matter covered by the policy but not the date by which a claim needed to be made.

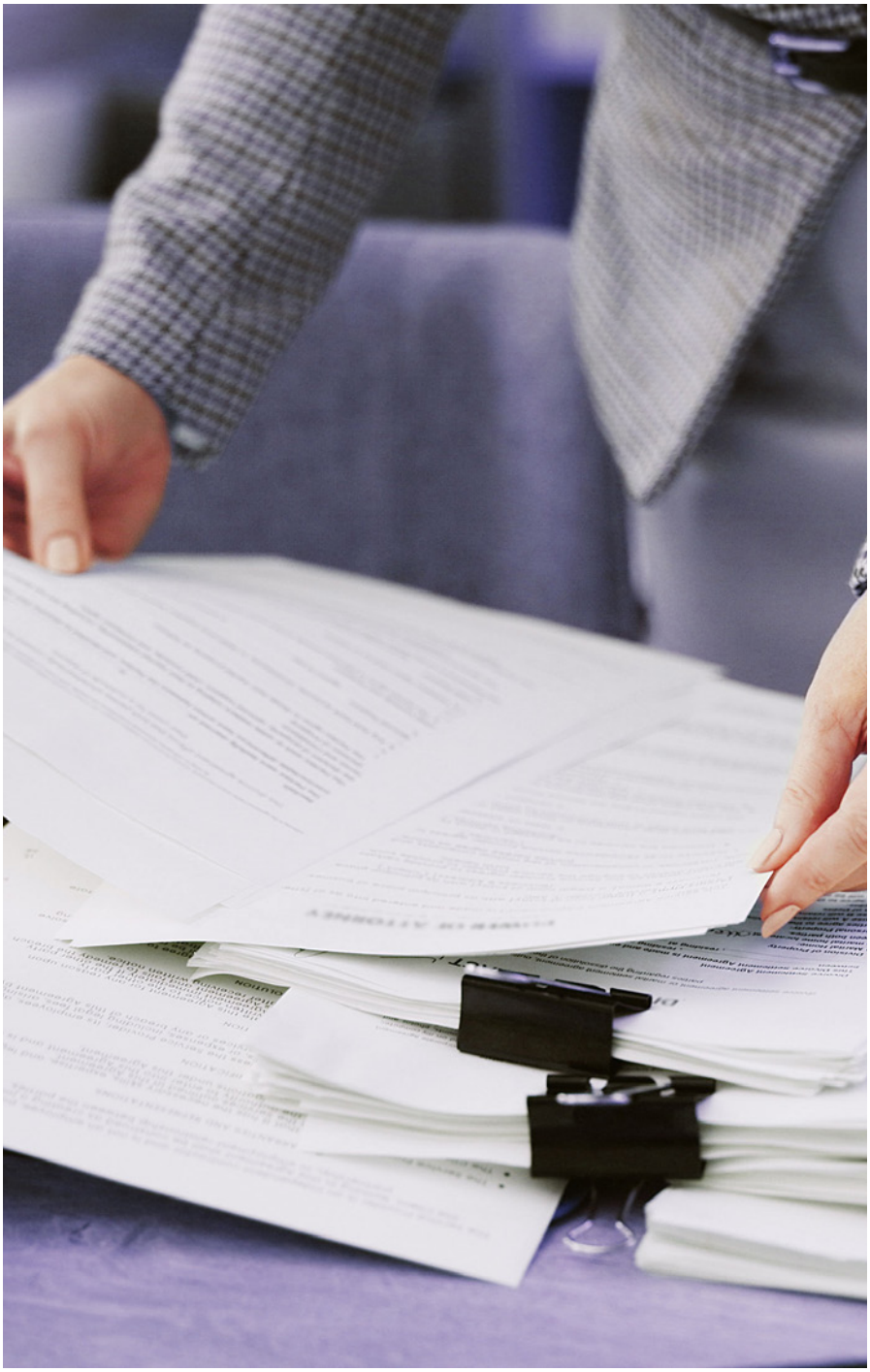
Lessons for Policyholders

This is the first occasion on which s 92(5) of the HBA has been judicially considered. It shows that s 92(5) will not relieve policyholders from the ten year "long stop" period in s 103BC(1). For policyholders who fall within the scope of the HBA, and indeed all policyholders, this reinforces the importance of remaining on top of limitation periods where there is a possibility for claims to arise.

The policy wording and timing also came together unhelpfully for the policyholder in this scenario. Policyholders should be cognisant of wording which predicates coverage on more than one future event, such as the existence of defects and insolvency of a party.

Leaving prior knowledge in the past

Allianz Australia Insurance Ltd v Uniting Church in Australia Property Trust (NSW) (2025) 308 FCR 308



This decision from the Full Federal Court addresses critical issues around notification obligations under s 40(3) of the *Insurance Contracts Act 1984* (Cth) (**Insurance Contracts Act**) and the enforceability of prior known circumstances exclusions in professional indemnity policies. It provides important guidance for policyholders and insurers on what can constitute a notifiable circumstance, imputed knowledge, and the limits of exclusion clauses.

For context, section 40(3) provides that a notification of a circumstance which may result in a claim against the policyholder can 'fix' cover for the subsequent claim under that policy, but importantly that notification must be made as soon as practicable after the insured becomes aware of the circumstance, and must be made before the expiry of the policy.

Facts

The Uniting Church in Australia (**UCA**) is an association of institutions that includes Knox Grammar School (**Knox**) in Sydney, New South Wales. Between 1999 and 2011, Uniting Church was insured under professional indemnity policies issued by Allianz.

On 7 May 2004, the Headmaster of Knox received an extensive report from a private investigator in relation to historical sexual and physical abuse at Knox (the **Report**). From about 2007, former Knox students or their parents brought civil claims against Knox in respect of historical sexual and physical abuse. The claims were notified in bulk to Allianz from about March 2009 after arrests of various individuals occurred. UCA paid settlement amounts to resolve a number of the claims and sought indemnity for those amounts from Allianz.

Despite indemnifying UCA for some early claims, prior to it becoming aware of the Report, Allianz subsequently asserted it was not liable to indemnify UCA for later claims on the basis that the bulk notification in 2009 was ineffective due a failure to notify of the earlier Report (and the Report could not be retrospectively notified as a circumstance).

UCA commenced proceedings against Allianz seeking indemnity for the later claims. The primary judge found that UCA was entitled to indemnity on the basis that the Report disclosed only the "bare possibility" of claims, such that it was not a notifiable circumstance pursuant to section 40(3) of the Insurance Contracts Act, and the March 2009 circumstance notifications were effective. Allianz appealed that decision to the Full Court, leading to this judgment.

Decision

The Court was asked to determine in particular the following matters:

1. whether the Report contained notifiable facts which UCA failed to notify at the time of the Report, such that it did not have the benefit of s 40(3) of the Insurance Contracts Act in respect of both the subsequent circumstance notification and subsequent claims; and
2. whether the prior known circumstances exclusion applied to the knowledge of UCA in relation to the Report.

Notification

Overturning the primary judge's conclusion, the Court found that the facts disclosed in the Report revealed more than the "bare possibility" of potential claims. The Report revealed a "problem" likely to give rise to claims, namely "many years of paedophilic conduct by Mr Nisbett and other teachers, the persistent grooming and sexual abuse of boys, and the existence of a school culture where that could occur". That type of "problem" was sufficient, the Court found, to require notification under the applicable policy consistent with s 40(3).[15]

UCA also argued that only Knox had knowledge of the Report, and that even if the Report was a notifiable circumstance, Knox's knowledge of the Report could not be imputed to UCA – if UCA did not have knowledge of the Report, it could not have made a notification of the Report as a circumstance in 2004. The Court disagreed, with Justice Derrington finding that UCA was fixed with the knowledge of the entity in respect of which it made a claim under the policy and Justices Colvin and McEvoy alternatively finding that UCA held the knowledge of Knox in its role as nominal defendant.

The Court therefore found that Allianz was not liable to indemnify UCA, because UCA had knowledge of the Report and failed to notify it "as soon as reasonably practicable" for the purposes of s 40(3).

Prior known circumstances exclusion

UCA argued that the "prior known circumstances" exclusion was void by reason of s 52 of the Insurance Contracts Act (as well as s 33, which was rejected by the Court). Section 52 voids any provision in an insurance policy which has "the effect of excluding, restricting or modifying, to the prejudice of a person other than the insurer". UCA argued that because the exclusion provided insurers with a contractual remedy for a non-disclosure by the policyholder, which was harsher than the remedy provided by the non-disclosure regime in the Insurance Contracts Act, it was caught by s 52. The Court was divided on this point.

Justices Colvin and McEvoy found the prior known circumstances exclusion to be void, through the operation of s 52 of the Insurance Contracts Act. The exclusion was on standard terms and would have the effect of entirely precluding indemnity from attaching to a claim arising from the prior knowledge of an insured. This was, their Honours found, at odds with s 28 of the Insurance Contracts Act which entitles insurers to reduce their liability proportionally according to the prejudice they suffer as a result of an insured's non-disclosure. Accordingly, s 52 had the effect of voiding the exclusion.

In dissent, Justice Derrington found that the exclusion was not void. In his Honour's view, the exclusion related to the scope of cover only, and not non-disclosure.

Lessons for Policyholders

The Court of Appeal adopted a broad approach to what can constitute a notifiable circumstance for the purpose of s 40(3) of the Insurance Contracts Act. This could ultimately be of benefit to policyholders wishing to notify of a "problem" or "hornet's nest" which might result in claims.

It is also significant for policyholders that the Court found that a prior known circumstances exclusion, put on fairly standard terms, was void.

We expect that insurers may seek to test this reasoning in future cases, including by reference to Justice Derrington's view.

15. Consistently with *P & S Kauter Investments Pty Ltd v Arch Underwriting at Lloyds Ltd* (2021) 105 NSWLR 11.

When insurers stall and interest starts to roll

WSP Structures Pty Ltd v Liberty Mutual Insurance Company [2025] FCA 160

This case examines when interest under s 57 of the *Insurance Contracts Act 1984* (Cth) (**Insurance Contracts Act**) begins to accrue on unpaid defence costs, following an insurer's delay in payment despite confirming indemnity under a public liability policy. It highlights the Federal Court's approach to what constitutes an "unreasonable" withholding of payment and offers practical lessons for policyholders managing invoice disclosure during disputes.

Facts

The policyholder claimed cover for defence costs under a public liability policy and the right to interest arising from the non-payment by the insurer of those costs.

On 23 November 2021, the policyholder made a claim for indemnity including for defence costs. On 28 January 2022, the public liability insurer confirmed indemnity in principle but subject to the policyholder satisfying the insurer that it did not have a claim under its professional indemnity insurance (ie that there was not "other insurance" which responded to the claim). By judgment dated 28 September 2023, the public liability insurer was found liable for the defence costs. Our article on the underlying liability can be found in our 2023 Policyholder Highlights publication (available here).

The insurer requested copies of all invoices for defence costs for the first time on 27 October 2023 and subsequently disputed 29% of the amount claimed. A third-party referee determined 90% of the defence costs were reasonable.

Section 57 of the Insurance Contracts Act governs the interest payable on insurance claims. In particular, s 57(2) requires insurers to pay interest for "the period commencing on the day as from which it was unreasonable for the insurer to have withheld payment of the amount" and ending on the day payment is made.

The insurer argued that it was only unreasonable not to pay the defence costs from either:

- the date of the referee's report, as it was only then that the extent of the defence costs liability was known; or
- three months after the date when copies of the invoices were first provided.

Decision

The Court rejected those arguments. The insurer's refusal to pay the invoices was not because of its incorrect legal position on liability for them. There was no reason to believe that the insurer would have paid the invoices earlier had they received them (indeed they did not pay the amount they considered reasonable after they received them).

The insurer confirmed indemnity on 28 January 2022. Thereafter, it may be expected that invoices for defence costs would be assessed promptly as they were issued. It would have been unreasonable to withhold payment of the whole of an invoice if part of it was disputed. Therefore, for invoices paid:

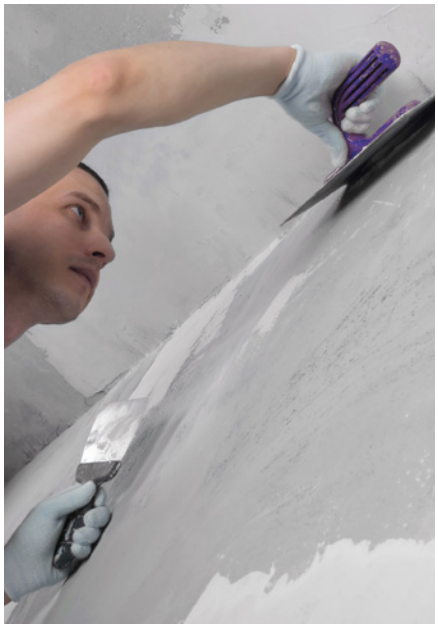
- prior to 28 January 2022, the interest began to run from that date; and
- after 28 January 2022, the interest began to run from the date they were paid to the third party. This was said to allow for a period of assessment.

The referee had observed that the policyholder's conduct had caused some delay, but this did not change the Court's view. The insurer had made no payment and had had the benefit of the money in the meantime.

Lessons for Policyholders

It is a strategic question to provide or withhold the invoices from insurers during the course of the underlying dispute. There may be valid strategic reasons for withholding invoices from insurers in circumstances where they are not actually paying the claim.

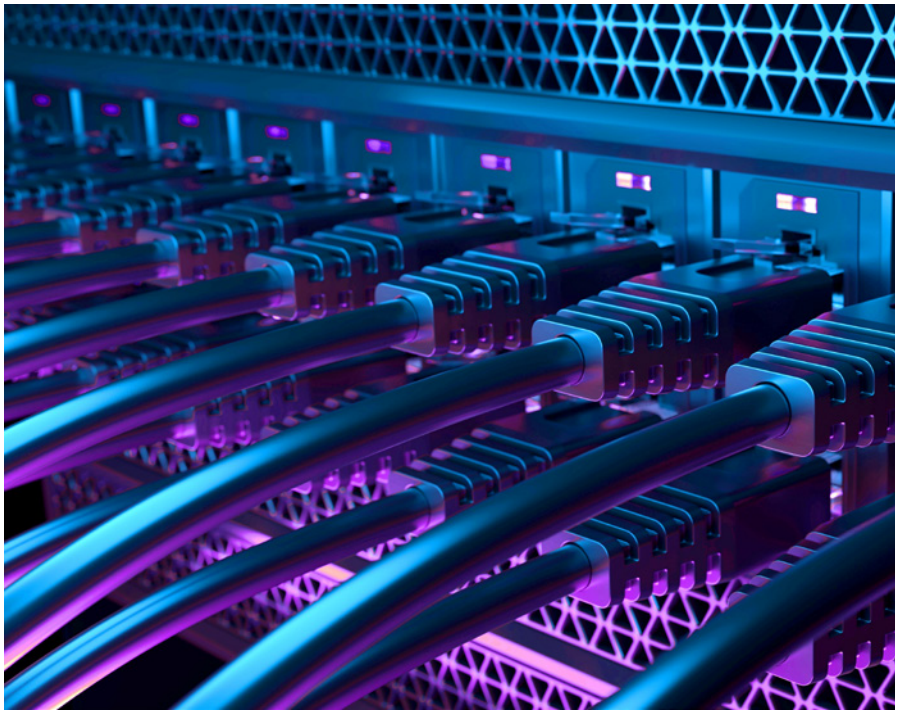
On the other hand, where indemnity has been confirmed, it is often appropriate to provide insurers with the invoices throughout the life of the dispute. Simply put, of course insurers will not pay invoices they have not seen. As a practical matter, it may be easier to advocate that invoices are reasonable while the underlying legal complexities and uncertainties are being negotiated, rather than doing so retrospectively after those issues and uncertainties have been resolved.



Director liability and insurance developments

Carolyn Pugsley
Partner, Corporate (Melbourne)

"Directors are continuing to scan the horizon for emerging risk areas and working with management to ensure they are appropriately covered in risk management frameworks, compliance programs and Board reporting. Non-financial risks continue to be a key focus for ASIC and other regulators, so AI, cyber-security and ESG-related risks continue to be front of mind. The introduction of mandatory reporting on climate-related financial risks is a good illustration of Boards being pushed to give new sign-offs on reporting for which there is no current benchmark (in Australia or globally) of what 'good' disclosure looks like. Given the uncertainty around the lens a court will apply in determining whether legal obligations have been appropriately discharged (at a company and director level), directors should ensure that their decision-making process is clearly documented and that Directors & Officers' insurance arrangements are keeping pace with regulatory and risk environment changes."



Introduction

Directors are facing an increasingly complex risk landscape as regulatory priorities evolve and enforcement becomes more assertive. Recent ASIC announcements and enforcement actions emphasise that traditional duties under the *Corporations Act 2001* (Cth) (**Corporations Act**) remain unchanged, even as technological (AI), ESG and cyber risks reshape corporate governance. At the same time, developments in insurance law – particularly around non-indemnification orders – highlight the tension between personal accountability and the protective function of directors' and officers' liability (**D&O**) insurance. These trends signal heightened scrutiny on board oversight and risk management frameworks, with significant implications for directors' exposure and the adequacy of insurance arrangements.

Regulatory risk

ASIC's 2025 enforcement priorities reinforced and expanded on areas of regulatory focus with key enforcement areas stated to include:

(a) greenwashing and misleading conduct involving ESG claims;

(b) failures to have adequate cyber-security protections, including lack of oversight of outsourced IT providers; and

(c) market integrity, including continuous disclosure and insider trading breaches.

This has been reflected in practice:

(a) Forward-looking statements relating to climate need to be treated with caution under the mandatory climate-related financial disclosures regime in Australia, which required Group 1

entities to prepare their first fully compliant sustainability reports for financial years from 1 January 2025, and extended to Group 2 entities[16] from 1 January 2026. ASIC has also released Regulatory Guide 280 which sets expectations on board oversight, verification and control frameworks needed for sustainability reporting and confirms that forward looking climate statements will be assessed for reasonableness and that stringent records must be kept to substantiate sustainability claims.

(b) In April 2025, ASIC published a Market Integrity Update, urging companies to review their AI governance and risk management arrangements. The regulator highlighted concerns that AI could pose operational and systemic risks to market integrity, particularly where oversight and controls lag behind deployment.

(c) In August 2025, ASIC Chair Joe Longo delivered a speech in which he emphasised that technological change does not alter the fundamental obligations of directors under the Corporations Act. Longo warned that boards must not only understand the risks posed by digital transformation but also ensure that governance frameworks are robust enough to manage them. He stated that ASIC will continue to hold directors accountable where failures in oversight or risk management expose companies to harm, including in the context of cyber incidents.

(d) In October 2025, ASIC's Deputy Chair, Sarah Court:

- described ASIC's approach as "proactive, strategic and bold". This included taking an approach that went beyond "conservative" enforcement action where that approach was supported by evidence and legal advice;
- noted that while directors' duties are longstanding, they continue to evolve through the lens of community expectations, from various stakeholders including politicians, the media and consumer groups; and
- indicated that ASIC is still seeing issues with companies not getting the basics right.

ASIC's recently announced 2026 enforcement priorities are more consumer focussed including matters such as misleading pricing practices impacting cost of living for Australians, poor private credit practices and claims and complaint handling failures by insurers. However:

- ASIC has identified financial reporting misconduct including failure to lodge financial reports and insider trading as priorities; and
- while risks such as cyber/data privacy and greenwashing have not been specifically identified as continuing or new priorities, it is unlikely they will drop off ASIC's agenda in 2026.

Non-indemnification orders

In our 2024 Policyholder Highlights publication, we reported on the Federal Court's decision in *Australian Competition and Consumer Commission v BlueScope Steel Limited (No 6)*[17] (***Bluescope***). *Bluescope* provides an example of where a court has issued a non-indemnification order against a director – preventing them from claiming the fine imposed on them against their D&O insurance and leaving them to bear the imposed liability personally. However, a 2025 decision of the High Court of Australia – *ACCC v Productivity Partners Pty Ltd (trading as Captain Cook College)*[18] (***Productivity Partners***) – demonstrates that such orders will not always be granted when sought.

By way of brief recap, in *Bluescope*:

- The Federal Court ordered a $57.5 million penalty on Bluescope Steel for cartel conduct and a $575,000 penalty on the former General Manager of Bluescope for attempting to induce that conduct.
- The ACCC sought a non-indemnification order under s 76(1) of the *Competition and Consumer Act 2010* (Cth) in respect of the penalty on the General Manager, to prevent him from obtaining indemnification for the penalty under his D&O insurance.
- The Court issued the non-indemnification order. Section 76(1) required the Court to have regard "to all relevant matters including the nature and extent of the act or omission and of any loss or damage suffered as a result of the act or omission…", those matters being that:

16. Which included listed and unlisted public and private companies with two of the following three features: over 250 employees; $500 million+ in consolidated gross assets; $200 million+ consolidated annual revenue.
17. [2023] FCA 1029.
18. (2024) 281 CLR 338 and [2025] FCA 542.

- the General Manager devised the entire strategy, and it was implemented under his direction, with other involved employees acting in accordance with his instructions;
- after the commencement of the ACCC investigation, the General Manager urged others to knowingly provide false or misleading information to the ACCC;
- there was an absence of evidence as to contrition; and
- the General Manager earned approximately $600k annually. Further, although the General Manager owned no assets by his financial planning choice at the time of the case being heard, his wealth was held by other family members.

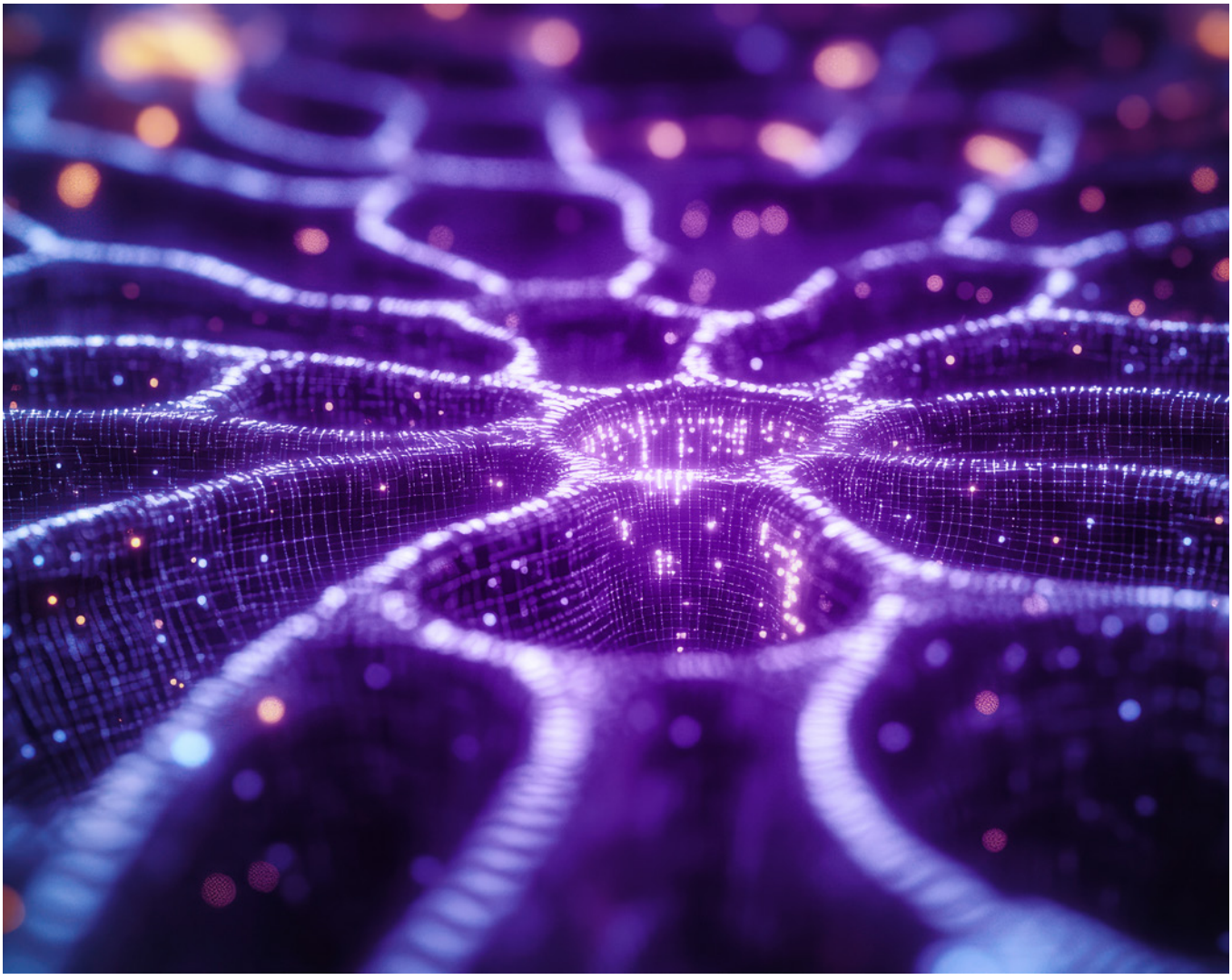
Following the Federal Court's decision in *Bluescope*, the High Court of Australia's recent decision in *Productivity Partners* emphasises that the issuing of a non-indemnification order is a matter of the Court's discretion and will not be ordered in all circumstances.

In *Productivity Partners*, Captain Cook College was a provider of vocational training courses funded under the Commonwealth VET FEE-HELP Scheme. Under that Scheme, the Commonwealth would pay fees on the condition students remained enrolled beyond a set "census date". This incentivised the College to keep students on beyond the census date, and the College only paid course advisers a commission if students passed the census date.

The High Court found that the College engaged in systemic unconscionable conduct and made false or misleading representations, and that its Chief Operating Officer (**COO**) was knowingly concerned in the contravention. The matter was remitted to the Federal Court to determine relief, where Justice Stewart:

- imposed penalties on both the College ($20.75 million in total) and the COO ($400,000); but
- refused to make a non-indemnification or personal payment order against the COO, on the basis that it would undermine the rationale and utility of D&O insurance if courts too readily made orders preventing someone from having the benefit of insurance. That was particularly because, while the COO was aware of the elements which gave rise to the unconscionability, he was not aware that the conduct was in fact unconscionable.

The convergence of regulatory enforcement and judicial discretion in determining insurance coverage reinforces the need for directors to adopt proactive governance strategies and review their insurance protections. ASIC's focus on AI, ESG disclosures, cyber resilience, and market integrity mean boards must ensure robust compliance and risk oversight, given recent cases on non-indemnification orders demonstrate that D&O cover cannot be assumed as a safety net for the financial repercussions in all circumstances. Directors should engage early with insurers and advisers to confirm the scope of cover and consider emerging risks because as regulatory expectations rise, so too does the potential for personal liability.



Insurance and class actions

Melissa Gladstone
Partner, Disputes (Sydney)

"Since *Myer*, there have been a series of shareholder class action decisions in Australia that have clarified the previously untested law and made running cases to trial a viable option where companies have a solid defence. There can no longer be a presumption of settlement. However, the law is continually evolving. The class action landscape is set for further developments in the first half of CY2026, with Courts poised to address critical questions of materiality, causation and loss, including the much anticipated decision of Murphy J in *Brambles*. As Courts develop the class action jurisprudence, companies, their advisors and insurers must stay abreast of these developments and remain flexible in their approach to defending class actions in Australia."

While the conditions in the D&O market seem to have eased from a policyholder perspective, this does not appear to be the result of fewer class actions nor Court successes for class action defendants. In fact, all markers point towards an increasingly active class action market, suggesting market conditions are being driven more by the competitive dynamics in the D&O insurance market.

Class action risk

The following statistics relating to Australian class actions in FY25 provide important context for the state of the market. There were:

- 79 class action filings, including 28 consumer class actions, 8 securities class actions, 13 government class actions and 25 labour class actions;[19]
- 25+ active litigation funders;
- 6 jurisdictions with a class action regime (and 2025 was the first year in which a class action was filed in each jurisdiction); and
- $1.9 billion in settlements.

These statistics and our experience of the class actions market more generally provide several key insights:

- The class action market remains very active, with a significant number of entrepreneurial plaintiff lawyers and funders actively pursuing (and competing to run) proceedings across a broad range of subject matters and sectors. After a general downward trend in filings between 2020 and 2023, there was a significant spike in 2024/25, particularly in the consumer and labour class actions space. Moving forward, we consider it likely that the trends in filings will continue to depend on key factors such as procedural and substantive legal developments in the class action space and the capacity of plaintiff firms to investigate and bring new actions, given there are so many matters active in the market.
- Settlements remain a key feature, providing significant financial incentive for plaintiff lawyers and funders – in FY2025 alone, $264.3 million in settlements were approved by Australian courts. However, there is an increasing trend for cases to run to trial and judgment. In the CBA *Zonia* shareholder class action, the Court of Appeal handed down a judgment in CBA's favour last year. Further, judgments in the *Brambles*[20] (first instance) and *Worley*[21] (appeal) class actions are awaited, and the trial in the *Boral* shareholder class action completed in December 2025. The High Court granted special leave to appeal the *Zonia* decision in February 2026.
- Shareholder class actions remain a significant area of interest for plaintiff firms and funders, and relatively speaking, filings are slightly increasing compared to non-shareholder class actions. That said, non-shareholder class actions comprise over two thirds of new filings, and companies need to be particularly mindful of potential class action risks relating to cyber and employment issues (particularly in light of potential regulatory reform and increasing union involvement).
- The Victorian Supreme Court is a favoured jurisdiction, as it is the only jurisdiction that permits contingency fee arrangements (referred to as Group Costs Orders). It seems that the Victorian Supreme Court will continue to be a, if not the, favoured jurisdiction, given that the High Court has now ruled out the possibility of solicitors seeking a solicitors' Common Fund Order in jurisdictions that are subject to the Legal Profession Uniform Law (NSW, Western Australia and Victoria).

19. 19 of which relate to the same cause of action - the Junior Doctors (VIC) Class action.
20. *Holly Southernwood, and William Vincent Kidd & Mary Agnes Collum as Trustees for the Magness-Bennett Superannuation Fund v Brambles Limited* (No VID 972/2018).
21. *Crowley v Worley Limited* (2022) 293 FCR 438.

- It remains the case that many class actions will be commenced after or in parallel with a regulatory investigation or enforcement outcome. This puts a real focus on the areas identified above as bases for class action activity.
- The cost to policyholders and D&O insurers (as well as other liability insurers for non-shareholder class actions) remains significant. Defence costs for a shareholder class action can be in the region of $15–20 million, though may be more if the discovery burden is significantly more than usual. In some cases, this will be borne almost entirely by the policyholder where a significant deductible applies. Settlements of shareholder class actions remain at an average of approximately $50 million.

All of that said, the risk of directors and officers being joined as defendants to shareholder class action proceedings has historically been low because:

- with the exception of prospectus claims, claims against individuals are forensically more difficult to prosecute, and therefore less attractive to plaintiff firms and funders on a cost benefit analysis; and
- where the defendant company's balance sheet is sufficient to withstand a judgment or settlement, there is no incentive to join individual directors and officers in order to access their D&O insurance asset.

This position is borne out by the current class action landscape, where directors have only been joined in the case of actual or perceived financial concerns with the corporate defendant. The corporate entity (which may have "Side C" securities class action cover under a D&O policy) therefore remains the focus for plaintiff lawyers and funders.

D&O market

It has been reported by the major insurance brokers that the trend of pricing reductions for ASX-listed companies has continued, due to ongoing competition as insurers seek to maintain market share and compete with new entrants to the market. Premium reductions may also be linked to a perception of reduced risks given favourable judgments for policyholders, but given settlements of shareholder class actions continue to be the norm, we do not think this should be a major driver.

We have generally observed a trend of insurers taking a more active role in the monitoring and defence of class actions, subject to the claims provisions in D&O policies. In addition, newer overseas insurers with less general familiarity with the underlying class action proceedings are now more frequently involved in large shareholder class action claims. It is important for policyholders to understand the potential differences in experience across a group of insurers in a D&O program and ensure this is accounted for as part of the claims process.

Shareholder class actions and D&O insurance – the decision in *Nuix*

The decision of *Nuix Limited v Berkshire Hathaway Specialty Insurance Company*,[22] provides an interesting insight into the convergence of shareholder class actions and the D&O insurance market, and the impact on questions of policy construction.

In *Nuix*, Justice Derrington of the Federal Court considered the operation of two different deductibles in D&O insurance and public offering of securities insurance (**POSI**) policies in the context of a shareholder class action.

22. [2025] FCA 1002.

The key factual background is as follows:

- The D&O policy had a deductible of $2.5 million for claims against individuals (to the extent liabilities in respect of these "claims" were indemnified by the company – commonly referred to as Side B coverage), and of $10 million for "Securities Claims" (commonly referred to as Side C coverage). The same deductible structure and amounts applied in respect of the POSI Policy, albeit limited to claims arising from the issue of a prospectus in November 2020.
- The D&O and POSI policies had broadly identical terms, including provisions by which different claims could be aggregated into a single claim for the purpose of the application of a deductible based on the connection between the different claims by way of wrongful acts or related facts or circumstances.
- An initial public offering of Nuix occurred in November 2020 by way of the issuing of a prospectus.
- In May 2021, Nuix received an ASIC notice requiring its assistance in relation to an investigation of a third party. In June 2021, it received an ASIC notice indicating ASIC had commenced an investigation into Nuix itself. Nuix notified the investigation notices to its insurers as "circumstances that may reasonably be expected to give rise to a claim" and subsequently advanced a claim in respect of individuals' costs under Side B of the policies.
- Three class actions were commenced against Nuix and others in late 2021 and early 2022, two of which were subsequently consolidated, and the third of which was permanently stayed. ASIC filed proceedings against Nuix in September 2022. Nuix advanced a claim under Side C of the policies in respect of the several class actions and ASIC litigation, and sought permission to incur defence costs in respect of such under the policies.

The question to be decided by the Court was whether the $2.5m deductible of the Side B coverage (**Side B Claim**) or the $10m deductible of the Side C coverage applied (**Side C Claim**), because both insuring clauses were engaged in the circumstances.

The Court considered the same question in respect of both the POSI policy and D&O policy. The Court's determination was limited to determining the appropriate construction of the policies within the context in which the issue arose. In this regard, the Court did not make any binding findings beyond what was necessary to construe the policy terms.

The Court concluded that the higher deductible of $10 million applied to both policies. Ultimately, this conclusion was reached on the basis of an application of uncontroversial principles of policy construction to the policies and background facts. However, relevantly, it was heavily informed by the commercial backdrop of shareholder class actions and demonstrates how over the last decade, shareholder class actions have become a significant feature in the D&O insurance market and vice versa. The Court ultimately ruled in favour of the insurers on the basis of some of the following key points:

- The policies were clear that the retention applicable to a "Securities Claim" was $10 million, and this made commercial sense. It was "notorious" that shareholder class actions often involved substantial demands from numerous shareholders amounting to many millions of dollars, and the costs of defending them were higher than standard litigation. The insuring of such potential claims therefore involved significant risk for an insurer, and would require a substantial retention by the policyholder, including as a deterrent to engaging in conduct which may lead to a shareholder class action. In addition, a substantial retention or deductible reduced the premiums charged and, consequently, rendered the cover more affordable for the policyholder.
- The differing levels of retention necessarily reflect the differential risk evaluation in relation to the types of claims that might be made and, importantly, are essential to the extent of the liability which the insurer assumes. In this way, the construction proposed by the insurers promoted the identified object sought to be achieved by the policies.

- The retention was part of the bargain struck, and there was no explicit basis in the policies to apply the lower deductible – in fact, quite the opposite: the policies emphasised that the applicable retention "shall apply to Loss resulting from each and every Claim". That drafting could be seriously negated if, due to the existence of a prior related Side B Claim, a retention of only $2.5m applied in relation to cover sought for a Side C Claim. Such a result would be far from business-like and unlikely, on any objective view, to have been one intended by the parties.
- Although the policies provided for multiple related claims to be a single "Claim" in certain circumstances, this did not purport to alter the character of the claims made against the insured(s) nor their applicable retention. While they were treated as a single claim for the purpose of timing and the imposition of the single retention, nothing in the policies suggested that the Side C Claim lost its characteristic as a substantial claim from which there may be substantial Loss and, in respect of which, a substantial retention applies. The inherent character of a Side C Claim is not altered merely because it is made after a Side B Claim.
- As a matter of practical reality, when a securities claim is made against the insured, one may reasonably expect that it would be accompanied by other claims to which a lower retention applies. The conduct associated with a securities claim is serious, and in the Australian corporate sector, often also gives rise to regulatory action, at the very least, by way of an ASIC investigation involving demands for interviews and information. It is therefore likely that the parties to the policies could reasonably have expected that a securities claim will have followed claims by insured persons attracting the lower retention.
- The construction advanced by Nuix (namely that the existence of the prior related Side B claim meant that the lower Side B deductible applied instead of the higher Side C deductible) did not provide greater certainty for the parties at the time of contracting, because the application of deductibles would be dependent on the "happenstance" of which claim was made first, rather than the nature of the claim made. This had no commercial logic to it.

The decision is of interest for a number of reasons:

- The commercial background to the placement of Side C cover, including the significant risk and defence costs of defending shareholder class actions (which is the type of proceeding to which Side C cover most commonly responds), formed an important part of the commercial background which drove the policy construction outcomes. It is clear that over the last decade at least, the commercial insurance issues associated with class actions have become familiar to insurers, policyholders and the courts.
- Separate questions can be a relatively time and cost efficient way of dealing with threshold insurance coverage issues such as this one. The risk nevertheless remains of an appeal, and this decision is the subject of an appeal to be heard by the Full Federal Court in March 2026.

Court gives ATE insurance the green light for Security

i-Prosperity Pty Ltd (in liquidation) v Crown Melbourne Ltd [2025] NSWSC 1525

This case explores whether an after-the-event (**ATE**) insurance policy with an anti-avoidance endorsement can satisfy security for costs requirements in litigation. Such arrangements are frequently relied upon in the context of shareholder class actions, albeit this is not the context in which it arose in this case. The Court's decision clarifies enforceability under the Insurance Contracts Act, addresses privity concerns, and confirms the adequacy of Lloyd's syndicate-backed security.

Facts

i-Prosperity Pty Ltd (**i-Prosperity**), who was backed by litigation funding from LCM Funding Pty Ltd (**LCM**), commenced proceedings against Crown Melbourne Ltd (**Crown**). i-Prosperity agreed that Crown was entitled to a total amount of $2,000,000 for security for costs.

LCM was the policyholder of an after-the-event insurance policy (**Policy**). An ATE policy covers the insured's legal liability to pay a defendant's costs in the event of an adverse judgement and subsequence costs order. LCM proposed that security be provided by way of an "anti-avoidance endorsement indemnity" (**Endorsement**) to the ATE policy which provided that Crown was indemnified for adverse costs irrespective of any exclusions of the Policy or any breach by LCM.

Crown raised enforceability concerns where it was not party to the insurance contract (ie a privity issue) and where the insurance policy was provided by not one insurer but various Lloyd's syndicates. Crown alleged that there was insufficient evidence of a "fund accessible to Crown" if insurers refused to pay.

Decision

The Court found that the ATE policy, and the Endorsement, were an adequate form of security.

The Court was satisfied that, subject to minor amendments, the Endorsement both validly formed part of the insurance contract and allowed Crown to sue the insurers to take advantage of the Endorsement. The privity issue was overcome either:

- by virtue of s 48 of the Insurance Contracts Act, which provides that third party beneficiaries to a policy have a right to recover from an insurer; or
- as the endorsement demonstrated an intention by Insurers that Crown had benefit of the contract of insurance (and was therefore insured pursuant to the test in *Trident General Insurance Co Ltd v McNeice Bros Pty Ltd*, which essentially held that a non-party to an insurance contract could still claim under it notwithstanding the lack of privity, including where the insurer accepted premium for providing such a benefit).

The Court further found that there was no real risk that the security was inadequate merely because the insurers were syndicates with specifically allocated liability in circumstances where each syndicate had been proven to have significant net assets. While those assets were not within the jurisdiction, that was not determinative (noting the existence of the Lloyd's security trust fund – a trust fund held in Australia as security for liabilities of certain Australian policies).

Lessons for Policyholders

This case provides support for the proposition that an ATE, with an appropriately drafted anti-avoidance endorsement, provided by London-based Lloyd's insurers, can provide adequate security for costs (without the need, for example, for a separate deed of indemnity from the insurer).

Contacts — who can help?

Australia

Anne Hoffmann
Partner
T +61 2 9225 5561
anne.hoffmann@hsfkramer.com

Ruth Overington
Partner
T +61 3 9288 1946
ruth.overington@hsfkramer.com

Guy Narburgh
Special Counsel
T +61 2 9322 4473
guy.narburgh@hsfkramer.com

Andrew Ryan
Executive Counsel
T +61 8 9211 7965
andrew.ryan@hsfkramer.com

Travis Gooding
Senior Associate
T +61 2 9225 5328
travis.gooding@hsfkramer.com

Asia

Daniel Chia
Managing Director and
Head of Litigation
T +65 68121363
daniel.chia@hsfkramer.com

Daniel Waldek
Partner
T +65 6868 8068
daniel.waldek@hsfkramer.com

United Kingdom

Sarah McNally
Partner
T +44 20 7466 2872
sarah.mcnally@hsfkramer.com

Alex Oddy
Partner
T +44 20 7466 2407
alexander.oddy@hsfkramer.com

EMEA

Alejandra Galdos
Partner
T +34 914 23 40 87
alejandra.galdos@hsfkramer.com

Nicolas Pol
Partner
T +33 1 5357 7408
nicolas.pol@hsfkramer.com

Stuart Paterson
Partner
T +971 4 428 6308
stuart.paterson@hsfkramer.com

Jonathan Ripley-Evans
Partner
T +27 10 500 2690
jonathan.ripley-evans@hsfkramer.com

Additional Contributors

Isabel Gahan, Nikala Speed, Simone Conyer and Lachlan Jones

For a full list of our global offices visit **HSFKRAMER.COM**