HIGH COURT OF AUSTRALIA

GLEESON CJ,
McHUGH, GUMMOW, KIRBY AND HAYNE JJ

FAI GENERAL INSURANCE COMPANY LIMITED APPELLANT

AND

AUSTRALIAN HOSPITAL CARE PTY LTD RESPONDENT

FAI General Insurance Company Limited v Australian Hospital Care Pty Ltd
[2001] HCA 38
27 June 2001
B23/2000

ORDER

Appeal dismissed with costs.

On appeal from the Supreme Court of Queensland

Representation:

P A Keane QC with R G Bain QC for the appellant (instructed by Clayton Utz)

S S W Couper QC with K N Wilson for the respondent (instructed by McLaughlins)

CATCHWORDS

FAI General Insurance Company Limited v Australian Hospital Care Pty Ltd

Insurance – Professional indemnity insurance – Claims made and notified policy – Term of policy deeming claim against insured made after expiry of period of cover to be covered by policy if, during period of cover, insured became aware of occurrence which gave rise to the claim and gave written notice to insurer – Claim by third party made after expiry of period of cover – Insured became aware of occurrence which gave rise to claim during period of cover but failed to notify insurer – Whether insurer entitled to refuse indemnity for failure to give notice – Whether s 54 of *Insurance Contracts Act* 1984 (Cth) applicable.

Insurance Contracts Act 1984 (Cth), s 54.

1 GLEESON CJ. The application of the general provisions of s 54 of the *Insurance Contracts Act* 1984 (Cth) ("the Act") to contracts of insurance of the kind presently in question has produced a deal of division of judicial opinion. My views on the subject are set out in *East End Real Estate Pty Ltd v C E Heath Casualty & General Insurance Ltd*[1] and *FAI General Insurance Co Ltd v Perry*[2]. I agree with the dissenting judgment of Pincus JA in the Court of Appeal of Queensland in the present case[3]. Since mine is a minority opinion, I will not repeat what I have said in earlier cases, but will state briefly why I would allow the present appeal.

2 The respondent insured was covered, for successive annual periods, by policies of professional indemnity insurance. The two periods of present relevance are 20 June 1991 to 20 June 1992 ("the first year"), and 20 June 1992 to 20 June 1993 ("the second year"). The appellant was the insurer for the first year. Lloyd's Underwriters were the insurers for the second year. It was held by the Court of Appeal of Queensland, and is not in issue in this Court, that the respondent was covered, in respect of the relevant occurrence, by the Lloyd's policy, that is, the policy in respect of the second year. The issue in the present appeal is whether the respondent was also covered, in respect of the same occurrence, by the policy in respect of the first year. The majority in the Court of Appeal held that it was.

3 The insuring clause of the policy stated that the appellant agreed "[t]o indemnify the [respondent] against any claim or claims for compensation first made … during the period of cover … for breach of professional duty … [or] by reason of any negligence …". It is to be noted that the indemnity is against claims, not against occurrences, or liability. A person or corporation against whom a claim for professional negligence is made may suffer financial loss even if no liability is established. The costs of defending the claim may be substantial, even if the defence is successful. A failure to recognise that the nature of the insurance is that it provides indemnity against claims seems to me to underlie parts of the respondent's argument. As will appear, the condition of the policy on which the respondent relies is closely tied in with the insuring clause.

4 The allegedly negligent conduct of the respondent, which ultimately led to a claim against it, occurred before the commencement of the first year. The injured party was Dr Tampoe, who was a patient at one of the respondent's

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1 (1991) 25 NSWLR 400.

2 (1993) 30 NSWLR 89.

3 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 153 FLR 448; 10 ANZ Insurance Cases ¶61-445.

hospitals in March 1991. No claim was made by Dr Tampoe until the second year. During the early part of the first year there had been some correspondence from, and communications with, Dr Tampoe's solicitors, but no claim was made, and no action was commenced. In June 1992, Dr Tampoe's solicitors advised him that his prospects of success were not good. He was evidently still undecided as to whether to take any action. When, in June 1992, the respondent applied for Lloyd's insurance for the second year, it stated in the proposal form that it was not aware of any circumstances that might give rise to a claim. The position at the end of the first year was that no claim had been made upon the respondent in respect of the relevant occurrence, it was not expected by the respondent that a claim would be made, the respondent had not notified the appellant of any possible claim, and the respondent had told its proposed insurer for the second year that it was not aware of any circumstance that might give rise to a claim. In the event, a claim was made by Dr Tampoe during the second year. The Lloyd's policy was held to cover the respondent. The decision of the majority of the Court of Appeal of Queensland was that the respondent is also covered by the appellant's policy. That outcome depended upon a conclusion that the fact that the respondent did not, during the first year, notify its insurer of the occurrence involving Dr Tampoe, was an omission of a kind against which s 54 of the Act relieved. That is a conclusion I am unable to accept.

5 The insuring clause provided that the appellant agreed to indemnify the respondent against claims for breach of professional duty or negligence first made during the first year. Condition 2 of the policy provided that it was a condition precedent to the respondent's right to indemnity that any such claim be notified to the appellant immediately. It is condition 3 of the policy which is of particular relevance. The condition provided that if, during the subsistence of the policy, the respondent should become aware of any occurrence which might subsequently give rise to a claim, and should, during the subsistence of the policy, give written notice of the occurrence to the appellant, then any such subsequent claim would, for the purposes of the policy, "*be deemed to have been made during [the first year]*" (emphasis added). Thus, if the respondent gave a timely notice of the kind referred to, any later claim would be deemed to have been made during the subsistence of the policy. The deeming mechanism was related to the language of the insuring clause. It was not a free-standing and alternative cover. It operated by deeming a claim to have been made within the period of cover. The policy covered claims first made during the first year. Claims would be deemed to have been made during the first year if notification of an occurrence was given during that year. In that context, "made" obviously meant "first made". That was the contract of the parties. The question concerns the effect of s 54 of the Act upon that contract.

6 Section 54 relieves an insured against loss of entitlement to indemnity, in certain circumstances. It refers to "some act of the insured", but, by definition, a reference to an act includes a reference to an omission. So understood, in its application to the present case the section provides:

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

7 Why, in the circumstances of the present case, the respondent might be thought to be in need of relief is difficult to understand. This is not some kind of gratuitous statutory interference with freedom of contract. It is purposeful, remedial, legislation. The task is to apply the language of the legislation, even though the facts of the case disclose no need for a remedy. But, as the past division of judicial opinion shows, the meaning of the language, in its application to certain contracts of insurance, is far from clear.

8 But for s 54, the appellant, as insurer under the policy which subsisted during the first year, would have been entitled to refuse a claim for indemnity in respect of the claim later made by Dr Tampoe. That was because no claim was made by Dr Tampoe during the subsistence of the policy, and nothing was done by the respondent which, by reason of condition 3 of the policy, meant that the claim subsequently made by Dr Tampoe was deemed to have been made during the subsistence of the policy. Put another way, the policy no longer subsisted when Dr Tampoe made his claim, and the respondent never gave a notice which would have produced the result that Dr Tampoe's claim was deemed to have been made during the subsistence of the policy.

9 Section 54 makes two references to a causal relationship between an omission and the insurer's refusal to pay. The first is to a refusal "by reason of" an omission. The second is to a refusal "by reason only" of that omission. Let it be assumed, contrary to my view, that it is proper to characterise the fact that the respondent gave no notice to the appellant, during the subsistence of the policy, of an occurrence involving Dr Tampoe, as an omission. Section 54 apart, the justification for not treating the respondent as indemnified was that there was no claim made upon the respondent during the subsistence of the policy, and, therefore, the insuring clause did not cover the case. The fact that no such claim was made was the result of inaction by Dr Tampoe. The respondent might, nevertheless, have done something which would later mean that a claim by Dr Tampoe would be deemed to have been made during the subsistence of the policy, contrary to the fact. But the justification for refusing indemnity, expressed naturally, in terms of the insuring clause, was that the policy covered claims made during a certain period, and this claim was not made during that period.

10 On the assumption being made as to the meaning of omission, there was also an omission by Dr Tampoe. It was common ground in argument, and is accepted by the majority in the present case, that if the only relevant omission were that of Dr Tampoe, s 54 would not have availed the respondent[4]. That does not mean, however, that Dr Tampoe's omission can be ignored. The policy provides, or fails to provide, cover, against a claim by him. It is his claim that, by the terms of the policy, must either have been made, or be deemed to have been made, within a certain period, if the respondent is to be entitled to indemnity under the policy. When regard is had to the nature of the policy, and, in particular, to the language of the insuring clause, the more natural explanation of the reason why the insurer could refuse to pay the insured's ultimate claim on the insurer was that the policy entitled the insured to indemnity against claims made in a given period and no such claim was made. And how can it be said that it is *by reason only* of the inaction of the respondent that the appellant was justified in refusing to indemnify the respondent?

11 The repeated references in condition 3 to the subsistence of the policy emphasise that, although the contractual force of the policy was not spent after the end of the first year, the events to which the policy would respond were events (claims and deemed claims) during that period. This is not a case where the effect of the contract of insurance was made to depend upon a matter of form rather than substance. The event against which the insured was indemnified was an event happening during a defined period. Such an event did not happen, either in fact, or by virtue of a deeming provision. When one is dealing with a commercial contract, there is a limit to the extent to which a preference for substance over form can justify disregarding the agreement of the parties. The respondent's argument seems to me to exceed that limit. The effect of the respondent's argument is that a policy which indemnifies against claims made, or potential claims notified, during a particular period, is transformed by s 54 into a policy which indemnifies against claims whenever made, even though the insurer is not notified of any occurrence during the period, and may never be notified until the claim materialises. The concluding words of s 54(1) provide no adequate protection, because the extent to which the insurer's interests were prejudiced may be impossible to measure. That impossibility reinforces the view that s 54 was not directed at a case such as the present.

12 In *Antico v Heath Fielding Australia Pty Ltd*[5] it was said that, for the purposes of s 54, an omission may be "a failure to exercise a right, choice or liberty which the insured enjoys under the contract of insurance". Here the insured, for reasons that are not difficult to understand, allowed the period of

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4 *Greentree v FAI General Insurance Co Ltd* (1998) 44 NSWLR 706.

5 (1997) 188 CLR 652 at 669.

subsistence of the first policy to expire without taking a step which, if taken, would have meant that, if and when Dr Tampoe made a claim, the claim would be deemed to have been made during the subsistence of the policy. The insured chose to rely on the cover given by the second policy, or by any later policy that might have been in force at the time of Dr Tampoe's claim. I am not persuaded that the exercise of such a choice was intended by the legislature to be regarded as an act or omission to which s 54 applies, or that, even if that be what is euphemistically called an unintended consequence, it is required by the language of the section.

13 McHUGH, GUMMOW AND HAYNE JJ. In 1991, the appellant ("the insurer" or "FAI") made a contract of insurance with the respondent ("the insured"). The insured owned and operated hospitals including the Pindara Private Hospital. The policy, signed on behalf of the insurer in January 1992, was described as a "professional indemnity policy". It recorded that the insurer agreed, subject to some limitations, terms and conditions:

> "To indemnify the Insured against any claim or claims for compensation first made against the Insured during the period of cover specified in the Schedule and reported to the [insurer] during the period of cover specified in the Schedule,
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> (a) for breach of professional duty in the conduct of [the business conducted by the insured] by reason of any negligence …"

14 Among the conditions mentioned in the policy, there were two to which particular reference should be made:

> "2. The Insured shall as a condition precedent to his or their right to be indemnified under this Policy to [sic] give to the [insurer] immediate notice in writing:
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> (a) of any claim made against him or them;
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> …
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> 3. If during the subsistence hereof the Insured shall become aware of any occurrence which may subsequently give rise to a claim against him or them for breach of professional duty by reason of any negligence, whether by way of act, error or omission and shall during the subsistence hereof give written notice to the [insurer] of such occurrence, then any such claim which may subsequently be made against the Insured arising out of such negligence shall for the purposes of this Policy be deemed to have been made during the subsistence hereof."

15 During the period of cover specified in the policy (from 4.00 pm 20 June 1991 to 4.00 pm 20 June 1992) the insured received a letter from a firm of solicitors which said that Dr Tampoe, their client, was "giving consideration to bringing an action against [the insured] in relation to the treatment he received" while a patient at the Pindara Private Hospital. The appeal in this Court was conducted on the basis that this letter did not constitute the making of a claim on the insured, but it did make the insured aware of an occurrence of the kind referred to in condition 3 of the policy – an "occurrence which may subsequently give rise to a claim against [the insured] for breach of professional duty by reason

of any negligence". The insured gave no notice of this occurrence to the insurer during the period of cover.

16 In fact, Dr Tampoe did not make a claim on the insured during the period of cover. It was not until December 1992 that he sued the insured and the surgeon who had operated on him at the insured's hospital. By that time the period of cover under FAI's policy had ended and the insured had made a contract of insurance with Lloyd's underwriters. Both FAI and the Lloyd's underwriters denied liability in respect of the insured's claim for indemnity against its liability to Dr Tampoe. The insured therefore brought third party proceedings for indemnity against a representative of the Lloyd's underwriters and against FAI.

17 At the trial of the third party proceedings the insured failed in its claim against the Lloyd's underwriter, but succeeded in its claim against FAI. The insured appealed to the Court of Appeal of Queensland against the dismissal of its claim against the Lloyd's underwriter; FAI appealed to that Court against the judgment against it. The insured's appeal against the Lloyd's underwriter succeeded. By majority (Derrington and Chesterman JJ; Pincus JA dissenting), the appeal by FAI failed[6]. Only FAI appeals to this Court. None of the questions of double insurance, which would seem to arise if FAI's appeal fails, were argued or now fall for decision.

18 The central issue in the appeal to this Court is what operation s 54 of the *Insurance Contracts Act* 1984 (Cth) has in the events that have happened. In particular, does s 54(1) preclude the insurer from refusing to pay the insured's claim on the ground that the insured omitted to give to the insurer, within the period of cover, notice of an occurrence which may give rise to a claim?

19 So far as presently relevant, s 54 provides:

> "(1) Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into … the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the

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6 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445.

extent to which the insurer's interests were prejudiced as a result of that act.

…

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

(a) an omission …".

20 There are several matters to which reference should be made at the outset. First, s 54(1) has operation only where, but for the section, the effect of a contract of insurance according to its terms would be that the insurer may refuse to pay a claim, either in whole or in part. As was said by the majority in *Antico v Heath Fielding Australia Pty Ltd*[7]:

> "[Section 54] takes as its starting point the existence of a claim and a contract the effect of which is that the insurer may refuse to pay the claim."

That is, if s 54(1) applies, the parties to a contract of insurance will necessarily have different rights and duties from those for which their contract of insurance provided.

21 Secondly, if s 54(1) is engaged in respect of some act or omission, and as a result of that act or omission the insurer's interests were prejudiced, the insurer's liability in respect of the claim is reduced "by the amount that fairly represents the extent" to which those interests were prejudiced. Any contention that the section is to be construed in a way that will avoid what is characterised as an "unfair" or "unjust" departure from the contract of insurance must be assessed against the two propositions we have mentioned.

22 Thirdly, it is important to recall that it was established in *Antico* that an omission for the purposes of s 54 may be a failure by the insured "to exercise a right, choice or liberty which the insured enjoys under the contract of insurance"[8]. It is not restricted to omissions to do something which an insured was *obliged* to do. Further, a relevant act or omission may be that of a person who is not a party to the contract of insurance[9].

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7 (1997) 188 CLR 652 at 669 per Dawson, Toohey, Gaudron and Gummow JJ.

8 (1997) 188 CLR 652 at 669 per Dawson, Toohey, Gaudron and Gummow JJ.

9 (1997) 188 CLR 652 at 669-670 per Dawson, Toohey, Gaudron and Gummow JJ.

23 The last of the preliminary matters to which particular attention should be directed is that labelling contracts of insurance as "claims made" or "claims made and notified policies", as distinct from "occurrence policies", may be convenient short forms of reference. These labels are, however, not a substitute for strict attention to the terms of the particular insurance contract in question and to the operation of the relevant statutory provisions in connection with that contract. If it is useful to apply a label to the contract in question in this matter it is evident, when regard is had to condition 3, that it would be inaccurate to describe it as a "claims made and notified policy". That would describe only one aspect of its operation. It would, perhaps, be more accurate to describe it as a "discovery policy"[10], as the critical facts under the contract are the insured's discovery of the making of a claim on it or its discovery (its "becom[ing] aware") of an occurrence which may give rise to a claim. In the end, however, the application of labels to the contract may obscure more than it illuminates.

24 A great deal of the argument in this matter proceeded by reference to the decisions of the New South Wales Court of Appeal in *East End Real Estate Pty Ltd v C E Heath Casualty & General Insurance Ltd*[11], *FAI General Insurance Co Ltd v Perry*[12] and *Greentree v FAI General Insurance Co Ltd*[13], and to the decision of Hodgson CJ in Eq in *Permanent Trustee Australia v FAI General Insurance Co Ltd*[14]. It will be necessary to return to consider what is said in those cases, but in the first instance it is better to examine the matter by reference to the terms of s 54 and the relevant contract of insurance.

25 Much of the weight of the insurer's argument was placed upon the reference in s 54(1) to the "effect" of a contract of insurance. The insurer submitted that it was entitled to refuse to indemnify the insured in respect of the claim, not by reason of the insured's failure to give notice of an "occurrence", but because the policy never afforded indemnity against claims made by third parties outside the period of cover. It was said that a distinction should be drawn

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10 cf *Reid Crowther & Partners Ltd v Simcoe & Erie General Insurance Co* [1993] 1 SCR 252 at 264 per McLachlin J.

11 (1991) 25 NSWLR 400.

12 (1993) 30 NSWLR 89.

13 (1998) 44 NSWLR 706.

14 (1998) 44 NSWLR 186.

between acts or omissions having an effect under a contract of insurance, and acts or omissions which had no effect "because the policy has expired".

26 To say of the policy of insurance that it had "expired" at the time that Dr Tampoe's claim was made against the insured is apt to distract attention from the considerations that are relevant under s 54. The section directs attention to the effect of the contract of insurance and, in particular, to whether but for s 54 its effect would be that the insurer may refuse to pay the claim which the insured has made. The contract of insurance which is now in question provided for what it called a "period of cover". The specification of that period did not, however, mark out the duration of the contractual rights and duties of the parties. Rather, it provided temporal limits to the operation of certain of the stipulations upon which the parties had agreed. Most notably, it marked the temporal limits within which the "claims" referred to in the insuring clause were to be made if that clause was to have application, and the temporal limits of the reference in condition 3 to the "subsistence" of the policy.

27 That is not to say, however, that the contract of insurance between the parties was discharged and of no further effect at the end of the period of cover. The contract still subsisted and, if its terms had been met, the parties continued to be entitled to require performance of relevant obligations under it, notwithstanding that the period of cover had come to an end. Adopting and adapting the language of s 54, if a claim had been made on the insured and notified to the insurer during the period of insurance, the effect of the contract of insurance would be that the insurer might not refuse to indemnify the insured against that claim, notwithstanding that the time for satisfaction of that indemnity may not arise until some years later. It is, therefore, not right to say that the ending of the period of cover is itself sufficient reason to conclude that s 54 is not engaged.

28 The insurer further submitted that to give s 54 a literal application would travel well beyond the mischief to which it was directed and would lead to results properly regarded as absurd. In particular, reference was made in argument to the way in which s 54 would operate in relation to a contract of insurance, in terms similar to those now under consideration, where no claim was made by a third party on the insured during the period of cover and where the insured did not, during that period, become aware of the occurrence which subsequently gave rise to the claim by that third party. The insurer contended that applying s 54(1) literally would hold an insurer liable for such a claim and that, because this cannot have been the intended result of applying the section, it should be confined in its application. These reasons will seek to demonstrate that on its ordinary meaning s 54 does not have this operation. Before dealing with these matters, it is desirable to expose the commercial reasoning which is said to lie

behind the contention that some applications of s 54 should be regarded as unintended and absurd.

29 In *Reid Crowther & Partners Ltd v Simcoe & Erie General Insurance Co*[15], McLachlin J discussed the reasons for insurers in the United States and Canada issuing claims made and similar policies of insurance more frequently than once was the case. These reasons centred upon the "long-tail" nature of occurrence policies. McLachlin J said[16]:

> '"Occurrence' liability insurance policies work reasonably well in covering insureds such as automobile owners and drivers. Where an automobile operator is negligent and thereby causes damage, the nature of the negligent act and the resultant damages are in almost all cases known upon the happening of the negligent act or shortly thereafter. But for insureds who are professionals such as doctors, lawyers, engineers, etc, damages can result (or be discovered) many years after a negligent act is committed. This is even more the case for manufacturers and other types of insureds who can cause damages by producing hazardous products or toxic waste. Therefore, for each of these types of insureds, insurers are at risk for an unknown number of claims that may be made many years after the expiry of a particular policy of 'occurrence' liability insurance.
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> Another type of problem associated with the 'long-tail' nature of 'occurrence' policies resulted where defendants to claims had been insured successively under liability insurance policies from different insurers over the years. In those types of situations, there arose disputes between the insurers as to when the 'occurrence' in question happened – and, therefore, which insurer had to provide an indemnity for the loss. These kinds of disputes further added to the uncertainty in calculating insurers' actuarial risk, and also caused added expenses to the insurance industry in engaging in this type of litigation.
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> The 'claims-made' type of policy was seen (as were hybrid policies) as a means of providing liability insurance at reasonable rates while avoiding the problems associated with the 'long-tail' nature of 'occurrence'

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15 [1993] 1 SCR 252.

16 [1993] 1 SCR 252 at 262-264.

policies. The date at which a claim was made would be easier to ascertain than the date at which an 'occurrence' happened, and more importantly, insurers would be better able to project the likely level of claims that would be payable under liability insurance policies."

30 Matters of this kind were not considered by the Australian Law Reform Commission in its 1982 report on *Insurance Contracts*[17] which was the precursor to the *Insurance Contracts Act*. There is, however, some reference to these considerations in later discussions of the operation of s 54[18].

31 For present purposes, we are content to assume that considerations of the kind referred to by McLachlin J are among the reasons for insurers offering professional negligence insurance in Australia moving away from occurrence-based policies of insurance and towards claims made or discovery policies. They are not, however, considerations which necessarily find reflection in legislation like the *Insurance Contracts Act*. That Act reflects the legislative decision not to leave these issues to the agreement of the parties.

32 It is convenient to deal at this point with the New South Wales decisions mentioned earlier. As Gleeson CJ rightly pointed out in *East End*[19], "by choosing words of generality and avoiding reference to the particular type of contractual provision that might produce the result that the insurer may refuse to pay a claim, the legislature … evinced an intention to avoid the result that the operation of s 54 depends upon matters of form." Some of the suggested bases for confining the operation of s 54 have, however, depended on the form of the contract of insurance. In argument in *East End*, it was suggested that there were two bases on which the apparent generality of its words could, and should, be qualified. It was argued that its operation should be limited to cases in which the insurer relied on some condition of, or exclusion in, the contract to deny liability. That is, it was suggested that the form of the contract of insurance (and, in particular, whether the basis for refusing liability was to be found in a condition or exclusion) should determine the operation of s 54.

33 The first basis proffered for this construction was that the words "refuse to pay a claim" inferred that there was prima facie a liability, but that the liability was to be avoided "by reason of some act [or omission] of the insured or of some

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17 Report No 20.

18 Masel, "Taking Liberties with Claims Made Policies", (2000) 11 *Insurance Law Journal* 104 at 104-105.

19 (1991) 25 NSWLR 400 at 403.

other person". This was said to occur only if a loss was within the cover provided by the policy but a condition or exclusion operated to allow the insurer to refuse to pay the claim[20]. We do not accept that the words "refuse to pay a claim" lead to the suggested inference. Moreover, the distinction between "cover" on the one hand, and "condition or exclusion" on the other, is a distinction that depends on the form of the contract and not on its substantive effect. No distinction can be made, for the purposes of s 54, between provisions of a contract which define the scope of cover, and those provisions which are conditions affecting an entitlement to claim. The substantive effect of the contract can be determined only by examination of the contract as a whole.

34 The second basis suggested in argument in *East End* for reading s 54 down was that, if that were not done, there would be some inconsistency between s 40 and s 54. Sections 40 and 54 deal with different problems. Section 40 is concerned with certain contracts of liability insurance and, among other things, with the insured giving notice of a potential claim during the period of insurance cover when the claim is not made until after the expiration of that period. Section 54, by contrast, deals with the much more general subject of an insurer refusing to pay claims. It is concerned with acts as well as omissions, and with acts or omissions not only of the insured but also of "some other person". That is reason enough to conclude that any tension or overlap between the two sections should not be resolved by reading s 54 down. In any event, as Mahoney JA pointed out in *East End*[21], the suggested reading of s 54 would not remove any tension that may exist between the two provisions.

35 In *FAI General Insurance Co Ltd v Perry*[22], Gleeson CJ pointed to the difficulty of drawing some distinction, for the purposes of applying s 54, between provisions defining the scope of cover and conditions affecting the entitlement of an insured to claim. As his Honour said[23]:

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20 *East End Real Estate Pty Ltd v C E Heath Casualty & General Insurance Ltd* (1991) 25 NSWLR 400 at 408 per Mahoney JA; cf *Commercial Union Assurance Co of Australia Ltd v Ferrcom Pty Ltd* (1991) 22 NSWLR 389 at 414 per Handley JA.

21 (1991) 25 NSWLR 400 at 409.

22 (1993) 30 NSWLR 89.

23 (1993) 30 NSWLR 89 at 92.

> "A conclusion that the operation of s 54 … is governed by the draftsman's decision as to where the relevant provision is located on the printed policy form would represent a triumph of form over substance."

Nevertheless, the majority of the Court in *Perry* decided that an omission to notify an insurer of an occurrence which may give rise to a future claim did not constitute an omission of the kind with which s 54 is concerned[24]. Once it is accepted, however, as was later held in *Antico*[25], that for the purposes of s 54 an "omission" may be a failure by the insured to exercise a right, choice or liberty which the insured enjoys under the policy, it is apparent that s 54 can be engaged by an omission by the insured to give notice of an occurrence, even if that omission results from a deliberate choice by the insured. The reasoning of the majority in *Perry* is inconsistent with *Antico*. *Perry* must therefore be regarded as overruled.

36 It has been suggested that some distinction can be drawn between omissions (of the kind with which s 54 is concerned) and what have been referred to as "non-events"[26]. In *Greentree*, it was said that the distinction is between "conduct wholly external to the policy"[27] and, it seems, events which have some effect *under* the policy. *Greentree* arose out of facts essentially identical to those proffered as demonstrating that literal application of s 54 leads to absurd results and it concerned a contract of insurance that was not materially different from the contract now in question. It was a case in which, during the period of cover, there was no claim by a third party on the person who was insured under a claims made and notified policy, but where it was argued that s 54 required that indemnity should nevertheless be extended in respect of a claim made after that period. This argument was rejected. Spigelman CJ said that[28]:

> "The absence of a claim *on* the insured does not create any 'effect' that an 'insurer may refuse to pay a claim' *by* the insured. Until the first kind of

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24 (1993) 30 NSWLR 89 at 93 per Gleeson CJ, 107 per Clarke JA; cf at 103 per Kirby P.

25 (1997) 188 CLR 652 at 669.

26 *East End* (1991) 25 NSWLR 400 at 405 per Gleeson CJ; *Greentree v FAI General Insurance Co Ltd* (1998) 44 NSWLR 706 at 710 per Spigelman CJ.

27 (1998) 44 NSWLR 706 at 710 per Spigelman CJ.

28 (1998) 44 NSWLR 706 at 710.

claim is made, no issue of a claim of the second kind arises at all. This is not a matter of drafting or of mere form. The 'claim' [on the insured] is an event wholly external to the policy and precedes any consideration of its 'effect'."

37 The difficulty with referring to events as "wholly external to the policy" is that no question about the effect of a contract of insurance can ever be asked in isolation from external facts and circumstances. The question is inevitably about the application of the contract in the light of certain real or hypothesised facts and circumstances. Those facts and circumstances will always be wholly "external" to the policy.

38 Criticism can also be made of the formulation of Hodgson CJ in Eq in *Permanent Trustee v FAI*, who said that where there is no claim by a third party during the period of cover under a claims made policy "the gravamen of the refusal [by the insurer to meet a later claim on it] is not that someone omitted to do something, but rather that something did not happen"[29]. That distinction is readily applied in cases where, for example, there is no damage by flood to insured premises during the period of cover, but such damage occurs shortly thereafter. The absence of a flood during the period of cover clearly is not an omission; it is much more naturally described as a "non-event". Importantly, however, a flood can be fully described without reference to any act or omission by any person. The distinction drawn by Hodgson CJ in Eq cannot readily be applied when the circumstance or event said to be an omission cannot adequately be described without reference to a person (such as, for example, the failure of a third party to make a claim against an insured during a policy period). By what criteria is a person's failure to take some step to be categorised as a "non-event" rather than an "omission"?

39 The reasoning in *Greentree* and in *Permanent Trustee v FAI* should, therefore, be rejected but the actual decision in each was right. Although the distinctions suggested in those cases are open to the criticisms we have made, the discussion reveals that there is thought to be a difficulty in reading the section literally. That difficulty stems from an intuitive rejection of a construction of s 54 which would require an insurer to pay a claim where there has been no event during the period of cover which the insured could have relied on as engaging the insurer's obligations under the contract. In the end, however, the difficulty is more apparent than real. Close attention must be given to the elements with which s 54 deals: the effect of the contract of insurance between the parties; the

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29 (1998) 44 NSWLR 186 at 227.

"claim" which the insured has made; and the reason for the insurer's refusal to pay that claim.

40 Section 54 directs attention to the effect of the contract of insurance on the claim on the insurer which the insured has *in fact* made. It is not concerned with some other claim which the insured might have made at some other time or in respect of some other event or circumstance. It requires the precise identification of the event or circumstance in respect of which the insured claims payment or indemnity from the insurer. For example, in *Greentree* the insured claimed indemnity against liability for a claim which the third party had first made on it outside the period of cover. (To distinguish between the claim which a third party makes on the insured, and the claim which the insured makes on the insurer, it is convenient to refer to the former as the "demand" by the third party.) The insured's claim necessarily incorporated a temporal dimension. The contract of insurance applied only if the third party's demand on the insured was made within the period of cover. The insured's claim on the insurer therefore had to identify when the demand was made. That being so, the claim could not properly be described without that temporal element.

41 Even if the fact that the third party made no demand on the insured within the period of cover were said to be an "omission" it is, nevertheless, of the first importance to recognise that the claim to which s 54 refers is the claim by the insured on the insurer that was actually made. It is not a claim for indemnity against some other demand (such, for example, as a demand assumed to have been made during the period of cover). Section 54 does not permit, let alone require, the reformulation of the claim which the insured has made. It operates to prevent an insurer relying on certain acts or omissions to refuse to pay that particular claim. In other words, the actual claim made by the insured is one of the premises from which consideration of the application of s 54 must proceed. The section does not operate to relieve the insured of restrictions or limitations that are inherent in that claim.

42 The restrictions that are inherent within a claim vary according to the type of insurance in issue. Under an "occurrence" based contract, no claim can be made under the contract unless the event insured against takes place during the period of cover. Under a "claims made and notified" policy, if no demand is made by a third party upon the insured during the period of insurance, any claim that may subsequently be made by the insured on the insurer (that is, the claim to which s 54 refers) would necessarily acknowledge that indemnity is sought in relation to a demand not of a type covered by the policy (because not within the temporal limits that identify those demands in relation to which indemnity must be given).

43 In the context of "discovery" contracts, containing clauses such as condition 3, the analysis is similar. If an insured "become[s] aware of any occurrence which may subsequently give rise to a claim" during the period of cover, an event of the type contemplated by the contract of insurance has occurred. Any subsequent claim would be for indemnity against a demand of a type covered by the contract.

44 It is apparent that, in the circumstances considered in *Greentree*, the effect of the contract of insurance was that the insurer might refuse to pay the claim that had been made. This was not, however, by reason of any act or omission of the insured or some other person. The claim made by the insured was for indemnity against liability for a demand that was not a demand of the kind dealt with by the policy because it was not a demand by a third party made within the period of cover. The reason for refusal was *not* some act or omission of the insured or some other person. It was that the policy did not extend to the demand referred to in the claim for indemnity.

45 By contrast, if a third party had made a demand on the insured during the period of cover but, for whatever reason, the insured had not notified the insurer of the making of that demand until after the period of cover ended, it is apparent that the effect of the contract, but for s 54, would be that the insurer may refuse to pay the insured's claim only by reason of the failure to notify the fact of the demand.

46 Similarly, in the present case, the claim which the insured made on FAI was for indemnity against liability for an occurrence of which the insured first became aware during the period of cover. The effect of the contract of insurance is that FAI could refuse to pay that claim by reason only of the fact that the insured did not give notice of the occurrence to it. Section 54, therefore, requires the conclusion that FAI may not refuse to pay the insured's claim. The effect of the contract of insurance, but for s 54, would be that the insurer may refuse to pay the insured's claim by reason only of the omission of the insured to notify the occurrence which, at the time, was one which might subsequently give rise to a claim by the third party against it. That being so, the section is engaged. No prejudice to the insurer's interests was suggested.

47 The appeal should be dismissed with costs.

48 KIRBY J. This appeal[30] requires the resolution of a question that has agitated courts and commentators for several years. It concerns a common problem of insurance law.

49 The question is whether s 54 of the *Insurance Contracts Act* 1984 (Cth) ("the Act") is available, in the circumstances of the case, to relieve an insured of a failure to give written notice to the insurer of an occurrence, of which the insured was aware, which might subsequently give rise to a claim against the insured for breach of professional duty, or otherwise to make a claim, within the specified period of the insurance. The insurance policy in question afforded cover only for claims first made against the insured during the defined period. The insurer contends that the policy was one of a variety known as "claims made" or "claims made and notified". According to the insurer, once the "period of cover" expired, without either a claim first being made against the insured or an "occurrence" which might subsequently give rise to a claim being notified to the insurer, insurance was not recoverable. Section 54 of the Act could not be invoked to revive an expired policy. To allow that to happen, so it was said, would be inconsistent with the very nature, or essence, of the insurance cover. Put another way, the insurer argues that s 54 of the Act is inapplicable because this is not a case where the insurer is "refus[ing] to pay a claim" "by reason of" a relevant act or omission. The policy is simply inapplicable. It does not respond to the circumstances. Nothing in s 54 could retrospectively breathe life into it.

Judicial construction of s 54 of the Act

50 In *Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd*[31] and in *Antico v Heath Fielding Australia Pty Ltd*[32] this Court adopted a construction of s 54 of the Act which placed emphasis on the breadth of its language[33], its remedial purpose[34], its application to substance rather than form[35]

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30 From a judgment of the Supreme Court of Queensland (Court of Appeal): *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445; 153 FLR 448.

31 (1993) 176 CLR 332 ("*Ferrcom*").

32 (1997) 188 CLR 652 ("*Antico*").

33 *Ferrcom* (1993) 176 CLR 332 at 339-340; *Antico* (1997) 188 CLR 652 at 669, 672-673.

34 *Antico* (1997) 188 CLR 652 at 675.

35 *Antico* (1997) 188 CLR 652 at 660, 668-669 adopting the reasons of Gleeson CJ in *East End Real Estate Pty Ltd v C E Heath Casualty & General Insurance Ltd* (1991) 25 NSWLR 400 at 403-404.

and the inadmissibility of adopting a narrow approach by reference to pre-existing law or supposed assumptions inherent in the insurance contract between the parties. In *Newcastle City Council v GIO General Ltd*[36], in giving meaning to s 40 of the Act (which provides relief to an insured that is in some ways analogous) this Court adopted a similar approach. It rejected a narrow or literal reading of the Act and preferred one which achieved its perceived purpose of protecting the insured. On the Act, its application and interpretation, this Court has, in this regard, therefore spoken with a consistent voice[37].

51 A similar approach to the Act marked the early decisions of the New South Wales Court of Appeal, where many of the initial cases concerning s 54 were decided. Thus, it was reflected in that Court's decision in *Ferrcom* in which I participated[38]. It was reaffirmed in *East End Real Estate Pty Ltd v C E Heath Casualty & General Insurance Ltd*[39] in which both Gleeson CJ[40] and Mahoney JA[41] rejected attempts to confine s 54, or to limit its operation, by reason of the presence in the Act of s 40.

52 Then, in *FAI General Insurance Co Ltd v Perry*[42] that Court adopted a different, and somewhat narrower, approach to s 54. I dissented[43]. Subsequently, when *Antico* was before the Court of Appeal[44], whilst adhering to the views I had expressed in *Perry*[45], I conformed to the interpretation of s 54 of the Act favoured

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36 (1997) 191 CLR 85.

37 See also *Akai Pty Ltd v People's Insurance Co Ltd* (1996) 188 CLR 418.

38 *Commercial Union Assurance Co of Australia Ltd v Ferrcom Pty Ltd* (1991) 22 NSWLR 389.

39 (1991) 25 NSWLR 400 ("*East End*"). Special leave was refused: *C E Heath Casualty & General Insurance Ltd v East End Real Estate Pty Ltd* (1992) 7 Leg Rep SL 2.

40 (1991) 25 NSWLR 400 at 405 (Clarke JA concurring at 410).

41 (1991) 25 NSWLR 400 at 408.

42 (1993) 30 NSWLR 89 ("*Perry*"); see Burns, "FAI v Perry: High Noon in the High Court", (2000) 12 *Insurance Law Journal* 79.

43 (1993) 30 NSWLR 89 at 94-104.

44 *Antico v C E Heath Casualty & General Insurance Ltd* (1996) 38 NSWLR 681.

45 *Antico v C E Heath Casualty & General Insurance Ltd* (1996) 38 NSWLR 681 at 705.

by the majority in *Perry*[46]. But when *Antico* reached this Court[47], the views expressed by the majority in *Perry* were disapproved[48]. Instead, the earlier, beneficial approach to the construction of s 54, adopted in *East End*, was expressly endorsed[49].

53 Since this Court's decision in *Antico* there has been much debate about the continuing authority of *Perry* and whether its approach should now be taken to have been overruled by this Court. The Full Court of the Federal Court, in *obiter dicta*, considered that it had been[50]. So did the majority of the Queensland Court of Appeal in the present case[51]. So did Rolfe J in a decision in the Supreme Court of New South Wales[52]. However, a contrary opinion was expressed by the New South Wales Court of Appeal in *Greentree v FAI General Insurance Co Ltd*[53], by Pincus JA dissenting in the present case[54] and by Hodgson CJ in Eq in a decision in the Supreme Court of New South Wales[55]. Commentaries on the case

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46 *Antico v C E Heath Casualty & General Insurance Ltd* (1996) 38 NSWLR 681 at 705-706.

47 *Antico* (1997) 188 CLR 652.

48 *Antico* (1997) 188 CLR 652 at 670.

49 *Antico* (1997) 188 CLR 652 at 660 per Brennan CJ, 668-669, 673 per Dawson, Toohey, Gaudron and Gummow JJ.

50 *HIH Casualty and General Insurance Australia Ltd v DellaVedova* (1999) 10 ANZ Insurance Cases ¶61-431 at 74,870 [28].

51 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445 per Derrington J and Chesterman J (Pincus JA dissenting); 153 FLR 448.

52 *Einfeld v HIH Casualty & General Insurance Ltd* (1999) 166 ALR 714 at 721 [25]; 10 ANZ Insurance Cases ¶61-450 at 75,164; 152 FLR 211 at 218-219.

53 (1998) 44 NSWLR 706 at 721-722 ("*Greentree*").

54 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445; 153 FLR 448.

55 *Permanent Trustee Australia v FAI General Insurance Co Ltd* (1998) 44 NSWLR 186 at 227-228. *Perry* was followed in the Full Court of the Supreme Court of Western Australia before the decision in *Antico* was delivered by this Court: *Kelly v New Zealand Insurance Co Ltd* (1996) 9 ANZ Insurance Cases ¶61-317; 130 FLR 97.

law have, with varying degrees of enthusiasm[56] or doubt[57], embraced the notion that some aspects of the holding in *Perry* survived the decision of this Court in *Antico*, so as to limit the reach of s 54 of the Act and its capacity to provide relief to an insured in a "claims made", "claims made and notified" or hybrid policies of that type ("claims made type policies").

54 It was to resolve these uncertainties, and to afford an authoritative interpretation of s 54 of the Act, that special leave was granted in the present case. In my view, this Court should adhere to the consistent approach which it has taken to s 54. Notwithstanding certain difficulties that may arise in claims made type policies, the approach adopted in *East End* should once again be endorsed. The approach in *Perry* should again be rejected. Contrary to the concerns of at least one commentator[58], such a decision would not strike at the heart of claims made type policies. But it does mean, in a case such as the present, that the insured is entitled to the relief for which s 54 of the Act provides.

The facts, insurance conditions and legislation

55 The facts of the present dispute between FAI General Insurance Company Limited ("the insurer") and Australian Hospital Care Pty Ltd ("the insured") are explained in the reasons of McHugh, Gummow and Hayne JJ[59], as is the course of proceedings leading to the judgment under appeal[60]. So too are the relevant provisions of s 54 of the Act[61] and a more detailed discussion of the course of authority concerning s 54, summarised above.

56 I will not repeat any of the foregoing matters. However (as was done in the Court of Appeal) it is worth noting the additional fact that (as found by the primary judge) the insured's "usual practice", where it received a complaint even

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56 Clarke, "After the Dust Settles on Antico: FAI v Perry Lives", (1997) 9 *Insurance Law Journal* 29.

57 Kelly and Ball, *Principles of Insurance Law* (2001) at 5391-5438 [5.0190.15].

58 Masel, "Taking Liberties with Claims Made Policies", (2000) 11 *Insurance Law Journal* 104 ("Masel").

59 At [13]-[16]; see also the reasons of Gleeson CJ at [1]-[5].

60 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445 at 75,085-75,086, 75,091-75,093; 153 FLR 448 at 452-455, 462-464.

61 Set out at [19].

without a formal claim in respect of treatment received by a patient at its hospital, was to "[report] such matters to the insurer"[62]. That was certainly a prudent practice, having regard to the terms of condition 3 of the policy[63]. That provision extended to the insured certain privileges although the "period of cover"[64] had expired. This is so if, "during the subsistence [of the policy] the Insured [becomes] aware of any occurrence which may subsequently give rise to a claim against [it] for breach of professional duty by reason of any negligence" and "during the subsistence [of the policy gives] written notice to the [insurer] of such occurrence". The failure to give such notice in the present case, "before the expiry of the policy", was the result of the insured's investigation of the matter "to its own satisfaction", its belief that "after consultation with the hospital's expert staff, the patient's solicitor appeared to be satisfied that there was no indication of malpractice" and the subsequent absence of "any further relevant activity during the remainder of the policy period"[65].

57 If the insured had conformed to its usual practice of reporting such matters to the insurer and had done so in writing as condition 3 of the policy required, then, notwithstanding the failure of the claimant to make a formal "claim" against the insured within the "period of cover" provided by the policy, the insured (other things being equal) would have been entitled to indemnity from the insurer in the event of a later claim. That was because, by condition 3, "for the purposes of this Policy" any such claim, subsequently made against the insured, was "deemed to have been made during the subsistence" of the policy.

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62 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445 at 75,085, 75,089 per Derrington J; 153 FLR 448 at 453, 458.

63 Set out in the reasons of McHugh, Gummow and Hayne JJ at [14]. Condition 3, viewed in the context of the subject policy, was not akin to an option to extend the insurance cover to some extra, additional and different kind of insurance such as against libel and slander (extension 1), previous business risks (extension 2), outgoing principals (extension 3), dishonesty (extension 4), fidelity (extension 5) or loss of documents and property damage (extension 6). Condition 3 was not, in form or effect, a term expanding the scope of the policy. It was part of the operative provisions defining the insurance cover and providing when the insuring clause would come into effect.

64 As defined in the insuring clause: see the reasons of McHugh, Gummow and Hayne JJ at [13]. The Schedule specified the period of cover: 4pm on 20 June 1991 to 4pm on 20 June 1992.

65 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445 at 75,085 per Derrington J; 153 FLR 448 at 453.

58 There was a dispute at trial, and in the Court of Appeal, as to whether the communication to the insured by the patient was such as to make the insured "aware of any occurrence which may subsequently give rise to a claim" as required by condition 3 of the policy. However, that contest was unanimously resolved by the Court of Appeal in favour of the insurer[66]. The point (which was wholly without substance) has not been re-agitated in this Court.

59 In these circumstances, to dispose of this appeal, it would be enough for me to return to, and apply, the approach that I adopted in my dissenting opinion in *Perry* where the terms of the insurance cover, and of the applicable legislation, were relevantly the same[67]. In that case I said[68]:

> "The extent of the cover is primarily provided for in the insuring clauses. This is done in terms of claims made against the insured and reported to the insurer during the period of cover. But that provision, although primary, is not an end of the definition of the insurer's accepted liability. Under condition 3, for the purposes of this particular policy, a notional definition of when a 'claim' is made is provided. It cannot matter that this appears among the conditions of the policy. For the reasons which the Court pointed out in *East End* (and which the Australian Law Reform Commission had earlier explained in the report which gave rise to the Act) it could not be left to the insurer to control the operation of the Act by the way in which it drafted its terms. The provision appearing in condition 3 could just as easily have appeared in the ensuing clauses or amongst the definitions. The policy was to be read as a whole. Where, in the insuring clauses 'claim ... first made' appears, that phrase must be understood in terms of the elaboration provided by condition 3.
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> ...
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> The omission of the insured to give the written notice required by the terms of the condition is subject to the relief expressly provided for by s 54 of the Act. For that omission the insurer is now denied the entitlement which would otherwise have existed under the general law or under its policy, to refuse to pay the claim. Instead, the Court is directed to the apportionment referred to in the closing words of s 54 of the Act.

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66 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445 at 75,082 per Pincus JA, 75,086 per Derrington J, 75,094 per Chesterman J; 153 FLR 448 at 449, 454-455, 464.

67 *Perry* (1993) 30 NSWLR 89 at 101.

68 *Perry* (1993) 30 NSWLR 89 at 101-102.

…

> The insurer sought to expunge its own condition, with its special notional definition of when a claim was made, from the policy altogether. This was a curious effort and one doomed to failure."

60 By majority, the "effort" referred to in this passage did not fail in *Perry*. This presumably explains why condition 3 was retained by the insurer, unaltered and maintained in the policy applicable to this case[69]. This was not a case in which the "omission" relied upon was one that sought to alter the "substance"[70], "effect"[71], "core"[72] or essence of the "claims made" type of policy issued by the insurer, as would occur where it was suggested that the relevant "omission" was an "omission" of the insured to elect in favour of an expansion of the cover afforded by the insuring clause[73] or the "omission" of a third party to make its "claim" during the "period of cover" which would activate a policy of this variety. On the contrary, as I pointed out in *Perry*, the policy itself, by condition 3, specifically contemplated the possibility of indemnity in respect of a "claim" made after, perhaps long after, the "period of cover". All that was required to secure indemnity was that, if the insured became aware of an occurrence that might subsequently give rise to such a claim, it should give written notice of it to the insurer and do so within the period of cover. Conforming to its usual practice, the present insured would normally have given such notice. In this case it "omitted" to do so. That omission was, by s 54(6) of the Act, equivalent to an "act" of the insured. It was one that occurred after the contract of insurance was entered into. It was not one in respect of which s 54(2) of the Act applied. The effect of the contract of insurance was that, but for s 54(1), the insurer might, for default of the notice (and in the absence of a claim) "within the period of cover", refuse indemnity.

61 However, by reason of s 54(1) of the Act the insurer became disentitled to refuse to pay the claim by reason only of the insured's "omission" to give the notice, on this occasion, of the occurrence within the "period of cover" which, after that period, was followed by a formal "claim". The insurer would be entitled to a reduction of its liability by the amount that "fairly represent[ed] the

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69 The terms of condition 3 are set out in *Perry* (1993) 30 NSWLR 89 at 99.

70 *Greentree* (1998) 44 NSWLR 706 at 708 per Spigelman CJ.

71 *Greentree* (1998) 44 NSWLR 706 at 710 per Spigelman CJ.

72 *Greentree* (1998) 44 NSWLR 706 at 718 per Mason P.

73 *Kelly v New Zealand Insurance Co Ltd* (1996) 9 ANZ Insurance Cases ¶61-317 at 76,518; 130 FLR 97 at 110.

extent to which [its] interests were prejudiced as a result of" the "omission" to give the notice of the occurrence. In this case, there was no such assertion or suggestion of prejudice to the insurer by the late giving of the notice, save that, if the insured's construction were accepted, it "revived" the insurer's liability on a policy that the insurer could otherwise have treated as having expired. "Prejudice" of that kind is not relevant to reducing the insurer's liability for it is a consequence expressly contemplated by condition 3 of the policy, as resuscitated by s 54 of the Act, in respect of the insured's "omission" to give the notice as that condition contemplates.

62 The foregoing represents no more than the application to the policy of the plain language of s 54 of the Act. It secures the achievement of the remedial objective of s 54, as repeatedly upheld by this Court and as explained by the Court of Appeal itself in *East End*, before *Perry* intruded upon the scene. It requires dismissal of the insurer's appeal. However, out of deference to the judges who expounded, or who have subsequently supported, the reasoning in *Perry*[74] (and in response to the arguments of the insurer which endeavoured to have that reasoning applied in the present case) I will offer some comments of my own concerning the way in which the language and purposes of s 54 of the Act are to be reconciled with the claims made type of insurance policy.

Section 54 of the Act and claims made type policies

63 The essence of the problem, that has seen so many judges "struggling with issues of construction and application of the words adopted by parliament"[75] in s 54 of the Act, is that if the section is given the large ambit urged for it by the insured, it might effectively permit courts to repair all kinds of "omissions" on the part of insured persons and third parties and effectively to rewrite insurance policies accordingly. Courts could do so in a way that would essentially destroy the basic foundation upon which claims made type policies are based. This is a legitimate concern. I acknowledged it in *Perry*[76]. It needs to be addressed. Various answers have been offered by the courts.

64 Claims made type policies have been available "for decades in Canada, and as far back as the first half of [the twentieth] century in the United States"[77]. They have also been offered for some time in Australia. Such policies differ

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74 Including in *Greentree* (1998) 44 NSWLR 706.

75 *Greentree* (1998) 44 NSWLR 706 at 714 per Mason P.

76 (1993) 30 NSWLR 89 at 96-97.

77 *Reid Crowther & Partners Ltd v Simcoe & Erie General Insurance Co* [1993] 1 SCR 252 at 262 ("*Simcoe*")

from "occurrence" policies in that, instead of attaching the insurer's liability to indemnify the insured to the happening of an occurrence during the period of cover, they attach the liability in various ways (according to the description in the policy) to the making of a claim against the insured, its notification by the insured to the insurer or the "discovery" of a claim[78] within the period of cover. It is the happening of these events, as defined (rather than the time when the actual occurrence happened out of which the claim is made), that, in a pure claims-made policy, gives rise to the insurer's liability to indemnify the insured. In some cases[79], however, the claims made policy may have certain attributes of an "occurrence policy". The variety of insuring clauses and conditions makes it unsafe to classify all policies with "claims made" features by reference to that label. In every case, there is a need to consider the actual language in which the policy is expressed and its apparent commercial purpose. And in Australia, such policies must now be read subject to the Act.

65 Nevertheless, claims made type policies have become so common that it would be absurd to ignore the peculiarities of this form of insurance[80]. It is a variety of insurance that has distinct advantages from the point of view of insurers. Those advantages include the elimination, or severe curtailment, of the risk of liability on the part of the insurer for the "long-tail"[81] that may often follow the negligent acts and omissions of professional persons that give rise to damage many years later. The same is even more true of manufacturers and other insureds whose goods or services produce damage from hazardous or toxic conditions, manifesting themselves years after the expiry of an "occurrence", producing numbers of claims requiring the reopening of files long regarded as closed[82].

66 For insurers, claims made type policies were designed to permit the more accurate forecast of the insurer's risk exposure, the more certain placement of reinsurance, and the more assured closure of files after the period of insurance[83]. The benefit to the insured was the provision of a lower premium, reflecting the deletion of the insurer's liability to "long-tail" risks, as well as anticipated economies of administration. Necessarily, for the lower premium, the insured

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78 *Simcoe* [1993] 1 SCR 252 at 264.

79 One such case was *Simcoe* [1993] 1 SCR 252 at 265.

80 See *Perry* (1993) 30 NSWLR 89 at 103.

81 *Simcoe* [1993] 1 SCR 252 at 263.

82 *Simcoe* [1993] 1 SCR 252 at 263.

83 *GIO General Ltd v Newcastle City Council* (1996) 38 NSWLR 558 at 571.

was expected to assume responsibility for the consequences of any negligent acts and omissions occurring during the period of cover but not coming to light until thereafter. Alternatively, the insured was expected to maintain claims made type policies from year to year, in which event (as was held in the present case) a subsequent insurer, indemnifying the insured during a year in which a claim was made against it, might be held liable although the occurrence in question had occurred some time before its cover had commenced.

67 The centrality of notification provisions under claims made type policies has been emphasised by decisions in the United States. Thus in *Federal Deposit Insurance Corporation v Barham*[84], the United States Court of Appeals commented:

> "Because notice of a claim or potential claim defines coverage under a claims-made policy, we think that the notice provisions of such a policy should be strictly construed. See *Driskill v El Jamie Marine, Inc* 1988 WL 93606 (E D La Sept 7, 1988) ('In occurrence policies, the notice requirement is merely to "aid the insurance carrier in investigating, setting, and defending claims," but in claims-made policies, the notice requirement is as important as the requirement that the claim be asserted during the policy period. It is the transmittal of notice of the claim that invokes coverage.')".

68 The problem for this form of insurance in Australia is that such an approach must now be read subject to the Act. For a number of reasons, it would be surprising if the Act were to permit "omissions" to make or notify claims, or to notify occurrences, within the period of cover that had the effect of altering the essential character of the cover provided in the contract of insurance. It would be surprising if it permitted an insured, at its option, to convert a claims made type policy, effectively, to a kind of occurrence policy for which a substantially higher premium would ordinarily have been levied by the insurer.

The arguments for the insurer's construction of s 54

69 There are at least four reasons why such a result would be surprising. They include, first, that claims made type policies are now a well-established feature of the international insurance market. They have advantages to insurers and insureds alike, such that it would not readily be assumed, without a clear legislative provision, that the Act was intended to restrict or curtail their availability in Australia.

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84 995 F 2d 600 at 604 n 9 (1993).

70 Secondly, to the extent that the Australian Law Reform Commission (upon whose report[85] the Act was based[86]) dealt specifically with issues that might arise in claims made type policies, it did so by s 40 of the Act. It did so in a limited way, falling far short of radical surgery that would substantially alter the character of such policies, as suggested above. The insurer argued that, to the extent that s 54 of the Act was available to supplement the specific provisions of s 40 of the Act (a possibility which at one stage it questioned), the operation of the former provision should be confined to affording incidental relief against acts and omissions involved in giving effect to the claims made type policy as agreed between the parties. According to this argument, the Act postulated an insurance policy that applied to the claim. Cover was logically anterior to the claim based upon the insurance. The only act or omission that was relevant, therefore, was one which disentitled the insured from what would otherwise have been its entitlement under that policy. The section should not be permitted to alter the very basis of the agreement or to change its character from a claims made type policy to some other type, imposed on the parties by a court[87]. If the insured wanted another type of policy, it should have negotiated such a policy with the insurer, and doubtless paid a higher premium[88].

71 Thirdly, the insurer argued that, unless the ambit of s 54 of the Act were confined in this way, the section carried the seeds of the destruction of claims made type policies. If the relief afforded by the section was against all "omissions", such relief could theoretically extend not only to the "omission" of the insured to notify a claim made during the period of cover but also to the "omission" of a third party claimant to bring its claim promptly within the period of cover (when the insured would have been indemnified) instead of outside the period of cover (when the insured might not be indemnified). Or it would apply to the "omission" of the third party claimant, within the period of cover, to notify the insured of an occurrence that might subsequently give rise to a claim against it, so as to enliven the insured's entitlements under condition 3. If such "omissions" on the part of third parties were treated as within the literal terms of s 54 (so the insurer contended), the whole point of claims made type policies would be destroyed. Courts sympathising with insureds, who had obtained a policy with some temporal connection to the events out of which the claim arose,

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85 Australian Law Reform Commission, *Insurance Contracts*, Report No 20 (1982).

86 *Commercial Union Assurance Co of Australia Ltd v Ferrcom Pty Ltd* (1991) 22 NSWLR 389 at 391-392, 402-403; *Ferrcom* (1993) 176 CLR 332 at 340-341; *Newcastle City Council v GIO General Ltd* (1997) 191 CLR 85 at 101-102, 110.

87 See *GIO General Ltd v Newcastle City Council* (1996) 38 NSWLR 558 at 571.

88 *GIO General Ltd v Newcastle City Council* (1996) 38 NSWLR 558 at 571; *Simcoe* [1993] 1 SCR 252 at 266.

might override the fundamental character of the form of insurance purchased, excuse the third party's "omission" and hold the insurer liable. If such a result were so absurd that it could not have been the purpose of s 54 of the Act, logic suggested (so this argument continued) that "omissions" on the part of the insured itself could not place the insured in a better position. The "omissions" to which the section was addressed were, upon this view, the failure of the insured to take advantage of a right belonging to it under the policy rather than a failure to comply with the insuring clause defining the scope of that policy in the first place[89].

72 Fourthly, the insurer submitted that its construction of s 54 was harmonious with the language of the section as it was intended to operate upon the wide variety of insurance policies to which it applied. It was said to be consistent with the apparent purpose of the reforms proposed by the Australian Law Reform Commission. Furthermore, the construction would have the practical consequence of reinforcing the essential character of claims made type policies and encouraging immediate notification of any such "claims" as were made within the period of cover. It would effectively oblige the immediate notification of "occurrences" that might subsequently give rise to a claim against the insured[90]:

> "It is the duty of the insured to disclose circumstances which might give rise to a claim each year in the proposal. That is the precise moment at which it is still open to the insured to give notice of circumstances which might give rise to a claim under the current policy. The insured's specific attention to the need for disclosure is invoked by a proposal question asking whether the insured, after due inquiry, is aware of any claims circumstances. This should not be too high a burden to ask of professionals who should always be bound by principles of honesty and good faith. Moreover, there is nearly always professional insurance broker advice available to the insured."

73 There is merit in the argument that, as far as its words permit, in the case of claims made type policies, s 54 of the Act should be construed to afford the relief contemplated in a way consistent with the maintenance of this type of insurance and not in a way that would be destructive of its availability. However, the duty of an Australian court is, relevantly, to the law as expressed in the Act. The question is therefore how s 54 of the Act is to apply to "omissions" said to be applicable to a claims made type policy. Unless the meaning of the section, derived from its language, permits or requires a court to confine relief in

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89 Masel, (2000) 11 *Insurance Law Journal* 104 at 108.

90 Masel, (2000) 11 *Insurance Law Journal* 104 at 110.

such cases, any dissatisfaction with the operation of the section in respect of this class of insurance is a matter for legislative amendment[91]. The judicial "struggle" with the requirements of the provision, as such requirements are found to be inherent in its language and apparent purpose, can only go so far.

Giving s 54 of the Act its remedial operation

74 The history of s 54 of the Act reinforces the impression, given by the language of the section, that it is intended to have a broad remedial application. Before the Act, there existed in a number of Australian States legislative provisions that relieved insureds, in defined circumstances, from a failure to observe or perform a term or condition of a contract of insurance[92], or to give notice within the time required by a policy[93]. Such provisions, according to their terms, exempted the insured from the harsh results that would otherwise have followed at common law: debarring the claim notwithstanding the fact that the insurer may have suffered little or no prejudice. The provisions of s 54 were obviously intended to build upon, and to extend, such relief and to make it available throughout Australia.

75 It is true that the Australian Law Reform Commission's discussion of the clause of its draft Bill that became s 54 of the Act did not advert specifically to the operation of the section in the context of claims made type policies[94]. However, the provision was deliberately cast in broad terms as was appropriate to a measure designed to extend and expand the pre-existing laws. Confirmation that this was the purpose of s 54(1) can be found in the fact that the sub-section is addressed to "the *effect* of a contract of insurance"; that it relates to a case where the insurer may refuse to pay a claim "either in whole or in part"; that it extends to a relevant "act" that by sub-s (6) includes an "omission"; that it relates not only to the acts and omissions of the insured but also to those "of some other person"; that it is addressed to the insurer's liability "*in respect of* the claim"; and that it permits a fair abatement of the insurer's liability by reference to any prejudice which the insurer has suffered "as a result of that act [or omission]".

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91 Masel, (2000) 11 *Insurance Law Journal* 104 at 111 suggested the possible need for legislative intervention "[i]f the courts cannot accommodate a workable distinction exempting acts and omissions which define or extend the scope of cover from the operation of s 54".

92 *Insurance Act* 1902 (NSW), s 18.

93 *Instruments Act* 1958 (Vic), s 27.

94 Australian Law Reform Commission, *Insurance Contracts*, Report No 20 (1982) at 132 [215], 141 [232], 146 [241].

76 In the face of these many indications of the wide ambit of s 54, it is little wonder that this Court[95], and other courts[96], have emphasised that the section must be given the broad application that its ample language and remedial purposes suggest[97].

77 Once this position is reached, the question is posed whether, and if so how, the concept of "an omission", provided for in s 54 of the Act, can be confined. Can it somehow be confined to exclude the "omission" of "some other person" (being the potential and later claimant) to make its claim or notify an occurrence which may subsequently give rise to a claim, within the period of cover[98]? Can it include an "omission" of the insured to notify a "claim", although received by it, or to notify an occurrence within the period of cover which, if a claim were later made, would deem such claim to have been made during the subsistence of the cover[99]? Can it extend to the "omission" of the insured to elect (in a way relevant to subsequent events) in favour of a broader ambit of cover with optional extras which, before its loss, the insured "omitted" to procure? May the words of the Act be read down to exclude an "omission" of an employee to keep jewellery in a locked safe, or to lock the safe properly, where these requirements represent the only circumstances covered by the insuring clause? Surely the "omission" referred to would not extend to an "omission" of the insured to secure insurance cover of a particular kind without which it would be without relevant cover at all[100]. These and other instances have been discussed in the cases in an attempt to plumb the relief which s 54(1) of the Act contemplates, operating as it must do in the context of a particular contract of insurance under which it is assumed that the insurer is entitled to refuse to pay a claim if it falls outside the scope of its promised obligations[101].

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95 *Antico* (1997) 188 CLR 652 at 669, 672-673.

96 eg *Antico v C E Heath Casualty & General Insurance Ltd* (1996) 38 NSWLR 681 at 703.

97 See Kelly and Ball, *Principles of Insurance Law* (2001) at 5392 [5.0190.15].

98 The position in *Greentree* (1998) 44 NSWLR 706.

99 The position in the present case.

100 eg an insurance cover of liability for motor vehicle injury instead of one for professional indemnity.

101 This assumption is noted in *Antico* (1997) 188 CLR 652 at 664-665.

Judicial attempts to confine the application of s 54

78 Various judicial attempts, grounded in the language of s 54(1) of the Act, have been offered to confine the section so that the acts (and omissions) that are excused are kept within manageable bounds.

79 First, attention has been focussed on the denotation of the word "omission". Thus, it was suggested in *Perry*[102] that "omission", in the context of s 54, implied something more than a mere failure to act. In *Greentree*[103], Handley JA embraced this notion. He suggested that "omission" in s 54 was used "in its secondary sense"[104]. It referred to the failure of the insured, or someone else, to perform an act for the benefit of the insured under the policy. Upon this view, the word did not include a failure to act "by others having no relevant relationship or connection with the insured, whose interests are adverse to the insured"[105]. No other member of the Court of Appeal in *Greentree* embraced this approach. Indeed, Spigelman CJ said that he did "not entirely adopt" it[106]. In my view, it is an approach that cannot stand with the holding in this Court in *Antico* that an "omission" within s 54 of the Act includes the "failure [of the insured] to exercise a right, choice or liberty which the insured enjoys under the [policy]"[107]. No duty or obligation on the part of the insured (or of some other person) is posited, simply a failure to act. The first suggested means of confining s 54(1) must therefore be rejected.

80 Secondly, an attempt has been made to distinguish an "omission" within s 54 of the Act from a so-called "non-event"[108]. This was the approach which Spigelman CJ preferred in *Greentree*. He described such "non-events" as "conduct wholly external to the policy"[109]. However, a similar distinction was

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102 (1993) 30 NSWLR 89 at 93 per Gleeson CJ, 107 per Clarke JA.

103 (1998) 44 NSWLR 706 at 723.

104 A reference to the definition of "omission" in the *Oxford English Dictionary* cited by Handley JA (1998) 44 NSWLR 706 at 723: "The primary meaning of 'omission' ... is 'the action of omitting, or fact of being omitted'. The secondary meaning is 'the non-performance or neglect of action or duty'."

105 *Greentree* (1998) 44 NSWLR 706 at 723-724.

106 *Greentree* (1998) 44 NSWLR 706 at 710.

107 (1997) 188 CLR 652 at 669.

108 *East End* (1991) 25 NSWLR 400 at 405 per Gleeson CJ.

109 *Greentree* (1998) 44 NSWLR 706 at 710.

described at first instance in *Antico* as "elusive"[110]. In the Court of Appeal in the present case, Pincus JA, whilst dissenting, referred to this supposed distinction and confessed to "a little difficulty in understanding it". His Honour remarked[111]:

> "It is not clear why there is any more reason to treat the insured's not having notified the insurer than a third party not having claimed against the insured as an omission within s 54, in view of the expression 'act of the insured or of some other person' in s 54(1)."

It seems unlikely that this differentiation would provide a sound, universal touchstone for the correct operation of s 54.

81 Thirdly, in *Permanent Trustee Australia v FAI General Insurance Co Ltd*[112], Hodgson CJ in Eq endeavoured to offer a point of limitation on the reach of s 54(1) by reference to the section's use of the word "omission". He drew a distinction between "someone's omission to do something" and a relevant event that "did not happen"[113]. I agree with the criticisms of the adequacy of this suggested criterion offered by McHugh, Gummow and Hayne JJ in their reasons in this case[114].

The classification of the insurer's "reason" to refuse the claim

82 The rejection of these control devices leaves standing only the two controls that appear to have been contemplated by the Australian Law Reform Commission itself and which are expressed in s 54(1) of the Act. These are, first, the provision for abatement in the insurer's liability where applicable (which is not here relevant)[115], and secondly, the causal relationship posited by the provision that where the preconditions set forth in s 54(1) of the Act apply "the insurer may not refuse to pay the claim *by reason only* of that act [or omission]".

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110 *Antico v C E Heath Casualty & General Insurance Ltd* (1995) 8 ANZ Insurance Cases ¶61-268 at 76,011.

111 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445 at 75,083 per Pincus JA; 153 FLR 448 at 450.

112 (1998) 44 NSWLR 186.

113 (1998) 44 NSWLR 186 at 227.

114 Reasons of McHugh, Gummow and Hayne JJ at [38].

115 *Ferrcom* (1993) 176 CLR 332.

83 By this Court's decision in *Antico*, it is established that s 54(1) of the Act "refers not to precise concepts of form but to the effect of the contract and asks whether that effect is that the insurer may refuse payment 'by reason of' the relevant act or omission"[116]. That question "does not express a limitation to the sole or unique cause of the entitlement of the insurer to refuse payment"[117]. It invokes a search for the relevant act or omission on the part of the insured or of some other person which, unrelieved by remedial intervention under s 54(1) of the Act, would allow the insurer to refuse to pay the claim. As in other cases where, for legal purposes, cause must be assigned, the phrases "by reason of" and "by reason only of" in s 54(1) of the Act invoke a commonsense decision[118]. What is required is a judgment that upholds the insured's entitlement to indemnity in accordance with the policy, read with the Act, without opening the floodgates to the types of "omissions" presented above by the insurer as a spectre of horrible possibilities.

84 If, for example, the problem presented to the New South Wales Court of Appeal in *Greentree* were to arise again, the real explanation of why the failure of a third party to make a claim on the insured in that case would not attract remedial intervention under s 54(1) of the Act is that the insurer's refusal to pay the claim was not "by reason only of that [omission]". On the contrary, it was a refusal "by reason of" the fact that the contract of insurance did not respond to the precise facts as found. Applying a commonsense approach, and accepting that s 54(1) of the Act is not limited to a sole or unique cause of the entitlement to refuse payment, such entitlement is not related to a third person's "omission". It is no more "by reason of" such "omission", in the sense that s 54(1) contemplates, than it would be "by reason of" an omission on the part of the insured itself to secure a better, larger or more ample policy of insurance. Similarly, the "omission" of the insured to take steps, prior to a loss, to elect an expanded form of cover, would not be an "omission" of the kind which would attract relief under s 54(1) of the Act. In such a case, the "reason" for the insurer's refusal to pay would be classified by the law as the absence of relevant cover between the insurer and the insured, not the "omission" of the insured to obtain a cover that was more ample.

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116 *Antico* (1997) 188 CLR 652 at 673.

117 *Antico* (1997) 188 CLR 652 at 672-673.

118 Recent cases include *Moneywood Pty Ltd v Salamon Nominees Pty Ltd* (2001) 75 ALJR 408 at 424 [96], 436 [157]-[158], 439 [172]; 177 ALR 390 at 412, 428-429, 432 concerning the phrase "in respect of" and *McCann v Switzerland Insurance Australia Ltd* (2000) 75 ALJR 325 at 336 [73]; 176 ALR 711 at 725 concerning the phrase "brought about by".

85 If the present case is considered (or a like case where an insured received a "claim" from some other person within the period of cover but failed to bring it to the notice of the insurer) the position is quite different. The real "reason" for the rejection of a claim, otherwise fully viable and to which, had there been notification, the policy of insurance would undoubtedly have responded, will be classified as the "omission" on the insured's part to notify the claim. Long before so much ink was spilt over s 54 of the Act, Mahoney JA in *East End*, in language that was cited and expressly approved by this Court in *Antico*[119], explained why this was so. It is worth quoting the passage in his Honour's reasons again[120]:

> "For [s 54(1)] to apply, the entitlement to refuse to pay the claim must be '*by reason of* some act of the insured or of some other person'. In the present case, the immediate reason why the insurer could refuse to pay the claim was not, in terms, *by reason of* an act (for which may be substituted 'omission') of 'the insured or of some other person' but *by reason* merely of the fact that, the making of the claim upon the insured not having been 'notified' to the insurer, the claim was not within the cover. But it was not within the cover *by reason of* an (omission) of the insured. Therefore the entitlement to refuse arose *by reason of* that omission."

86 By parity of reasoning in the present case, the entitlement of the insurer to refuse indemnity arose not "by reason of" the omission of the insured to notify a claim (for none was received within the period of cover) but "by reason of" its failure to notify an "occurrence" which might subsequently have given rise to a claim against the insured within condition 3 of the policy. I must again quote from what I wrote in *Perry* before the judicial analysis of s 54 took a wrong turning[121]:

> "It is, after all, scarcely convincing to say that the absence of liability in the insurer is not *by reason of* an omission on the part of the insured when it is clear that, had the insured only given notice and made a claim [later], that policy would have operated fully to protect him."

87 It is true that, as in other cases involving the determination of issues of causation, borderline decisions will fall to be made. Differences of opinion will occasionally arise[122]. However, in the present case, in my view, there is no real

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119 (1997) 188 CLR 652 at 673.

120 *East End* (1991) 25 NSWLR 400 at 407 (emphasis added).

121 (1993) 30 NSWLR 89 at 103 (emphasis added).

122 As they did in *Chappel v Hart* (1998) 195 CLR 232.

difficulty. As in *Perry*, the outcome is relatively clear. It is also far from unjust[123]. Indeed, in my opinion, the present case illustrates exactly the kind of situation in which s 54(1) of the Act was intended to operate, and should operate.

Conclusion: s 54 applied to afford relief from the "omission"

88 The insured, otherwise entitled to indemnity, made a mistake. The mistake was an "omission". The insured omitted to follow its normal practice. It omitted to notify the insurer when it became aware of an occurrence which might subsequently give rise to a claim. Had it not made that "omission", but observed its ordinary practice, the insured would have been fully protected in the event of a "claim" made later. It would then have been deemed to have been made during the insurance period. No relevant prejudice was suffered, or asserted, by the insurer as a consequence of the insured's "omission". To refuse indemnity in such circumstances would be completely disproportionate to the "omission" on the part of the insured. It was thus the kind of "omission" that attracted a consideration of the provisions of s 54 of the Act. It follows that the majority of the Court of Appeal were correct to hold that s 54 of the Act applied to afford relief to the insured for its mistaken "omission". Once such relief was given, the insured was entitled to full indemnity. As Derrington J pointed out in the Court of Appeal[124], the result was not, as the insurer would have it, a serious departure from the "core", "essence" or "substance" of the insurance cover agreed between the parties. On the contrary, it was no more than the application to the policy provisions, for which the insured had paid its premium, of the relief from an immaterial "omission" provided by the remedial provisions of the Act.

Orders

89 The appeal should be dismissed with costs.

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123 This was a point earlier made by the principal author of the Australian Law Reform Commission report on *Insurance Contracts*, D St L Kelly. His opinion is set out in *Perry* (1993) 30 NSWLR 89 at 103. See also Mead, "The Effect of Section 54 of the Insurance Contracts Act 1984 and Proposals for Reform", (1997) 9 *Insurance Law Journal* 1.

124 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (1999) 10 ANZ Insurance Cases ¶61-445 at 75,087, 75,089 per Derrington J; 153 FLR 448 at 456, 458.