

12

12 Performance of private insurers

For thousands of people whose homes were ruined and possessions destroyed or lost, insurance was an important issue in the aftermath of the 2010/2011 floods. It received significant public attention, a great deal of it critical of insurance companies. Some fundamental aspects of flood insurance – aspects which caused many policy-holders considerable stress – were also brought into sharp focus:

- Many insurance policies did not provide cover for damage caused by flood, but did provide cover for stormwater damage – or, in some cases, stormwater damage and flash flood – and other natural disasters.
- Many people did not believe or did not realise that their policies excluded flood from cover.
- Definitions of ‘flood’ in policies varied and were generally complicated.

The Commission was given a term of reference requiring it to examine ‘the performance of private insurers in meeting their claims responsibilities’. The term of reference is focussed specifically on the question of how insurers performed in dealing with claims which arose from the 2010/2011 floods and for which they were responsible, beginning at the point at which policy-holders contacted their insurers to make a claim. The Commission’s task did not extend to considering the broader issues of the availability and affordability of flood insurance, definitions of ‘flood’ or policy-holders’ awareness and understanding of the terms of their cover. Other reviews were established to consider these issues.

12.1 Other reviews

Three different reviews commenced at the federal level in the months after the 2010/2011 floods: the Natural Disaster Insurance Review, and reviews conducted by the Commonwealth Treasury and the House of Representatives Standing Committee on Social Policy and Legal Affairs.

The first, the Natural Disaster Insurance Review, was established on 4 March 2011, principally because of ‘the absence of flood insurance for many policy-holders, particularly in Brisbane and Ipswich’.¹ Its central focus was on ways of improving the availability and affordability of insurance for flood and other natural disasters. It considered other matters also, including measures to improve policy-holders’ understanding of the cover provided by insurance policies, and possible improvements to insurers’ claims management and dispute resolution processes. The second topic was relevant to the Commission’s inquiry, and the Commission and the review exchanged information where appropriate during the course of 2011.

The Natural Disaster Insurance Review provided a report to the Commonwealth Government on 30 September 2011 which was released to the public on 14 November 2011. The report contained 47 recommendations. One of the most significant was a recommendation that all home building, home unit and home contents insurance policies

include flood cover,² with recommendations for the establishment of arrangements to make that cover feasible. Of the latter, of particular interest to the Commission was the review's recommendation for a national repository of flood risk information.³ The Commission has considered a related question, of how information needed for flood studies can be maintained and made accessible: see 2.5.5 *Central repository of flood study data*. The review made some recommendations about insurers' handling of claims, which are discussed in the relevant sections of this chapter (see 12.5 *Timeliness* and 12.6 *Communication with policy-holders*).

The review also endorsed proposals made by the Commonwealth Treasury in its discussion paper, *Reforming Flood Insurance – Clearing the Waters*, released in April 2011.⁴ The Treasury discussion paper focussed on two issues outside the Commission's term of reference: the variation in how 'flood' is defined in policies and the problem that some policy-holders were not aware that their policies excluded flood. The paper proposed the introduction of:

- a standard definition of flood
- a requirement that insurers give policy-holders purchasing or renewing a household insurance policy a 'Key Facts Statement' setting out, in effect, what is covered and what is excluded under the policy.

The Commonwealth Government released its response to the Natural Disaster Insurance Review's report on 14 November 2011. It announced, as part of the response, that the Treasury's proposals would be implemented by legislation and, on 23 November 2011, presented the Insurance Contracts Amendments Bill 2011 (Cth) to Parliament. On 9 December 2011, draft regulations for a standard definition of 'flood' were released for public comment. Submissions closed on 3 February 2012. In addition, the Treasury released a second discussion paper in November 2011 proposing that insurers should be required to offer flood cover in home building and home contents insurance policies, for purchasers to choose to take up or decline.⁵ Submissions on the proposal close on 30 March 2012.

The House of Representatives Standing Committee on Social Policy and Legal Affairs conducted the third federal inquiry into insurance issues. On 2 June 2011, the Assistant Treasurer and Minister for Financial Services and



Flood cleanup at Auchenflower, Brisbane, January 2011 (photo courtesy Steven Bolland)

Superannuation asked the committee to inquire into and report on the insurance industry's response to the extreme weather events around Australia in 2010/2011. The committee delivered its report on 28 February 2012. The report can be found at www.aph.gov.au. Its inquiry was not limited to the 2010/2011 floods but also encompassed other recent disasters in Australia, including Cyclone Yasi. The committee's focus, like that of the Commission, was on issues of claims processing, including:

- the adequacy of information insurers provided to policy-holders about making a claim, the progress of the claim and policy-holders' rights to external dispute resolution (see sections 12.2.2 and 12.2.3)
- the reasonableness of the time insurers took to process claims (see section 12.5)
- the effect of the engagement of experts and consultants (such as hydrologists and lawyers) on claims processing (see section 12.7)
- the effectiveness and timeliness of insurers' internal dispute resolution processes (see sections 12.2.2 and 12.2.3)
- the effectiveness of the insurance industry's General Insurance Code of Practice (see section 12.2.3)
- the effectiveness of external dispute resolution by the Financial Ombudsman Service (see sections 12.2.2 and 12.2.3).

The committee held public hearings about these matters in various places, including Brisbane, Ipswich and Toowoomba. The Commission considered the transcripts of the committee's hearings. As the next section explains, aspects of all but the last of the above topics also came within the scope of the Commission's inquiry into the performance of insurers in meeting their claims responsibilities.

12.2 Insurers' claims responsibilities

Insurers' claims responsibilities come from the contract of insurance (the policy), legislation and the general law. Most insurers also accept the responsibilities imposed by the industry's voluntary code of practice.

12.2.1 Terms of the policy and the general law of insurance

An insurer's foremost responsibility is to meet its obligations under the insurance policy, and in particular, to pay claims for which the policy provides cover. No insurer is required to pay a claim which is outside the terms of its policy or which falls within an exclusion. Notwithstanding, two insurers of which the Commission is aware – RACQ Insurance and CommInsure – made 'compassionate payments' to some policy-holders whose claims were declined because of the operation of the flood exclusion.⁶

In most cases with which the Commission was concerned, policies provided cover for stormwater damage (and in some instances, flash flood) and excluded damage caused by flood, as defined by the policy. The policies of the majority of insurers from which the Commission received information contained that distinction. RACQ Insurance's household policy, for instance, provided cover for 'flash flood and/or stormwater run-off', which was defined as: 'A sudden flood caused by heavy rain that fell no more than 24 hours prior to the flash flood or stormwater run-off.'⁷ Flood, excluded under the policy, was defined as: 'Rising water which enters your home as a result of it running off or overflowing from any origin or cause.'⁸

In each case where water had inundated a property, those insurers whose policies drew distinctions of that kind had to establish what type of water inundation had caused damage. (The onus is on the insurer to prove that an exclusion applies.⁹) Determining causation was far from straightforward, often involving complex questions of fact and law. An insurer is liable for loss where the event covered by the insurance policy is its effective or 'proximate cause'.¹⁰ Some of the complexities in resolving claims lay in determining which form of inundation was the proximate cause of the damage. And, in some cases, there were concurrent causes of damage. Where a loss has two or more proximate causes, one of which comes within the scope of the policy, the insurer will be liable, as long as none of the other causes is expressly excluded under the policy.¹¹ The sequence of events was significant in some cases: if inundation damage was caused in the first instance by waters covered by the policy (for example, stormwater) followed by subsequent inundation by water not covered by the policy, the policy-holder was entitled to recover from the insurer for that damage (for more information, see *12.7.2 Site-specific hydrology reports*).¹²

Having to resolve such questions inevitably protracted the decision-making process. Hydrology information was needed in most cases. In complex or uncertain cases, site-specific hydrology advice was necessary (for details,

see sections 12.5.1 *Determination of liability* and 12.7 *Assessment process*). Insurers that provided automatic flood cover, such as Suncorp and other insurers in the Suncorp Group, did not need to undertake this task; because their policies covered inundation from any source, the cause of the damage was not contentious.

Some insurers have announced that they will be providing automatic flood cover from February 2012. As already mentioned, the Natural Disaster Insurance Review recommended that all domestic policies include flood cover, and the Commonwealth Treasury has proposed that insurers should have to at least offer flood cover in home building and home contents policies, based on a standard definition of flood.¹³ If the proposal is adopted, it will go some way to removing the distinction between policies and the complexities associated with that distinction.

12.2.2 The *Insurance Contracts Act 1984*

The Commonwealth Government has power to make laws regulating private insurance policies.¹⁴ In 1984, it passed the *Insurance Contracts Act 1984*.¹⁵ The purpose of the Act is:

to reform and modernise the law relating to certain contracts of insurance so that a fair balance is struck between the interest of insurers, [policy-holders] and members of the public and so that those insurance contracts, and the practices of insurers in relation to such contracts, operate fairly.¹⁶

The *Insurance Contracts Act 1984* does not contain provisions expressly relating to the performance by insurers of their claims responsibilities, but section 13 implies into the insurance contract a requirement that each party act with 'utmost good faith'. The utmost good faith requirement requires 'fair dealing in which the one party puts the interests of the other at least at the same level of protection as his own'.¹⁷ It encompasses notions of fairness, decency and reasonableness.¹⁸ Among other things, the utmost good faith requirement requires insurers not to act with undue delay in processing a policy-holder's claim. Thus, for claims which are covered by the policy, the duty requires prompt admission of liability and prompt payment.¹⁹

The Australian Securities and Investments Commission (ASIC) has supervisory and investigatory powers under the *Insurance Contracts Act 1984*, including the power to monitor complaints regarding insurance matters.²⁰

The *Corporations Act 2001* requires insurers to have a dispute resolution system that consists of:²¹

- an internal dispute resolution process approved by ASIC, and
- membership of an ASIC approved external dispute resolution scheme.

The ASIC sets requirements for insurers' internal dispute resolution procedures.²² One requirement is that insurers should determine complaints within 45 business days.²³ For more information about the timeliness with which insurers dealt with disputes, see section 12.5.3.

The relevant external dispute resolution scheme is the Financial Ombudsman Service. Most insurers are members of this resolution scheme. It resolves disputes between policy-holders and their insurers, usually after the policy-holder has been through the insurer's internal dispute resolution process. The Financial Ombudsman Service also monitors insurers' compliance with the General Insurance Code of Practice.²⁴

12.2.3 General Insurance Code of Practice

The General Insurance Code of Practice is a voluntary industry code developed by the Insurance Council for insurers. It came into operation on 18 July 2006 and is independently reviewed every three years; the last review was completed on 30 October 2009. Although it is not compulsory, more than 90 per cent of general insurance providers have signed up to the code.²⁵

The code is to be applied having regard to the duty of utmost good faith.²⁶ Set out as a series of undertakings to policy-holders, it establishes minimum standards for insurers to meet in handling claims and complaints. The code sets timeframes in which insurers will appoint loss assessors; give policy-holders updates as to the progress of their claims; respond to policy-holders' requests for information; determine whether claims are payable; and handle complaints.²⁷ It also requires insurers to give written reasons for declining claims²⁸ and entitles policy-holders, with certain exceptions, to access any information relied on in the assessment of their claims and the opportunity to correct any mistakes or inaccuracies (for information about what this standard entails, see 12.8.2 *Provision of information*).²⁹

The document acknowledges, however, that during times of ‘catastrophe and disaster’ (which includes fires, flooding, earthquakes, cyclones, severe storms and hail)³⁰ large numbers of claims may prevent insurers from meeting all the prescribed standards.³¹ Notwithstanding, insurers undertake to establish internal processes for dealing with catastrophes and disasters, responding in a ‘fast, professional and practical way and in a compassionate manner’.³²

According to the code, insurers will handle complaints in a fair, transparent and timely manner, responding within set timeframes. If a policy-holder is not satisfied with the insurer’s response, the matter is then treated as a dispute and reviewed by a different employee. The insurer is required to keep the policy-holder informed of the progress of the response and respond within set timeframes, in writing, giving reasons for the decision. The insurer must also advise the policy-holder about his or her right to take the matter to the Financial Ombudsman Service.³³

In reviewing a policy-holder’s complaint, the Financial Ombudsman Service gives the policy-holder and insurer an opportunity to make submissions. It is not bound by the rules of evidence and may consult industry and consumer advisors or experts. Following this process, the Financial Ombudsman Service may make a recommendation. If both the policy-holder and insurer accept the recommendation, the complaint or dispute is resolved. If the recommendation is not accepted, the Financial Ombudsman Service proceeds to make a determination which is binding on the insurer but not the policy-holder who has the option of commencing legal action.³⁴

12.2.4 Topics of investigation for the Commission

The Commission’s consideration of the claims responsibilities which arise out of the *Insurance Contracts Act 1984*, the general law, the terms of insurance policies and the General Insurance Code of Practice has focussed on these matters:

- the timeliness of insurers’ decision-making (see *12.5.1 Determination of liability*)
- the adequacy of communication with policy-holders (see *12.6 Communication with policy-holders*)
- the adequacy of the assessment process (see *12.7 Assessment process*)
- the adequacy of information given to policy-holders whose claims were denied (see section *12.8 Information to policy-holders whose claims were denied*)
- the process and timeliness of internal dispute resolution (see *12.5.3 Timeliness of internal dispute resolution* and *12.9 Internal dispute resolution*).

12.3 Process of investigation

Fifty-three insurers are members of the Insurance Council of Australia. The Commission focussed its investigation on eight insurers:

- Australian Associated Motor Insurance Ltd (‘AAMI’, part of Suncorp Group Limited)
- Allianz Australia Insurance Limited
- CGU Insurance Limited (part of the Insurance Australia Group Limited)
- CommInsure
- NRMA Insurance (also part of the Insurance Australia Group Limited)
- QBE Insurance (Australia) Limited
- RACQ Insurance Limited
- Suncorp Metway Insurance Limited (‘Suncorp’, also part of the Suncorp Group).

The sample of insurers was chosen on the basis of two sources of information: submissions the Commission received and informal reports from advocates for policy-holders (Legal Aid Queensland and the Caxton Legal Centre). The latter were able to identify problems they had encountered and the insurers involved; of some interest were the numbers of complaints they had received in respect of particular insurers (which may have been a function of the numbers of claims those insurers received).

From those eight insurers the Commission obtained (by way of Requirements under the *Commissions of Inquiry Act 1950*) general information on the topics within the insurance term of reference. The extent to which the Commission could explore issues within its term of reference depended, however, on being able to examine the

way individual claims were dealt with, which in turn depended on policy-holders providing their accounts of their experiences. Unfortunately, the Commission received a limited number of submissions about insurance generally. The number relevant to the Commission's term of reference was even more limited. Most concerned issues outside the scope of the Commission's inquiry. They were provided to the Natural Disaster Insurance Review where they were relevant to the review's inquiry and where the submitter was happy with that course.

The Commission took steps to encourage people to provide information about their experiences with their insurance claims. It wrote to local councillors and members of Parliament and also to a large group of policy-holders represented by Legal Aid Queensland. It invited (by way of media statement) people to provide information on a confidential basis if they preferred to do so. To encourage greater participation, police officers working for the Commission also visited flood-affected areas, including regional areas, from which the Commission received comparatively fewer submissions. Additional submissions were received as a result of these steps. Public hearings in September and October 2011 also prompted more submissions. However, the numbers were still not significant and some of those making them preferred that their information be kept confidential.

There may be a number of reasons for the lack of submissions. It seems likely that policy-holders were concerned with recovering from the effects of the 2010/2011 floods and had too much to contend with, or wanted to get on with their lives and did not want to re-live the experience through making submissions or giving evidence to the Commission. Some may already have given accounts of their experiences to the Commonwealth reviews previously mentioned, and felt disinclined to repeat them. The Commission is also aware that some policy-holders did not want to prejudice ongoing claims or negotiations with their insurers.

The Commission could, of course, have used its powers under the *Commissions of Inquiry Act* to require insurers to provide representative samples of policy-holders' files, but it did not think it appropriate to encroach on individuals' privacy in that way. Similarly, when people who provided submissions were not prepared for the Commission to seek information from their insurers, the Commission respected their wishes. However, the Commission did investigate a number of individual cases where policy-holders had approached the Commission and were willing to have their cases examined. It did so by requiring insurers to provide information about how those claims were handled. This process yielded a useful – albeit limited – body of case examples by which to test some insurers' performance. Some of the cases were examined in the Commission's public hearings. This report does not comment on every case the Commission reviewed or complaint it received. References are made to some of these cases, generally by way of illustration of the point under consideration. In some instances, however, more detailed discussion and specific comment about a case the Commission examined is warranted.

The following points must also be made about the submissions the Commission received, and how they informed the Commission's investigation. As would be expected, most submissions were made by policy-holders who had some complaint against their insurer. The Commission did, however, receive some positive reports.³⁵ Secondly, the submissions almost entirely concerned household insurance claims (home and contents claims). The investigation concentrated on those kinds of claims as a result.³⁶

12.3.1 Co-operation of insurers

The Commission required the eight insurers to provide in a limited period of time a large amount of information: general information about the topics under investigation, information about particular claims and data (see section 12.3.2 below). The Commission received a great deal of co-operation and assistance from many of the insurers. In particular, the co-operation of Suncorp and AAMI (both part of the Suncorp Group) and RACQ Insurance, from which extensive information was sought, is acknowledged. Unfortunately, one insurer – CGU – was, in some instances, less meticulous in its responses to the Commission's Requirements (see *Appendix 5 Glossary* for a definition of Requirement).

Some of CGU's responses were incomplete. In one case, CGU was required to produce 'copies of records of all communications' between it and the ASIC and the Financial Ombudsman Service 'concerning any matter relating to insurance claims arising from the Queensland floods'. It is evident that some correspondence was not provided to the Commission, while some correspondence that was provided made reference to telephone conversations or meetings, of which no record was produced.

CGU's correspondence with ASIC and the Financial Ombudsman Service raised questions about the accuracy of a statement by CGU which responded to this question in a Requirement: 'Is CGU or has CGU been the subject

of any investigation by the Financial Ombudsman Service ... or any other regulatory body about the manner in which CGU has dealt with claims relating to the Queensland floods?' CGU said that to the best of its knowledge and belief, it 'had not been subject to such an investigation'. It added, however, that in April 2011 it had 'received correspondence from ASIC requesting information addressing concerns that were raised anonymously to ASIC', it responded to that correspondence, and it did 'not believe that the matter [had] been taken any further'.³⁷

It is not accurate that the matter had not been taken any further. After CGU provided its response to ASIC's inquiries,³⁸ the regulator requested further information in June 2011³⁹ and then again in August 2011.⁴⁰ ASIC wrote to CGU again in September 2011 when it did not receive a response to the latter request.⁴¹ More to the point, however, CGU's statement did not include any reference to inquiries by the Financial Ombudsman Service which commenced in April 2011.⁴² It is apparent that by 14 July 2011 CGU was made aware, formally, of an investigation by the ombudsman into a 'possible systemic issue'⁴³ and possible breach of the code of practice. That investigation resulted in a finding by the ombudsman, notified to CGU on 26 August 2011, of a 'definite systemic issue'.⁴⁴ The correspondence indicates that, in fact, CGU had been subject to an investigation by the Financial Ombudsman Service of which it must have been aware when it provided information to the Commission.

Another statement CGU made was shown to be plainly wrong. The insurer stated that all letters advising customers that their claims had been denied 'detail[ed] the reasons for the decision' and 'referenced all material relied upon to come to the decision'.⁴⁵ CGU conceded the statement was not correct.⁴⁶ The concession was sensible: the insurer's pro forma letters, which were provided to the Commission, did no such thing.

CGU said, by way of explanation, that the shortcomings were inadvertent, the result of pressures of work. The Commission accepts that CGU was put to considerable work in order to comply with the Commission's Requirements (and it must be noted that its legal representatives also had to co-ordinate responses to Requirements issued to NRMA Insurance, which is also part of the Insurance Australia Group). It considers, however, that in those instances, the insurer was neither careful nor diligent in its responses to Requirements.

12.3.2 Insurance statistics

The Commission obtained data from the eight insurers as to:

- the number of household claims (home building claims, home contents claims, and home and contents claims) received as a result of the 2010/2011 floods⁴⁷
- the time taken to decide to accept or decline the claims
- the time taken to finalise the accepted claims, whether by way of cash settlement, replacement of goods or repairs
- the number of the claims which were reviewed in the internal dispute resolution process and the time taken to complete the reviews.

The Commission obtained this information on two occasions. Insurers provided an initial set of data at the end of September 2011, with further, updated figures furnished in mid-December 2011. The data presented in this report relates to the period up to and including 1 November 2011.

However, because insurers do not collect and record data uniformly, some of the data was presented to the Commission in different ways. This made it difficult to collate it and to make meaningful comparisons between insurers. By way of example:

- Some insurers count composite home and contents claims as a single claim, while other insurers record them as two separate claims.
- One insurer recorded claims which were accepted in part as declined claims. The other insurers recorded such claims as accepted claims.
- Insurers defined the dates on which claims were accepted and declined differently.
- Insurers defined the dates on which accepted claims were finalised differently.

Where statistics are presented in the report, the qualifications that apply to the data are explained in the text and in endnotes. The statistics must be read with the qualifications in mind. The statistics provide some indication of the performance of eight insurers but little more.

12.3.3 The body of evidence

The general information and data the Commission received from insurers and the information derived from examination of particular claims formed a body of evidence which was necessarily limited. The Commission has had to be wary about making broad findings based on an unrepresentative number of cases. It has, however, been able to draw some recommendations it considers useful from the evidence available to it, particularly from the experiences of the people who provided information to the Commission.

There were, in addition, some discrete issues of insurer performance which warranted close attention. Those issues are discussed in some detail in this chapter.

Before discussing any of these matters, however, it is necessary to set out some context.

12.4 The picture as a whole

12.4.1 The number of claims

Insurers received an exceptionally high volume of claims as a result of the 2010/2011 floods. The Insurance Council of Australia has reported that, as at 24 November 2011, 58 463 residential and commercial claims⁴⁸ were made as a result of the 2010/2011 floods.⁴⁹ Residential claims (excluding, it seems, contents claims) alone totalled 26 554.⁵⁰ Those figures did not include all insurers,⁵¹ but the Insurance Council estimated that its statistics represented 96.8 per cent of all residential and commercial claims made as a result of the 2010/2011 floods and also Cyclone Yasi.⁵²

The total household claims (which did include contents claims) of the eight insurers which provided data to the Commission added up to 23 210 claims. The number of household claims each insurer received is presented in Figure 12(a).

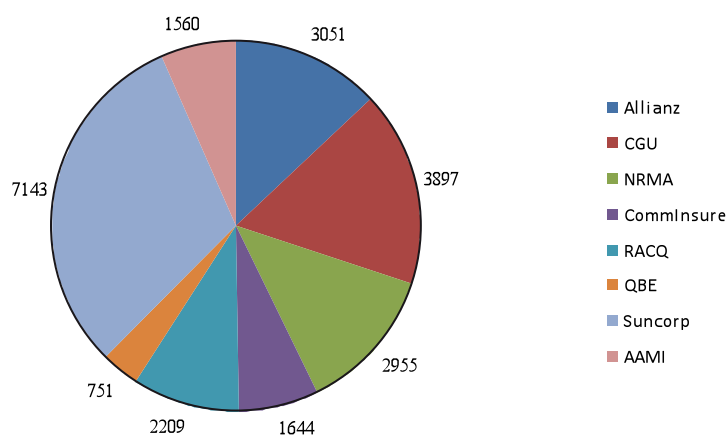


Figure 12(a): Total household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, across eight insurers (N=23 210)⁵³

These numbers do not, however, give the full picture. Firstly, the figures relate only to household claims. Other kinds of claims insurers had to process, such as business insurance claims and motor vehicle claims, are not included. RACQ Insurance only included in its data what it called 'inundation claims': claims for water damage resulting from a 'flood' or 'flash-flood or stormwater run-off' as defined in its policy. It did not include nearly 3000 claims which related only to storm and rain which occurred during the period of the floods.⁵⁴ That is, the insurer received over 5000 household claims from the 2010/2011 floods, more than double the number represented in Figure 12(a).⁵⁵

Insurers also had to deal with claims resulting from other events around the period of the 2010/2010 floods, including Cyclone Yasi. By way of example, as at 31 August 2011, RACQ Insurance had received a total of 11 836 household claims and 3980 motor vehicle claims from storms in Brisbane in mid-December 2010, the 2010/2011

floods and Cyclone Yasi.⁵⁶ The Insurance Council has reported that (as at 24 November 2011) 72 203 claims⁵⁷ resulted from Cyclone Yasi, of which 41 687 were residential claims. In addition:⁵⁸

- 7952 claims resulted from the floods in Victoria which occurred over the period 13 January 2011 to 18 January 2011
- 49 396 claims resulted from severe storms in Melbourne in early February 2011
- 410 claims resulted from bushfires in Perth in early February 2011.

The Commission accepts that the volume of claims made as a result of the 2010/2011 floods and other events in the period of, or soon after, the floods, put insurers under strain, and contributed to delays in the determination process (for details, see 12.5.1 *Determination of liability*).

12.4.2 Accepted versus declined claims

Figure 12(b) shows that, across the eight insurers which provided data to the Commission, the proportion of accepted claims (73 per cent) far exceeded the proportion of declined claims (27 per cent).

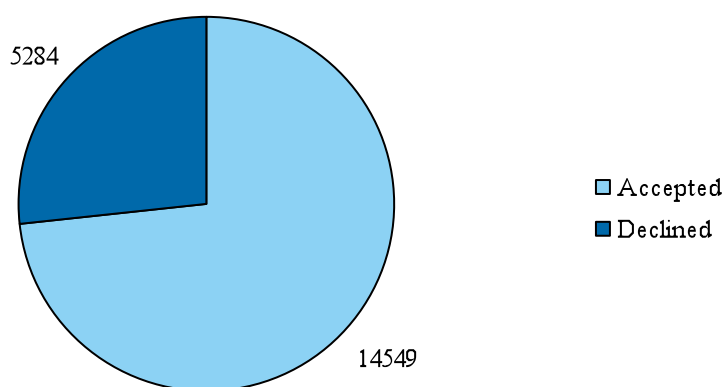


Figure 12(b): Total number of accepted and declined household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, across eight insurers (N=19 833)⁵⁹

The total claims accepted and declined by each insurer are shown in Figure 12(c).

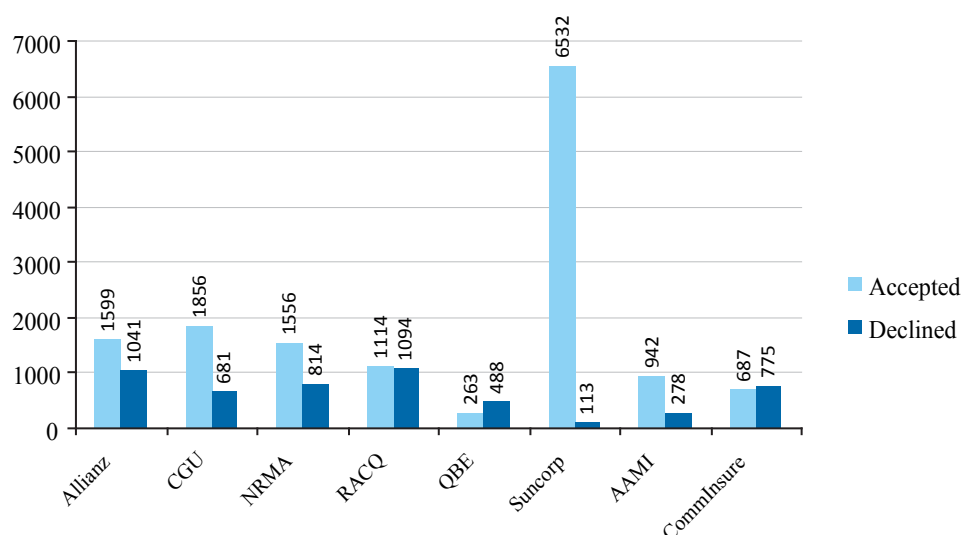


Figure 12(c): Total accepted and declined household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, across eight insurers (N=19 833)⁶⁰

Figure 12(d) shows the proportions of accepted claims and declined claims for each insurer.

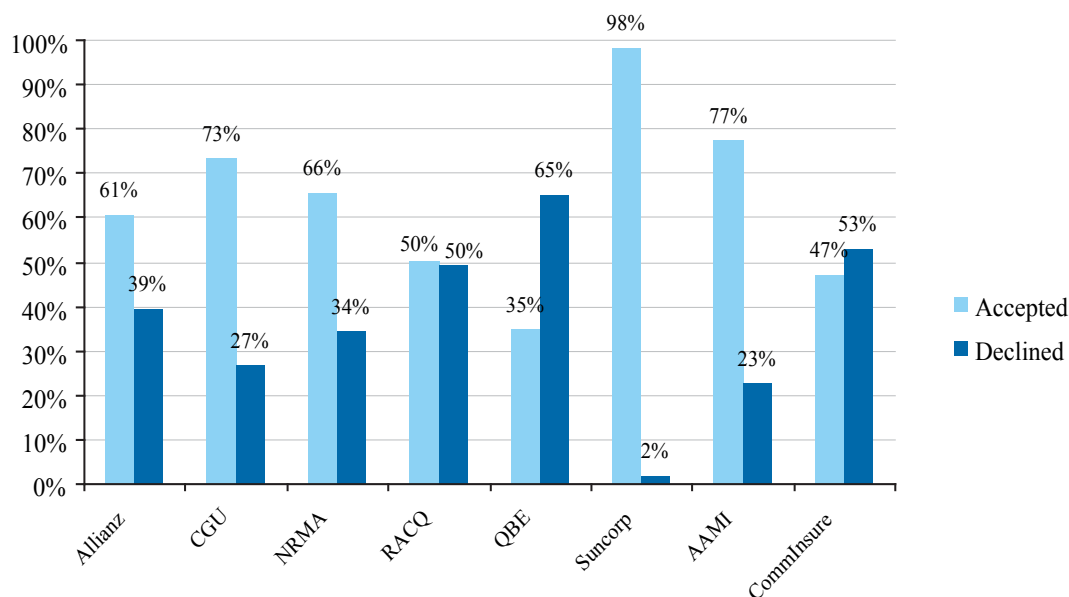


Figure 12(d): Total accepted and declined household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, displayed as a percentage proportion of the total claims decided by each insurer (N=19 833)⁶¹

The claims represented in figures 12(b), 12(c) and 12(d) were accepted and declined under the following terms (or other policy terms):

- In the case of four insurers – AAMI,⁶² Allianz,⁶³ CGU,⁶⁴ NRMA⁶⁵ – claims were accepted under terms providing cover for stormwater and declined under a flood exclusion.
- QBE provided cover for stormwater damage but some policies also covered ‘flash flood’ or ‘flood’. Accepted claims shown in figures 12(c) and 12(d) were accepted under those terms. Declined claims were generally declined on the basis of a flood exclusion.⁶⁶
- RACQ Insurance covered damage caused by ‘flash flood and/or stormwater run-off’⁶⁷ and excluded damage caused by ‘flood’.⁶⁸ Flood cover was offered as an option, however. So, where that option had been taken, claims were accepted under the flood cover; otherwise, they were accepted under cover for ‘flash flood and/or stormwater run-off’. The declined claims in figures 12(c) and 12(d) are claims declined under the flood exclusion.
- CommInsure also provided cover for ‘flash flood’⁶⁹ and excluded ‘flood’.⁷⁰ The claims represented in figures 12(c) and 12(d) were accepted and declined under those terms.
- Suncorp provided automatic flood cover. Suncorp claims account for 45 per cent of the total accepted claims in Figure 12(b). A very small proportion of claims were declined, as figures 12(c) and 12(d) show. Those claims were declined under an exclusion which applied if a policy was purchased within 72 hours of the event which caused the damage, or because there was no insured loss.

When Suncorp’s claims are removed from the total claims, the proportion of accepted claims (61 per cent) is still higher than the proportion of declined claims (39 per cent), as shown in Figure 12(e).

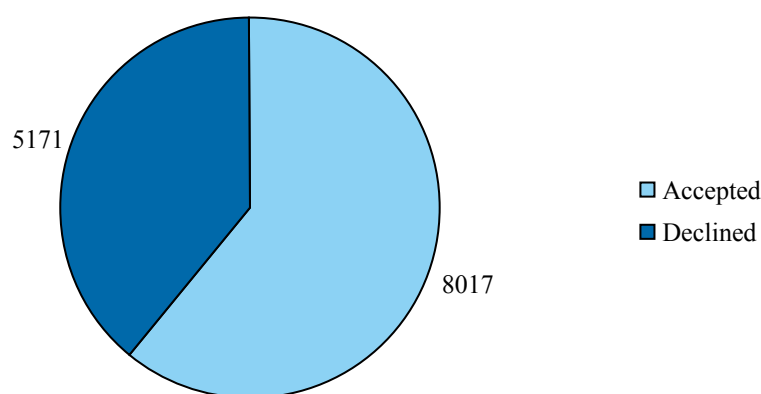


Figure 12(e): Total number of accepted and declined household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, across seven insurers (that is, excluding Suncorp) (N=13 188)⁷¹

The Commission received submissions both from people whose claims were accepted and from people whose claims were denied, although the majority of submissions were from individuals in the second category. Many of the policy-holders who provided information and gave evidence were, or had been, in dispute with their insurer. As the next section shows, however, on the whole, across the eight insurers, the proportion of claims the subject of dispute was relatively small.

12.4.3 Disputed claims

The Financial Ombudsman Service reported in a submission to the Natural Disaster Insurance Review that flood claims yielded a higher level of dispute at its level, because many policies excluded flood. Flood claims raise complex questions of causation which contribute to delays involved in deciding claims and give rise to questions as to whether policy-holders were clearly informed of the exclusion.⁷² On the same reasoning, it is likely that flood claims also led to more disputes than usual in insurers' internal dispute resolution processes.

Figure 12(f) shows the number and outcome of claims that went to internal dispute resolutions for each of the eight insurers from which the Commission received data.

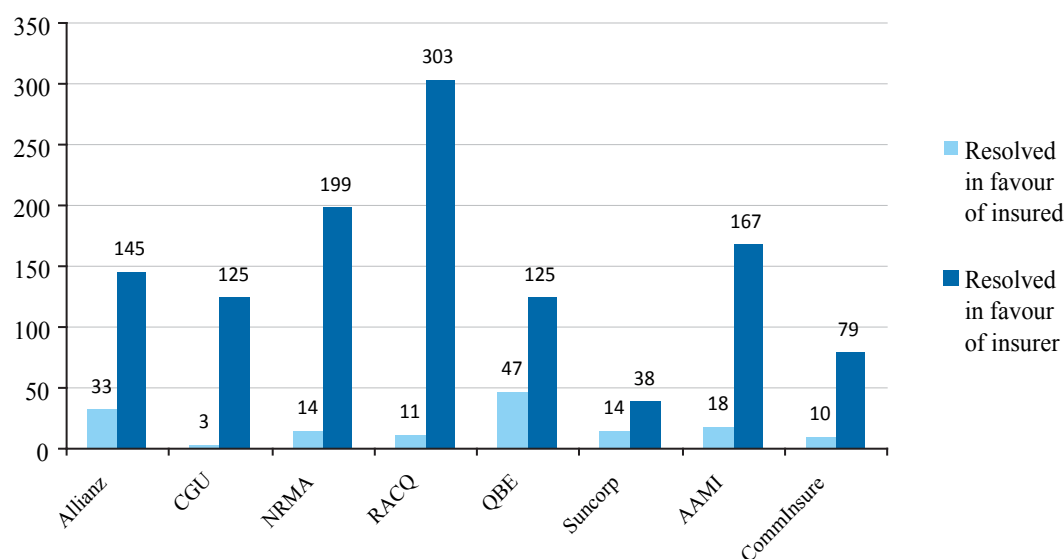


Figure 12(f): Number and outcome of claims reviewed in internal dispute resolution, as at 1 November 2011, across eight insurers (N=1331)⁷³

Across the eight insurers, the total number of claims which were the subject of dispute and referred to internal dispute resolution represents only a small proportion (7 per cent) of the total number of decided claims.⁷⁴ In other words, across those insurers, 93 per cent of insurers' decisions were not disputed (keeping in mind, though, that Suncorp did not have to determine whether stormwater damage or flood had occurred). Taking each insurer separately, the proportions of decided claims the subject of dispute were:

- AAMI – 15 per cent
- Allianz Australia Insurance Limited – 7 per cent
- CGU Insurance Limited – 5 per cent
- CommInsure – 6 per cent
- NRMA Insurance – 9 per cent
- QBE Insurance (Australia) Limited – 23 per cent
- RACQ Insurance Limited – 14 per cent
- Suncorp – 0.8 per cent.

The eight insurers also informed the Commission about the number of household cases which had been, or were, the subject of dispute before the Financial Ombudsman Service as at mid-December 2011:

- Eighty-five AAMI claims had been or were the subject of dispute. Seven cases apiece had been determined in favour of the policy-holder and insurer. Four cases were settled without the ombudsman's making a recommendation or determination (and two cases had been withdrawn).
- Forty-nine Allianz claims had been or were the subject of dispute, but 11 cases did not proceed to determination (eight of that group of cases were accepted by Allianz after the policy-holder registered a dispute with the ombudsman). Six disputes had been determined. The policy-holder was successful in two of the cases. The remaining cases were determined in Allianz's favour.
- Fifty-two CGU claims (45 household claims and 7 landlord claims) had been or were the subject of dispute. Thirteen cases had been determined, four in favour of the policy-holder, eight in favour of CGU and one partially in favour of both parties.
- CommInsure was or had been involved in 44 cases. Six had been determined: three apiece in favour of the insurer and policy-holder.
- Eighty-three NRMA claims were or had been the subject of dispute, 14 of which had been determined. Two of those cases were determined in favour of the policy-holder, 11 were determined in NRMA's favour and one was determined partially in favour of both parties.
- QBE had been or was involved in 59 disputes. Five had been determined in favour of the policy-holder, six had been determined in favour of QBE and five were settled before any determination.
- One hundred and forty-three RACQ Insurance claims were or had been the subject of dispute. Five cases had been determined in favour of the policy-holder and six in favour of RACQ Insurance. Thirty-three cases had been withdrawn, the majority of which were resolved by agreement between the policy-holder and insurer.
- Suncorp was or had been involved in 40 disputes. Two disputes had been finalised in the policy-holder's favour, five in Suncorp's favour and 10 were resolved by conciliation or agreement before the ombudsman made a recommendation or determination.

Most of these disputes (other than those which involved Suncorp) were about the insurer's determination that flood was the effective cause of the damage to the policy-holder's property. In cases where policy-holders were successful (in full or part), it was because the ombudsman had arrived at one of three conclusions: he had found that the insurer's evidence was inadequate, because it had not established that the flood exclusion applied; or that stormwater run-off had caused some damage before the property was inundated by floodwater; or that the insurer had failed to show it had clearly informed the policy-holder of the flood exclusion.⁷⁵

12.5 Timeliness

12.5.1 Determination of liability

One of the main criticisms directed at insurers in public discussion was that they took too long to decide claims. Many policy-holders expressed frustration and distress in complaints to the Commission, and also to the Natural Disaster Insurance Review,⁷⁶ about the time taken to determine their claims.

Insurers have an obligation to determine claims in a timely way. It is an aspect of their duty to act with utmost good faith.⁷⁷ The General Insurance Code of Practice imposes a 10-day time limit on insurers to determine claims:

- from the date the claim is received if the insurer has all necessary information when the claim is lodged and no further assessment or investigation is required⁷⁸
- otherwise – where further information or investigation is required – from the time the insurer receives all necessary information and all investigations are completed.⁷⁹

The timeframes can be extended by agreement between the insurer and policy-holder.⁸⁰ Insurers are not required to adhere to the time limits set in the code when dealing with a large number of claims following a natural disaster.⁸¹

There is no question that in a large number of cases insurers could not meet the 10-business day timeframe and that delays occurred. The Natural Disaster Insurance Review reported that insurers took, on average, 28 days to accept claims related to the flood in Brisbane, four times more than the average time taken to accept claims which resulted from Cyclone Yasi.⁸² One insurer which, on average, determines 'business as usual claims' in five business days, told the Commission that the average time it took to determine claims arising from the 2010/2011 floods was 35 business days. (Claims resulting from Cyclone Yasi were determined on average in 14 business days.⁸³)

Delays were more extensive in many other cases. The majority of claims which were the subject of a complaint to the Commission were determined in two to four months;⁸⁴ the longest period of delay was nearly five months.⁸⁵

The time taken to determine claims must be viewed, however, in the light of the investigations insurers (other than those which provided automatic flood cover) were required to undertake in order to decide whether to accept or decline claims (these investigations are considered in *12.7 Assessment process*). Those steps generally included appointment of a loss assessor to inspect and report on damaged properties and, where it was thought that flood had caused the damage, obtaining and considering hydrology information (for details see *12.7.1 Area hydrology reports*, *12.7.2 Site-specific hydrology reports* and *12.7.3 Loss assessors' reports*). Many claims were not determined until insurers had received and reviewed general hydrology reports. Hydrology reports commissioned by the Insurance Council of Australia, by way of example, did not become available until various dates in mid-February, March and late April 2011.⁸⁶ In some cases, on reviewing the available information, insurers considered that more information was required and instructed hydrologists to provide site-specific reports.⁸⁷ One insurer indicated that such advice was generally provided in six to eight weeks.⁸⁸ Another indicated it was in the order of eight to 12 weeks.⁸⁹ The investigations insurers undertook did result in delays, but were (generally speaking) necessary in order to properly determine coverage. Most of the claims the Commission examined were decided soon after hydrology reports were received.

Insurers said that a number of difficulties added to delays in the determination process, including:⁹⁰

- the high volume of claims arising from the floods, as well as other natural disasters which occurred within the relevant period of time (discussed in *12.4.1 The number of claims*)
- the complexity of some cases
- the difficulty of getting access to affected areas
- the limited availability of loss assessors and expert hydrologists
- the time taken to receive flood data and information from government agencies and councils. This point is discussed in the context of an examination of one insurer's re-assessment of a large number of claims (see *12.7.5 RACQ Insurance Limited*).

In light of these circumstances, it is not surprising that delays occurred.

The Commission sought data from the eight insurers as to the time taken to decide to accept and decline claims. The combined data of seven of the eight insurers is depicted in Figure 12(g).

AAMI's data could not be included because it provided data which reflected when claims were finalised, not when they were decided. Its data is represented separately in Figure 12(j) below. The omission of AAMI's data did not, however, substantially alter the results presented in Figure 12(g).

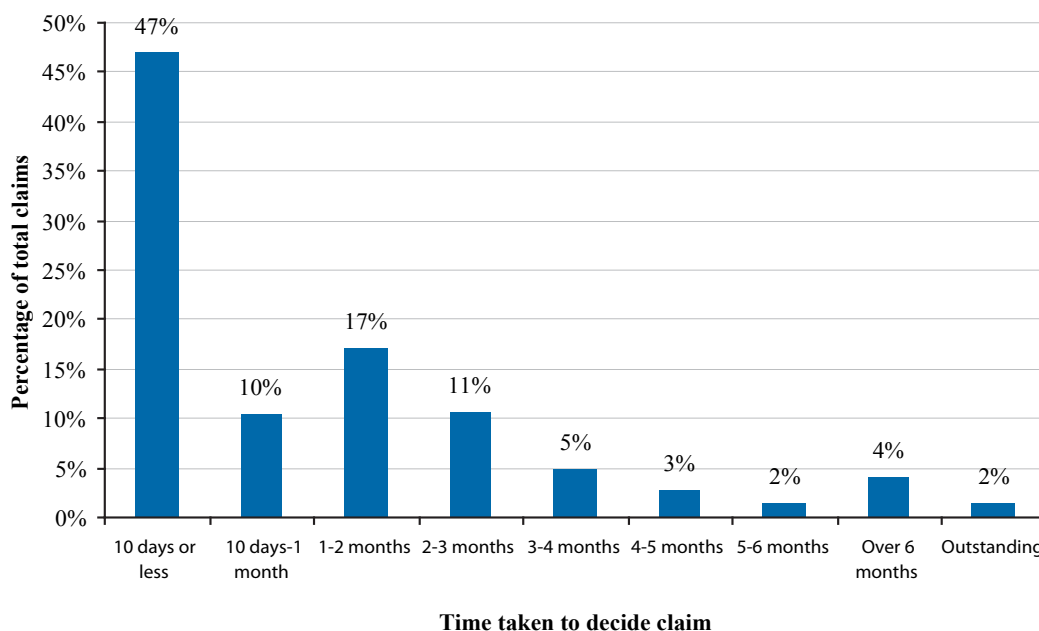


Figure 12(g): Time taken to decide household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, across seven insurers (that is, excluding AAMI), displayed as a percentage proportion of N (N=18 910)⁹¹

The results do not accord with the general impression created by media coverage and some public statements that insurers were slow to decide claims, at least not for the majority of cases. Figure 12(g) shows that across the seven insurers, more than half of claims were decided within one month. The largest proportion of claims – 47 per cent – was decided in 10 days or less.

The timeframes in Figure 12(g) are not definitive, however, because different insurers took different approaches to what constituted a ‘decision’ date. Five of the seven insurers – CGU, NRMA, CommInsure, Allianz and QBE – provided data indicating the time taken to determine liability and also communicate the decision to policy-holders. Generally policy-holders were informed of the decision on the same day it was made, or only a short time afterwards. One insurer (Allianz), however, said that the time between making a decision to decline a claim and notifying the policy-holder of the decision, could be as many as eight days. RACQ Insurance’s data did not encompass when decisions were communicated to policy-holders. It indicated when the general manager for Personal Insurance Claims made decisions about liability and conveyed those decisions to the claims officers. (The insurer said, however, decisions were generally communicated to policy-holders soon after they were made.)

Because Suncorp provided automatic flood cover, claims were accepted when they were lodged (unless the insurer suspected that an exclusion might apply).⁹² As a result, 98 per cent of Suncorp’s claims,⁹³ and all claims it accepted, were decided in 10 days or less. Suncorp’s claims explain the high proportion of claims decided within 10 days shown in Figure 12(g): they comprise a large majority (74 per cent) of that group of claims. Additionally, across the seven insurers, a very high proportion – 98 per cent – of the total claims decided within 10 days were accepted; and 91 per cent of the claims decided within one month were accepted.

The following figure, Figure 12(h), excludes Suncorp’s claims to show the data which relates to the six other insurers represented in Figure 12(g) which had to determine in each case whether ‘flood’ or ‘stormwater run-off’ or (in the case of two insurers) ‘flash flood’ had occurred. As discussed above, the information must be read in the light of the determination process insurers were required to undertake.

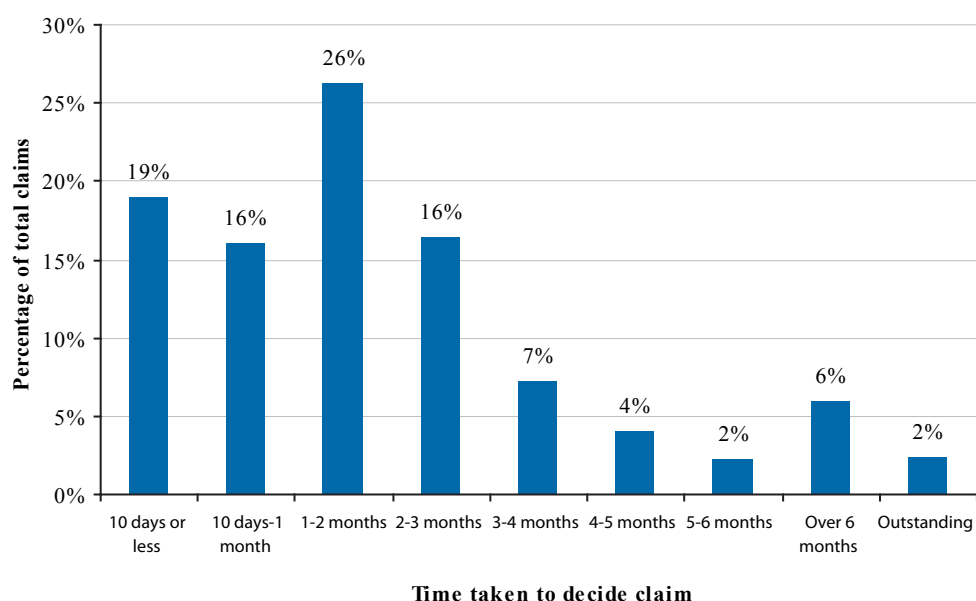


Figure 12(h): Time taken to decide household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, across six insurers (that is, excluding AAMI and Suncorp), displayed as a percentage proportion of N (N=12 265)⁹⁴

The proportion of claims determined within 10 days – and within one month – decreases when Suncorp’s data is removed. Still, over a third of claims were decided within one month and more than half (61 per cent) were decided in two months or less. Even without Suncorp’s claims, a large proportion of the claims decided within 10 days and within one month was accepted: 91 per cent and 79 per cent respectively.

NRMA Insurance contributes considerably to the number and proportion of claims accepted within 10 days (71 per cent) and one month (44 per cent) across the six insurers. Sixty-four per cent of NRMA claims were decided in 10 days or less.⁹⁵ Almost all of those claims (99 per cent) were accepted. This particular body of claims represents 96 per cent of NRMA’s total accepted claims (94 per cent of NRMA claims which were not decided within 10 days were declined).

Other insurers also accepted a large proportion of claims they decided within 10 days and within one month.⁹⁶ Across the six insurers, 48 per cent of the total accepted claims were decided within one month, as shown in Figure 12(i).

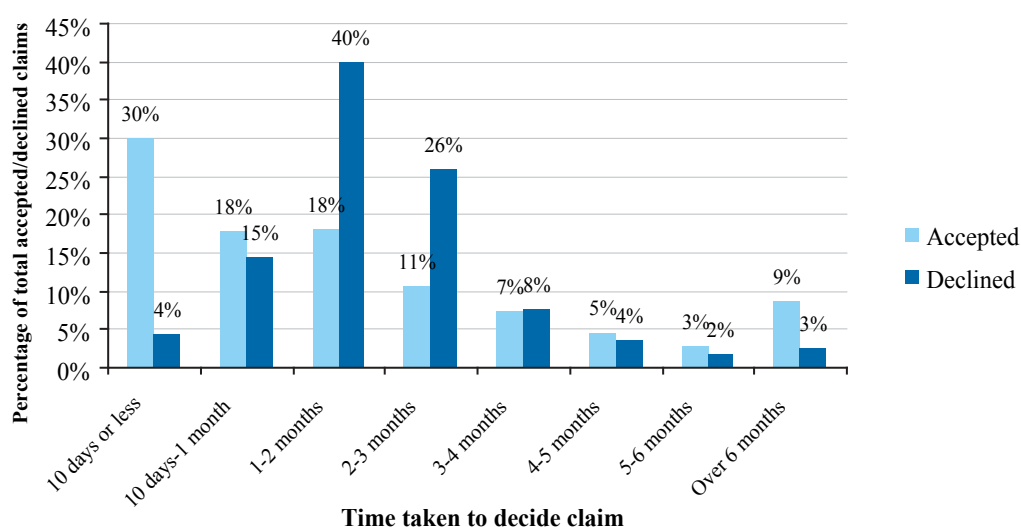


Figure 12(i): Time taken to decide accepted and declined household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, across six insurers (that is, excluding AAMI and Suncorp), displayed as a percentage proportion of total accepted (7075) or total declined (4893) claims for the six insurers (N=11 968)⁹⁷

The majority of accepted claims (66 per cent) were determined in two months or less, while the majority of declined claims (81 per cent) were determined in one to three months. This may suggest, broadly speaking, that it was easier to identify claims that would be accepted (hydrology information may not have been required or general hydrology information was sufficient). Where it was suspected flood had caused damage, claims were harder to determine, or were not decided until hydrology information had been received.

The Natural Disaster Insurance Review recommended the repeal of sections 4.3 and 4.4 of the General Insurance Code of Practice, which relieve insurers of the obligation to comply with standards in the code in times of natural disaster. It recommended the introduction of a four-month time limit, subject to exceptional circumstances, for insurers' determination of liability.⁹⁸ On 10 October 2011, the Insurance Council Board agreed in principle to amend the code in line with the review's recommendation. The amendments will also include timeframes for experts to provide reports to insurers.

In May 2011, about four months after the floods in January 2011, the Insurance Council said that its members had determined 97 per cent of claims resulting from the 2010/2011 floods and Cyclone Yasi.⁹⁹ Figure 12(h) shows that, across the six insurers represented in the figure, 84 per cent of claims were decided in four months or less. Taking each insurer separately, five of the six insurers decided a high proportion of claims within four months:

- NRMA Insurance decided 99.7 per cent of claims within four months (only five of 2371 claims were not decided within four months, and one claim was outstanding as at 1 November 2011).
- QBE decided 96 per cent of claims within four months.
- CommInsure decided 94 per cent of claims within four months.
- Allianz decided 90 per cent of claims within four months.
- RACQ Insurance decided 81 per cent of claims within four months.

The other insurer, CGU Insurance, decided 65 per cent of claims within four months.

The data AAMI provided to the Commission in December 2011 is represented in figures 12(j) and 12(k). The figures reflect when claims were closed, so the time taken from lodgement to finalisation of the claim. They cannot be compared with the data represented in Figure 12(g) or Figure 12(h).

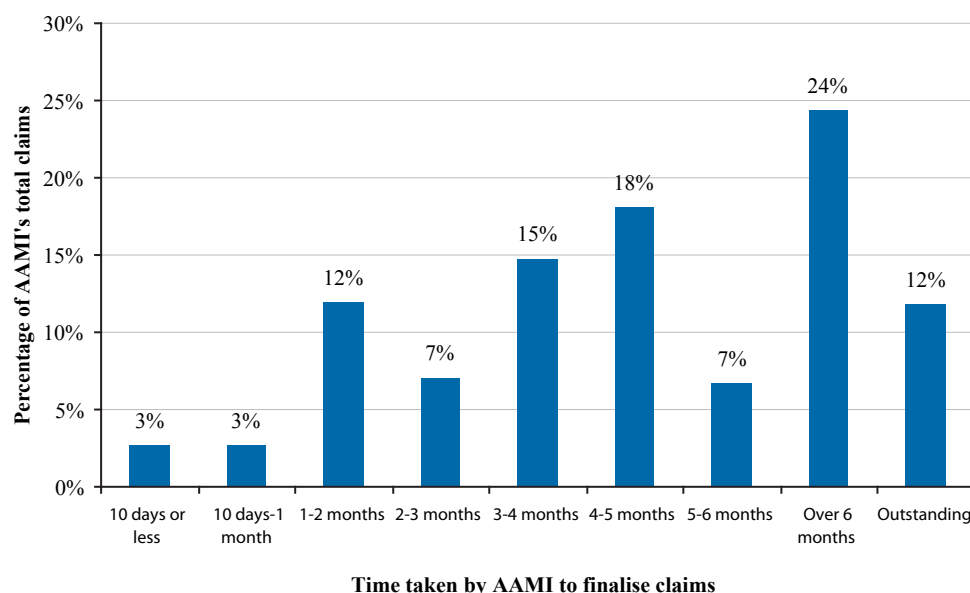


Figure 12(j): Time taken by AAMI to finalise household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, displayed as a percentage proportion of AAMI's total claims (N=1384)¹⁰⁰

Presumably the time taken to decline claims might still be reasonably (but approximately) reflected in AAMI's data: the time taken to finalise a declined claim, after the decision was made to deny it, would not be great. Accepted claims, on the other hand, could take some months to be finalised where losses need to be quantified and buildings

repaired. This may explain the proportion of claims finalised in over 6 months shown in Figure 12(j). A high proportion of those claims – 96 per cent – was accepted. This group of claims represented 34 per cent of AAMI's total accepted claims, as shown in Figure 12(k).

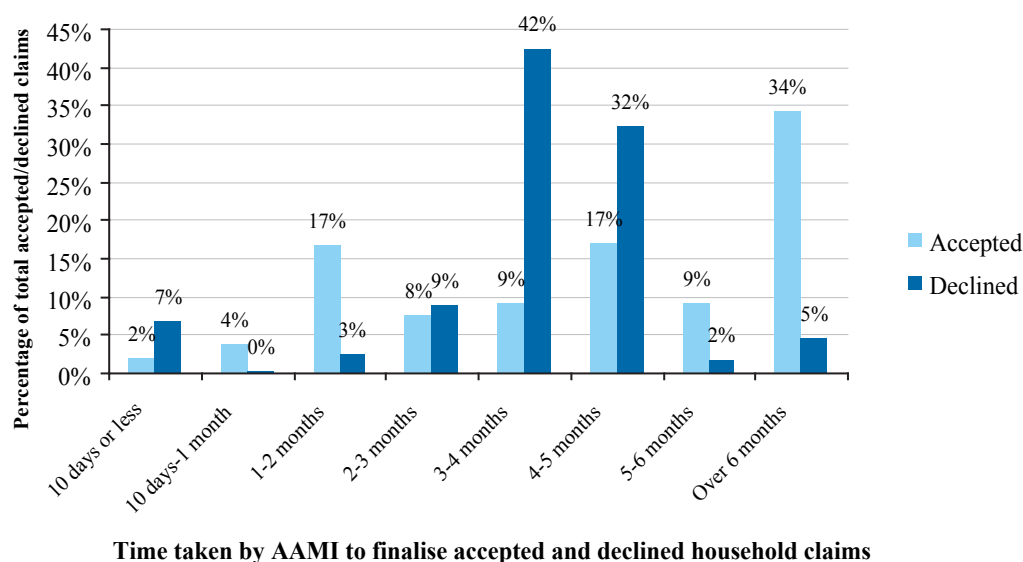


Figure 12(k): Time taken by AAMI to finalise accepted and declined household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, displayed as a percentage proportion of AAMI's total accepted (942) or total declined (278) claims (N=1220)¹⁰¹

The Commission did ask insurers to provide data as to the time taken to finalise claims.¹⁰² That data is presented in the next section (12.5.2 *Finalisation of accepted claims: settlement, replacement and repairs*). Again, AAMI's data could not be compared with that of other insurers because it included data which did not actually relate to finalised claims.

Delays in the determination process undoubtedly caused distress to policy-holders whose lives were significantly disrupted by the floods. The Commission supports the introduction of a time limit in the Code of Practice for the determination of claims arising from a natural disaster. In light of the evidence it received, the Commission considers a maximum of four months to decide flood claims, though lengthy, is reasonable in extraordinary circumstances such as those that prevailed in the wake of the 2010/2011 floods. Four months is, however, a long time for policy-holders to await decisions on their claims. It goes without saying that insurers should decide flood claims in a shorter period of time wherever possible.

12.5.2 Finalisation of accepted claims: settlement, replacement and repairs

In November 2011, the Insurance Council reported that 85 per cent of residential claims from the 2010/2011 floods had been 'closed', meaning that goods had been replaced, repairs completed or cash settlements made and the insurer considered the claim 'finalised'.¹⁰³ The repair process was underway in the remaining 15 per cent of cases.¹⁰⁴

In gathering the data, the Insurance Council asked insurers to separate their claims into 'open' and 'closed' categories.¹⁰⁵ The Commission sought similar data from eight insurers. The Commission asked for data relating to:

- the number of accepted claims which had been settled or finalised – excluding all partially paid claims
- the time taken for settlement or finalisation to occur, starting from the time the claim was lodged.

Suncorp and AAMI (both part of the Suncorp Group) provided data which indicated when the most recent payment had been made on a claim. This encompassed not only final payments but also progress payments or some other payment to a policy-holder or supplier. That is, those insurers included data which related to claims which

had not, in fact, been finalised. As a result, AAMI and Suncorp's data could not be compared with the data given by the six other insurers. It is represented separately in figures 12(l) and 12(m) respectively.

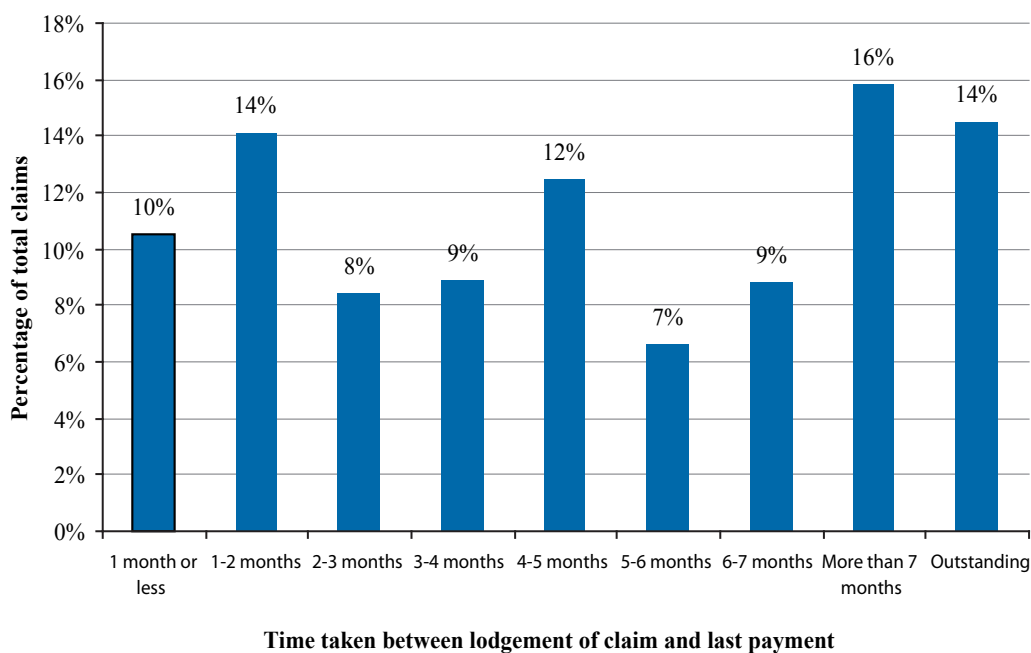


Figure 12(l): Time taken between lodgement of claim and last payment, as at 1 November 2011, displayed as a percentage proportion of AAMI's total accepted claims, excluding withdrawn claims (N=1106)¹⁰⁶

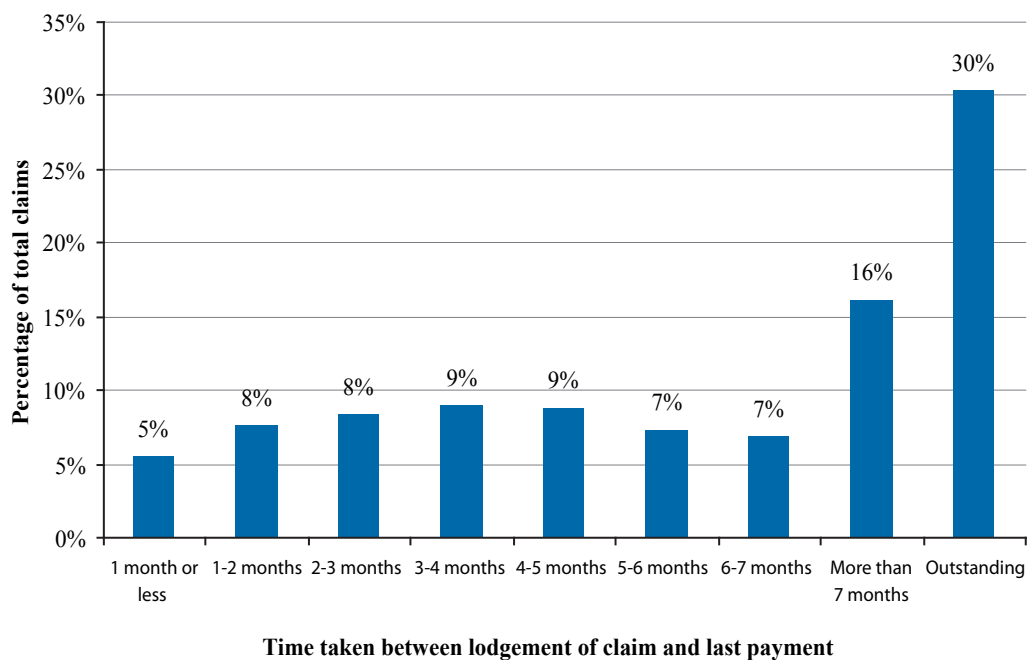


Figure 12(m): Time taken between lodgement of claim and last payment, as at 1 November 2011, displayed as a percentage proportion of Suncorp's total accepted claims, excluding withdrawn claims (N=6532)¹⁰⁷

The six other insurers took more logical and broadly similar approaches to what constituted ‘settlement’ or ‘finalisation’ of claims:

- Allianz used the date upon which all payments to the policy-holder, tradespeople and suppliers were complete.
- CGU and CommInsure used the date that all payments made on the claim were complete, including any administrative delays in processing payments.¹⁰⁸
- QBE, RACQ Insurance and NRMA Insurance provided data which represented when all payments had been made and the internal file was closed. RACQ indicated that administrative delays, such as processing invoices, were most likely around 16 days per claim. NRMA indicated that such delays could sometimes take up to 81 days.

The data of the six insurers was combined to produce Figure 12(n), but the differences in the data must be kept in mind. Figure 12(n) gives only a general impression of the time taken to finalise accepted claims across six insurers. It also encompasses both home building claims and home contents claims. Generally more was involved in finalising building claims, including appointment of an assessor to determine the scope of works, obtaining quotes, engaging builders (and perhaps engineers) and the building work.¹⁰⁹

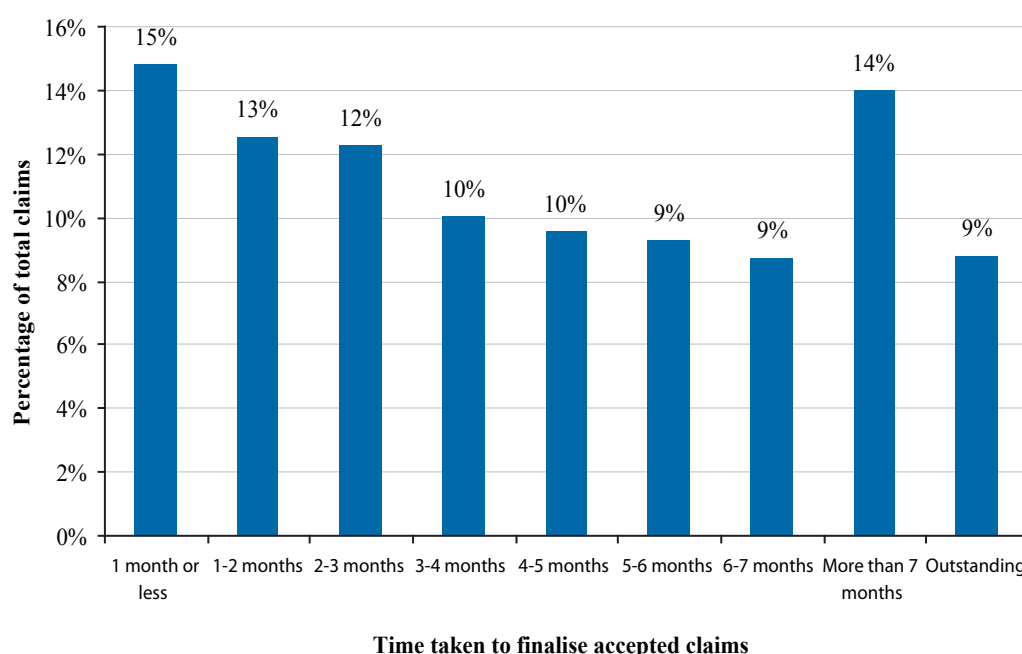


Figure 12(n): Time taken to finalise accepted household claims arising from the 2010/2011 Queensland floods, as at 1 November 2011, across six insurers (that is, excluding AAMI and Suncorp), displayed as a percentage proportion of N (N=7050)¹¹⁰

Figure 12(n) shows that, as at 1 November 2011, 91 per cent of household claims across the six insurers had been settled or finalised.

The Code of Practice does not prescribe any timeframe for the finalisation of claims.¹¹¹ The Natural Disaster Insurance Review did not consider it practical to impose a time limit on the finalisation of claims once accepted.¹¹² The Commission has not reached a different view. It did receive and examine a limited number of complaints about delays in the rebuilding process. The reasons for delay in those cases related, for the most part, to their particular circumstances; some matters were not within the insurer’s control.¹¹³ It is difficult to make general comment about those cases.

12.5.3 Timeliness of internal dispute resolution

Under the Code of Practice, insurers are required to respond to complaints (meaning an expression of dissatisfaction) and disputes (an unresolved complaint) within 15 business days.¹¹⁴ An insurer and policy-holder can agree on alternative timeframes, however, if further information or investigation is required;¹¹⁵ and in any case,

insurers do not have to meet these timeframes when dealing with a large number of claims arising from a natural disaster.¹¹⁶

If an insurer cannot resolve a complaint or dispute within 45 days, it must advise the policy-holder of the reasons for the delay and tell the policy-holder that he or she may take the grievance to the Financial Ombudsman Service.¹¹⁷ The Natural Disaster Insurance Review recommended changes to this part of the Code of Practice.¹¹⁸

The eight insurers provided data as to the time taken to complete reviews of disputed claims in the internal dispute resolution process. Figure 12(o) shows that, across the eight insurers, the highest proportion of disputes were finalised within the timeframe set in the Code of Practice. Seventy-eight per cent were completed in 45 days or less.

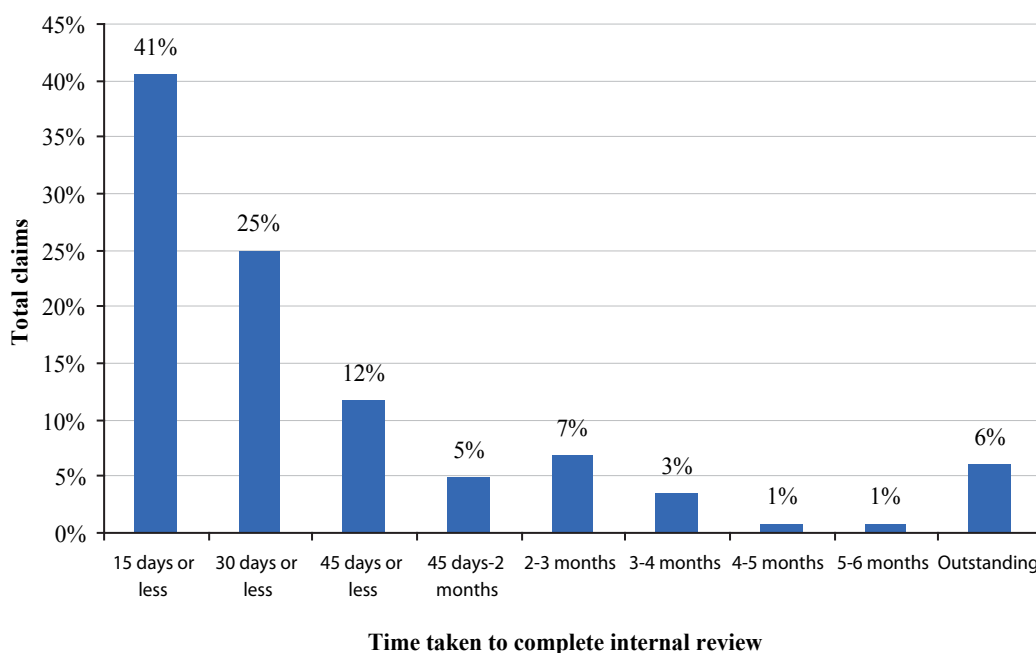


Figure 12(o): Time taken to complete internal reviews in the internal dispute resolution process, across eight insurers, as at 1 November 2011 and displayed as a proportion percentage of N (N=1402)¹¹⁹

In most of the cases which were the subject of a complaint to the Commission, internal reviews were completed in 15 business days or less.¹²⁰ Two matters took considerably longer (over three months). In one of those cases the policy-holder's claim was denied on 6 June 2011. On 15 June 2011, the policy-holder requested a review. That review was not completed until 20 September 2011, two days before the policy-holder gave evidence to the Commission.¹²¹

In the other case, the policy-holder indicated to the insurer an intention to dispute the insurer's decision to deny the claim. This notification did not, however, commence the internal review process. The policy-holder formally requested a review on 24 April 2011. The review was completed on 26 July 2011 but the policy-holder did not learn that the review was unsuccessful until three weeks later, because notification had been sent to the wrong address (this issue is discussed in *12.6 Communication with policy-holders*).¹²²

In each of these cases, the outcome – and time taken – depended on a site-specific hydrology report (for more information about the internal dispute resolution process, see *12.9 Internal dispute resolution*). The decisions were made soon after the reports were received.

There was also, in both cases, a lack of communication from the insurers during the course of the review process. This added to the policy-holders' frustration.

12.6 Communication with policy-holders

Submissions to the Commission raised a number of issues about communication. Complaints included the following:

- Insurers had dissuaded policy-holders from making claims.
- When they telephoned their insurers, policy-holders spent long periods of time on hold or could not get through.
- Insurers had not provided regular information about the progress of claims and had not returned policy-holders' phone calls.
- Insurers had told policy-holders, incorrectly, that their claims would be covered when they called to lodge claims.
- Insurers had not provided a single point of contact: policy-holders had to deal with different staff at different times.
- Insurers had, in some instances, treated policy-holders less than professionally or compassionately. Insensitive or inappropriate remarks had been made to some policy-holders.

The Commission did not, in its examination of a limited sample of cases, see evidence of an insurer's discouraging a policy-holder from making a claim. It was an issue reported to the Natural Disaster Insurance Review,¹²³ and the Insurance Council Board has resolved to amend the General Insurance Code of Practice so that, when a policy-holder calls about making a claim and asks if the policy provides cover, the insurer will specifically ask the policy-holder whether he or she would like to lodge a claim and explain that the claim will be fully assessed.¹²⁴

There was evidence of one instance of inappropriate communication which involved an insurer's chief executive officer. That issue is examined in detail in the section *Events concerning Sallyanne Doyle's claim*.

As to the other issues raised in submissions, lack of communication was a common complaint.¹²⁵ Some policy-holders said they did not receive regular updates on the progress of their claim and had to initiate most instances of contact with their insurers. In many cases the Commission examined, the evidence showed this to be true: the policy-holder contacted the insurer on more occasions than the converse. The Suncorp Group pointed out, however, that that did not necessarily indicate inadequate communication by the insurer. It said that comparing the number of times a policy-holder contacted an insurer with the number of times the insurer contacted the policy-holder was not a fair measure of the insurer's performance. The Commission agrees: the frequency and nature of the communications must also be taken into account, and often there were communications between policy-holders and loss assessors in the intervals between policy-holders' communications with the insurers.

The code requires that ordinarily insurers inform policy-holders of the progress of their claims at least every 20 business days.¹²⁶ It recognises that insurers may not be able to meet this standard when responding to large volumes of claims after a natural disaster.¹²⁷ After the 2010/2011 floods, one group of insurers notified the Financial Ombudsman Service it would not be able to do so and would instead update policy-holders every 40 business days (that is, every eight weeks).¹²⁸

The Commission accepts that, given the large numbers of claims and policy-holders with which insurers were dealing, it may have been difficult for insurers to provide regular updates to policy-holders.¹²⁹ It is also unsurprising – but still a source of frustration for policy-holders – that in the circumstances calls went unreturned and policy-holders spent long periods waiting on hold.¹³⁰

The evidence demonstrates, however, that policy-holders wanted frequent information about the progress of their claims (more frequent, perhaps, than the 20-business day period set in the code). This is understandable given the losses and disruption they had experienced and were experiencing, particularly in cases where they were not able to return to live in their homes. Regular communication is particularly important when claims take a long time to determine. As one policy-holder said:¹³¹

I think [communication] significantly affects one's perception of whether or not a process is timely. The reality is that sometimes things are going to take a long time, but you need to make sure people are kept in constant communication and... that they know they haven't been forgotten, especially in circumstances like these.

She suggested that regular updates (by way of email or text message, for example) would give policy-holders some comfort that their claim had not been forgotten.¹³² The Commission heard evidence from a policy-holder whose insurer sent him weekly text messages, which he found helpful.¹³³ Another insurer wrote to all its policy-holders in February 2011, explaining that it required hydrology reports to determine claims, which were not expected to become available until late February or early March 2011.¹³⁴ Keeping policy-holders informed on a regular basis goes some way towards reducing anxiety and dissatisfaction about delays in the determination process. The Financial Ombudsman Service has also noted that effective communication can reduce the level of disputes by policy-holders.¹³⁵

The effect of deleting section 4.3 of the Code of Practice – a recommendation of the Natural Disaster Insurance Review which the industry is adopting – is that the 20-business day timeframe for updating policy-holders will also apply to claims arising from a natural disaster.¹³⁶ This is a better situation than that which applied previously; that is, there was no ‘ceiling’ for intervals between updates. This is not to suggest that insurers should not consider more frequent updates where that is feasible. It was clear on the evidence received by the Commission that some policy-holders who had suffered serious losses would have drawn considerable reassurance from regular, perhaps weekly, provision of information. At the very least, however, insurers should put in place measures so that, in similar circumstances, they can give policy-holders updates every 20 business days.

The Commission also considers it would be beneficial for insurers to establish with policy-holders an agreed mode of contact. One insurer has recently introduced such a system.¹³⁷ The perils of not doing so were demonstrated in one case in which the policy-holder resided in Singapore. His preferred method of contact was email, but the insurer sent letters to his flood-damaged home in Brisbane and also tried to contact him by phone. As a result, the policy-holder did not receive important information until weeks after the event, causing confusion as to the status of the claim.¹³⁸

Recommendation

- 12.1 When a policy-holder makes a claim, the insurer should ascertain the policy-holder’s preferred method of contact and ensure that it is used (with other modes of communication if necessary) to keep the policy-holder informed about the progress of the claim. However, important decisions regarding the claim – for example, determinations about the outcome of the claim and settlement sums – should always be confirmed in writing.

12.6.1 Multiple case managers

Some policy-holders became frustrated by having to deal with different staff at different times,¹³⁹ rather than one person who had management of their claim. There are practical and sensible reasons why some insurers do not use single case managers.¹⁴⁰ Insurers should be aware, however, that processes using more than one person to manage a claim can cause confusion and some anxiety to some policy-holders. This could be reduced, perhaps, if insurers explained to policy-holders as clearly as possible that they will deal with multiple staff during the course of the claim, but that up-to-date information about the claim will be on their file and available to staff dealing with their claim.

12.6.2 File notes and recording calls

Processes that rely on multiple staff to deal with a policy-holder and his or her claim will inevitably fail if inaccurate or inadequate file notes are kept. The Commission saw examples of such file notes.¹⁴¹

Also, evidence in some cases revealed, unsurprisingly, discrepancies between the policy-holder’s recollection or impression of conversations and the insurer’s notes or recording of the same conversations. Two witnesses commented that versions of conversations recorded in the insurers’ file notes were not accurate or did not reflect the effect of the whole conversation.¹⁴² That evidence could not be tested, but it did point to the utility of insurers’ recording conversations with policy-holders. Where call recordings were available to the Commission, disputes about conversations were easily resolved.

Some insurers ordinarily record calls with policy-holders.¹⁴³ One insurer arranged for calls to be recorded for this particular event, because of the complexity of the claims and anticipation that a large number of disputes might occur. (It provided numerous recordings to the Commission.) The insurer said that taking that course had proved beneficial, to both the insurer and policy-holders.¹⁴⁴ Another insurer which did not record calls (because of technology limitations) said it believed – because of the number of disputed conversations – it would be prudent to do so in future.¹⁴⁵ A call recording would have assisted in one case where a policy-holder had alleged that when she made her claim, she was told that it was very likely that her claim would be covered. There was no recording or detailed note of the conversation. The investigation into the matter resulted in delay in the determination of the claim.¹⁴⁶

There are obvious benefits to recording calls with policy-holders, for both insurers and policy-holders, particularly where it is anticipated a high number of disputes may arise. The Commission understands, however, that there are significant costs associated with doing so; and it may not prove worthwhile or necessary in ordinary circumstances. The evidence the Commission received suggests that the recording of calls would be ideal, but such decisions are better left to insurers.

In the absence of call recordings, adequate and accurate file notes are especially necessary.

Recommendation

12.2 Insurers should review their existing systems and processes and implement any improvements necessary to ensure that accurate and complete records of conversations with policy-holders are made.

12.7 Assessment process

Insurers used a range of information to determine claims: information from policy-holders, aerial photography, flood maps showing the 2010/11 flood levels, loss assessors' reports, and hydrology reports. Some insurers also relied on legal advice as to whether claims were payable.¹⁴⁷ In cases where policies excluded flood but covered stormwater damage or flash flood, expert hydrology advice was usually required to determine which of these caused damage. Thus, in many cases, insurers regarded hydrology reports as essential in determining claims.¹⁴⁸

Insurers used two kinds of hydrology reports: reports covering broad areas or regions ('area hydrology reports') and reports relating to specific properties ('site-specific hydrology reports').¹⁴⁹ RACQ Insurance used what it described as 'hybrid reports': reports prepared on a regional basis but with regard to individual properties the subject of claims.¹⁵⁰ The process RACQ Insurance adopted to determine claims was distinct from the methods adopted by other insurers and is discussed separately in 12.7.5 *RACQ Insurance Limited*.

12.7.1 Area hydrology reports

The Insurance Council of Australia commissioned three hydrology firms to jointly prepare area hydrology reports for Toowoomba, Lockyer Valley, Brisbane, Ipswich and the Somerset region.¹⁵¹ AAMI, Allianz and QBE used these reports to determine claims.¹⁵² Other insurers – CGU and NRMA (both part of the Insurance Australia Group)¹⁵³ and CommInsure¹⁵⁴ – commissioned their own area hydrology reports.

These area-wide hydrology reports provided broad conclusions about the likely nature and causes of flooding on an area, rather than property-by-property, basis. They were based on desktop studies which generally did not involve any site-specific investigations.

Insurers relied on these hydrology reports (together with other information) in the majority of cases;¹⁵⁵ site-specific hydrology reports were obtained in particular cases when considered necessary.¹⁵⁶ For example:

- NRMA Insurance obtained site-specific hydrology reports for 160 claims,¹⁵⁷ out of 2371 claims it was required to decide (of which 1556 were accepted and 814 were declined).¹⁵⁸ It obtained another 38 site-specific reports at the internal review stage.
- CGU Insurance Limited commissioned site-specific hydrology reports in 126 cases,¹⁵⁹ out of 2821 cases (of which 1856 were accepted and 681 were declined).¹⁶⁰

- Site-specific investigations and assessments were carried out for 102 of CommInsure's claims,¹⁶¹ out of 1473 claims (of which 687 were accepted and 775 were declined).¹⁶²
- AAMI obtained 146 site-specific hydrology reports at the claims determination stage,¹⁶³ out of 1384 claims (of which 942 were accepted and 278 were declined).¹⁶⁴ Thirty-four site-specific reports were obtained at the internal review stage and 33 at the Financial Ombudsman Service stage.¹⁶⁵

Insurers said reliance on area hydrology reports was practical and necessary in the circumstances, given the shortage of hydrologists; delays would have been much greater had site-specific reports been sought in every case.¹⁶⁶ It was not logistically possible to obtain site-specific hydrology advice in every case before a determination was made.¹⁶⁷ The Insurance Council contended the use of area hydrology reports, in conjunction with other information, was appropriate in the circumstances.

The Commission accepts that, given the number of claims and the high demand for hydrological expertise in the period after the floods, reliance on area hydrology reports was a practical means by which insurers could inform themselves in a general way, and in a comparatively timely manner, as to cause of inundation in flooded areas. However, an important question is the extent to which the particular circumstances of individual claims were properly considered, and whether flooding could be properly identified as the cause of inundation at properties in respect of which no site-specific hydrology advice was obtained.

The Commission obtained advice on this issue from expert hydrologists it engaged, which can be distilled as follows.¹⁶⁸ It is not possible to say in the abstract whether insurers' reliance on an area hydrology report was appropriate. That judgment can only be made on a case-by-case basis, by reference to the nature and strength of evidence (contained in a hydrology report or otherwise) available in each matter on the following issues:

- a. whether the property was located well within an area of inundation, and
- b. whether local rainfall would have produced sufficient stormwater run-off to exceed the capacity of the local drainage system and cause the level of inundation experienced at the property.

Where, for instance, the evidence shows that a property was located well within an area of floodwater inundation and the local rainfall was unlikely to have been sufficient to exceed the capacity of the local drainage system,¹⁶⁹ flooding can reasonably be assigned as the cause of inundation. In cases where an insurer provides cover for 'flash flood',¹⁷⁰ the timing of the rainfall and inundation is also critical.

Area hydrology reports presented rainfall data which could have been used to determine the level of rainfall in the vicinity of a particular property (depending on its location). The reports generally did not, however, contain suitable aerial photography of flooded areas which would have indicated whether a property was located within an area of inundation. That question could also be determined by reference to flood mapping derived from aerial photography and/or from peak water levels and accurate terrain data or, alternatively, by comparison of a property's ground and floor levels with peak water levels in an adjacent waterway. The latter would typically require an inspection of the property.

The Insurance Council hydrology reports for Brisbane and Ipswich did contain flood extent mapping, but according to the advice the Commission received, that mapping, because of its scale and lack of resolution was often not adequate to ascertain whether a particular property was within an area of floodwater inundation.¹⁷¹ The report for Ipswich stated that the maps were indicative only and 'should not be used for assessing flooding behaviour at individual properties'.¹⁷² Some insurers used Near Map aerial photography or the Queensland Reconstruction Authority's interactive map, which was based on aerial flood photography and indicated the extent of the flooding, in assessing claims. Those sources were generally adequate to ascertain whether a property was located within an area of floodwater inundation.

Insurers said that hydrology reports were considered with other information, such as the policy-holder's account, reports by loss assessors who had inspected the damaged property and maps which indicated the extent of inundation.¹⁷³ (For information about loss assessors' reports, see section 12.7.3 below.) The approach of insurers was generally consistent: area hydrology reports were relied upon where the reports, when read with other information, provided sufficient information to reach a decision as to cause of inundation.¹⁷⁴ One insurer considered information – which usually comprised a policy-holder's account, loss assessor's report, the Reconstruction Authority's interactive map and an Insurance Council hydrology report – sufficient if it consistently pointed to a particular cause.¹⁷⁵ Another insurer relied on an area hydrology report in determining a claim if aerial photography, flood map and

the loss assessor's report indicated that flooding had occurred at the policy-holder's property.¹⁷⁶ It said that area hydrology reports were sufficient to determine reasonably quickly that claims in Toowoomba and the Lockyer Valley for damage resulting from stormwater run-off were covered; on the other hand, its area hydrology report for Emerald 'strongly indicated' that flooding (which its policies excluded from coverage) had occurred in that region.¹⁷⁷

In four of the cases the Commission examined (which related to properties in Brisbane and Ipswich), the insurer relied on an area hydrology report (its own or the Insurance Council's). In each case, the hydrology report was used in conjunction with other information, such as a loss assessor's report and the Reconstruction Authority's interactive map. (One insurer did not use flood extent mapping or aerial photography.) The Commission engaged independent hydrologists to review the evidence used in the four cases. In three of the cases, the evidence used was considered 'clearly adequate' to support the insurer's decision that flood had caused the damage.¹⁷⁸ The evidence in the fourth case was considered 'adequate'.¹⁷⁹

It is the Commission's view that generally it would not have been prudent to rely on an area hydrology report alone to reach a conclusion as to the likely cause of inundation at a particular property. As stated above, something more is usually required: whether that will be supporting information such as aerial photography, the policy-holder's account, flood extent mapping or site-specific hydrology (discussed below), will depend on the individual case. The Commission cannot point to any evidence that area hydrology reports were used other than appropriately. But nor does the Commission have sufficient evidence to say whether insurers sought adequate additional information, in particular site-specific hydrology advice, in all cases when they ought to have done so.

12.7.2 Site-specific hydrology reports

Whether a site-specific hydrology report should have been sought in a particular case depends on the strength of the information available in that case. The Commission received advice from the hydrologists it engaged that site-specific investigations should be carried out by a hydrologist in cases where it is not clear whether the property was located in an area of inundation and whether the amount of rainfall would have been likely to exceed the capacity of the local drainage system (and, where applicable, whether the timing of the rainfall corresponded with the relevant definition of 'flash flood'). It is advisable that the site-specific investigations include a site inspection.¹⁸⁰

It follows that in any given case the strength of the evidence needs to be assessed. Evidence received by the Commission indicates that decisions as to whether to obtain site-specific hydrology advice were taken by claims officers, with the exception of one insurer, whose decisions were made by the general manager on legal advice.¹⁸¹ Generally, prudence would dictate that someone with expertise in hydrology would make those decisions. In some cases, however, the assessment of whether site-specific investigation was needed could be undertaken by an individual with the ability to properly interpret aerial photography, flood extent mapping and rainfall data. The type of case envisaged here is where the information makes so obvious and certain the cause of inundation that it is clear that a conclusion can be reached without site-specific hydrology advice. Where, though, there is any doubt as to the cause of inundation, site-specific hydrology opinion should be sought.

Insurers explained that site-specific reports were obtained in particular cases where it was not possible – because of insufficient or inconsistent information – to make a decision on the area hydrology reports and other information available.¹⁸² One insurer said, by way of example, that if aerial photography did not show a continuation of water between the Brisbane River and a policy-holder's home, the area hydrology report would not be relied on and a site-specific hydrology report would be obtained. (That insurer obtained hydrology reports for specific properties or specific streets, as the case required.)¹⁸³ Another said site-specific hydrology reports were sought if an area hydrology report and loss assessor's report did not provide sufficient information to evaluate a policy-holder's assertion that stormwater runoff or drain backflow had contributed to the damage.¹⁸⁴ In a similar vein, another insurer said that it obtained site-specific reports if the information given by a policy-holder conflicted with the area hydrology report.¹⁸⁵

Site-specific hydrology reports were obtained to decide claims in a number of cases examined by the Commission.¹⁸⁶ In one case, the insurer commissioned a site-specific hydrology report because the Insurance Council hydrology reports did not cover the area in which the property was located (Narangba).¹⁸⁷ The same insurer obtained a site-specific hydrology report in another case because it considered the relevant Insurance Council report, on which it had intended to rely, did not enable the claim (relating to a property in Fernvale) to be decided.¹⁸⁸

Some insurers also obtained site-specific hydrology reports in cases where policy-holders disputed the insurer's determination.¹⁸⁹ This is discussed in more detail in *12.9 Internal dispute resolution*.

The independent hydrologists the Commission engaged reviewed the methodologies, approaches and assumptions used in eight site-specific reports¹⁹⁰ (and five hybrid reports used by RACQ Insurance, which assigned a cause of inundation to particular properties) and found no common problems.¹⁹¹ The methodology, approaches and assumptions used in those reports were generally considered sound.¹⁹² The reports were said to be based on a range of appropriate evidence,¹⁹³ and the conclusions reached in each of the site-specific reports – that flood was the cause of inundation – were said to be supported by strong evidence.¹⁹⁴

The Commission notes, however, that the Financial Ombudsman Service has identified as an issue that hydrology reports tended to focus upon peak inundation, rather than initial inundation; in other words, what the source of the water was when the flood was at its height at the affected building, rather than where the water came from when the building was first flooded.¹⁹⁵ The distinction was not the subject of any complaint to the Commission; but the point to be made is the same as for other questions about cause of inundation already discussed: it is important that expert opinion be directed to the causation questions the insurer is required to determine.

12.7.3 Loss assessors' reports

On the information available to the Commission, the determination of the majority of claims at least involved a site inspection and report by a loss assessor. Loss assessors gathered information about the circumstances of water damage at a property by interviewing the insured, and conducting site inspections, which usually included taking measurements and photographs. Some insurers used internal loss assessors; others used external loss assessing companies. The reports of loss assessors contained relevant factual information for determining cause of inundation.

Five of the seven insurers from which the Commission received information appointed loss assessors in virtually all cases.¹⁹⁶ Site inspections generally occurred early in the determination process.¹⁹⁷ Of these insurers, one conducted second site assessments in some cases (approximately 150) where more information was thought necessary (such as where policy-holders suggested stormwater damage had occurred).¹⁹⁸

Of the two insurers that did not appoint loss assessors in all cases, one insurer arranged site inspections in the majority of home building cases (79 per cent), but not in the remaining cases because it considered the information from the policy-holder and/or area hydrology report sufficient to reach a decision to accept or decline the claims.¹⁹⁹ The other insurer adopted a process which (initially at least) did not involve site inspections by loss assessors except in limited circumstances;²⁰⁰ distinguishing its claims determination process from those of the other insurers from which the Commission received information. That insurer's process was examined by the Commission in some detail and is discussed separately in section *12.7.4 CGU's desktop assessment process*.

Although it is the Commission's view that site inspections should generally form part of the process of determining cause of inundation (as discussed in *Comments on the desktop assessment process* in section 12.7.4), the proper role of loss assessors must be kept in mind: loss assessors, ordinarily, are not qualified in hydrology. Where determining the cause of inundation requires hydrological expertise, the opinions of loss assessors on the subject add nothing. Notwithstanding this, many of the loss assessors' reports viewed by the Commission expressed opinions as to the cause of water damage at a property (and also as to the insurer's liability for the claim).²⁰¹ Some insurers expressly instructed loss assessors to give those opinions.

Allianz, for example, instructed loss assessors to determine the likely cause of inundation at a property. Assessors' reports indicated whether, in the assessor's opinion, the damage was due to flood or stormwater. The insurer said, however, it considered the information in loss assessors' reports against area hydrology reports commissioned by the Insurance Council of Australia; it did not make final determinations on claims until it had reviewed the hydrology reports.²⁰² This was demonstrated in a case the Commission examined, in which the loss assessor reported his view that flooding of the Brisbane River and Oxley Creek was the principal cause of inundation of the property,²⁰³ but the insurer's decision to decline the claim was made some weeks later, after the Insurance Council's hydrology report for Brisbane was considered.²⁰⁴ This was one of the cases independent hydrologists reviewed for the Commission. The information used to determine the claim was considered 'clearly adequate'.²⁰⁵

AAMI indicated that site inspections by loss assessors 'were particularly focussed on determining the source of water damage'.²⁰⁶ Although loss assessors had no expertise in, and were not engaged to report on, hydrology matters,²⁰⁷ AAMI instructed loss assessors to 'provide a preliminary report as to the cause of inundation'.²⁰⁸ The

instructions were to ‘provide a preliminary opinion as to whether or not you believe the inundation may have been caused by flood as defined in the policy’ and to set out the factual evidence on which the preliminary opinion was based. But, like Allianz, AAMI said it considered loss assessors’ reports in the light of area hydrology reports.²⁰⁹ The Commission viewed three reports provided to AAMI which expressed the opinion that flood was the cause of inundation.²¹⁰ One report expressed a view that stormwater had caused the damage to the property and recommended that the insurer consider accepting the claim.²¹¹ Another report recommended that a hydrologist be appointed as the assessor was ‘unable to determine if floodwaters or overflowing road rains’ had caused the damage to the policy-holder’s property.²¹² In each case in which a loss assessor expressed a view as to the cause of inundation, the insurer did not decide the claim until it had received and considered hydrology reports. Two of the cases (in which the claims were declined) were among those independently reviewed for the Commission. In each case, the information was said to be ‘clearly adequate’ to support the insurer’s decision that the inundation had been caused by flooding.²¹³

CGU’s instructions to loss assessors stated that because of the difficulty in obtaining site-specific hydrology reports ‘within reasonable timeframes’, the insurer would ‘rely on’ the reports of loss assessors and ‘nearby hydrology reports’.²¹⁴ The expression ‘rely on’ is ambiguous: it might have meant that the insurer would act on information recorded in an assessor’s report or that it would adopt an assessor’s view as to the cause of inundation. The insurer explained that the role of loss assessors appointed by CGU was to gather information, including answers to a standard set of questions, to assist CGU staff to determine cause of damage and policy coverage and whether investigation by a hydrologist was required.²¹⁵ It acknowledged that ‘assessors were not suitably qualified and had no expertise in determining any hydrology issues’.²¹⁶

Notwithstanding, CGU gave loss assessors the following instructions:²¹⁷

If in your opinion, given the location of the property to a watercourse, you consider that the inundation was caused by flood then your report to CGU can contain the expression of your view to that effect. If however you are of the view that there may be storm water inundation, your report should NOT express that opinion. Your report should contain only factual statements. Your report should contain [the] insured’s account of what occurred and your factual observations. We do not want to be in a position whereby you have expressed a view in your report that the inundation was caused by storm water and then subsequently receive a hydrologists [sic] report expressing the opinion that the inundation was caused by flood.

The instruction is odd. On its face, it appears assessors were permitted to go beyond their role of reporting facts and give an opinion which pointed to the denial of a claim, but (unlike assessors appointed by Allianz and AAMI) were directed not to give an opinion which might have supported granting one. By way of explanation, the insurer said that an assessor’s opinion that inundation was caused by flood, given the proximity of a property to a watercourse, assisted CGU staff to make a determination about the claim, whereas an assessor’s opinion that stormwater had caused damage would not so assist.²¹⁸ That explanation is not compelling: assessors were not qualified to give either opinion, yet were invited to do so in respect of the type of opinion which would result in a denial of claim. The fact that a property was located near a watercourse was relevant to the determination of a claim, but the *opinion* of a loss assessor was not.

CGU said staff determined whether stormwater damage may have occurred by reference to answers to a set of standard questions (this is discussed in 12.7.4 *CGU’s desktop assessment process*), as reported in the assessor’s report, and other information such as area hydrology reports and aerial photography.²¹⁹ But, if claims were assessed fairly, the same process must have been applied to determine whether flood was the cause of damage: a loss assessor’s opinion should not have added anything to, or influenced, the determination of the claim.

The insurer’s justification lacks logic. If by it CGU was indicating that, in fact, an assessor’s *opinion* as to cause of inundation carried some weight in the determination of a claim, that is concerning. If the purpose of the instruction was not related to the assessment of claims, it must have related to management of customers, to which the instruction alludes.²²⁰ A report which stated damage had been caused by flood could be used to support a decision to deny a claim. But a report which stated stormwater had caused damage could create a difficulty with a customer if his or her claim were later denied: a difficulty which CGU seemingly preferred to avoid. From CGU’s perspective, the logic behind it is understandable, although unattractive. However, the real point is that the use of an assessor’s opinion as a reason to deny a claim would make the resulting decision dubious.

In one case examined by the Commission, it appeared that CGU might have placed undue reliance on an assessor's report. The insurer instructed the loss assessor to 'assess and report on [the] cause of damage'.²²¹ In the particular case, an issue was the extent to which sewerage problems reported by the policy-holder had contributed to the inundation. The insurer instructed the loss assessor: 'Need to ascertain if flood/storm damage or sewerage issues'. The loss assessor's report expressed a view on that question. It stated:²²²

At issue is whether the sewer backup was a distinct and separate event from the flooding, or whether it was an early manifestation of the flooding itself. This report favours the latter understanding and makes its recommendation accordingly.

It is unlikely that the loss assessor was qualified to make such an assessment. The report said the damage was the result of 'a flood event in which sewer backup preceded the inundation of water from the Brisbane River and Mt Ommaney Creek'. This view may have been based on information given by the policy-holder, which was recorded in the report. The report recommended that the claim not be accepted, as flood damage was excluded under the policy.

The claim was denied after the insurer received the assessor's report.²²³ The insurer told the Commission that the decision to deny the claim was based on other information as well: aerial photography, flood extent mapping and an area hydrology report, for example.²²⁴ However, the sequence of events and the explanation given to the policy-holder (by telephone and in writing) gives the impression that the insurer treated the report as determinative of the decision. When CGU advised the policy-holder of the decision, it informed her that CGU had received the report, which stated the cause of damage at her property was flooding, and flood was excluded under the policy.²²⁵ No reference was made to the other information on which the insurer said it relied. (It is possible, however, that this merely reflects a deficiency in the explanation given to the policy-holder, an issue discussed in *12.8 Information to policy-holders whose claims were denied*.)

The hydrologists the Commission engaged reviewed the assessor's report. In their view, the information contained in the report was 'barely sufficient' to support a conclusion that flooding caused the inundation.²²⁶ The most relevant information in the report was the level of inundation recorded and the observation (presumably by the policy-holder) that water which damaged the property had initially come from 'the toilets and drains, then, later from the Brisbane River... and Mt Ommaney Creek which overflowed'. In combination, those pieces of information indicated that flooding had caused the inundation; and the reviewers noted that no hydrological expertise would be required to conclude, given the observation that the water came from the river and creek, that the inundation resulted from the overflowing of watercourses. The expert hydrologists engaged by the Commission said that the conclusion in the report would have been greatly strengthened by one or more of the following:²²⁷

- comparison of peak flood levels in the Brisbane River adjacent to the property with reported inundation levels in the property
- analysis of local rainfall intensity
- analysis of relative timing of rainfall and inundation
- inspection of aerial flood photography.

Facts gathered and reported by a loss assessor are relevant to an insurer's determination, but loss assessors do not possess expertise in hydrology. In the Commission's view, any decision to deny a claim based solely on a loss assessor's opinion or advice that flood had caused the damage would be questionable. It is not a course which should generally be taken.

12.7.4 CGU's desktop assessment process

CGU established a special process for assessing Queensland flood claims, in order to deal with claims as quickly as possible. Referred to as a desktop assessment process (or 'desktop triage process'),²²⁸ it involved assessing claims in the first instance against aerial photography on the Near Map website and Google Maps, maps depicting inundation lines provided by the Insurance Council of Australia, area hydrology reports and policy-holders' responses to a standard set of 15 questions asked via telephone.

Once a policy-holder was taken through the set questions, the call taker assessed the claim. If he or she considered that the policy-holder's responses to the questions and the 'desk top data' (the maps and hydrology report) provided sufficient information to determine whether the claim was covered, the decision was made while the policy-holder

was still on the phone. If, in the claim officer's view, the information established 'conclusively' that flood had caused the damage to the policy-holder's property, the claim was denied and the policy-holder told that was the decision. If the information was not considered 'conclusive', further information, by way of a site assessment by a loss assessor (who also asked the policy-holder the set questions), was sought before a decision was made.²²⁹ Site-specific hydrology reports were also obtained in 126 cases.²³⁰ Approximately 340 claims (of nearly 3000)²³¹ were declined without any site assessment: that is, on the telephone, on the basis of the desk top data and responses to the set questions.²³²

CGU's assessment process evidently caused distress to some of its policy-holders. In February 2011, about 40 or 50 policy-holders protested outside CGU's offices.²³³ One of the group's main complaints was that the insurer had determined claims without carrying out any site inspections (this is discussed below in *Events concerning Sallyanne Doyle's claim*). The Commission examined CGU's assessment process in some detail. It heard evidence from three policy-holders. None of those policy-holders' claims, however, was declined on the telephone. The assessment of each case involved a site inspection. However, an examination of those cases – and one of the cases in particular, that of Ms Sallyanne Doyle, discussed below in *Site assessments* – gave some insight into how the desktop assessment process worked.

The Commission is also aware that the process has been the subject of inquiries by the Australian Securities and Investments Commission.

Standard set of questions

The desk top triage process was developed by a group of CGU's senior managers on or about 6 January 2011.²³⁴ The standard set of questions was developed on 5 January 2011.²³⁵ The questions were:²³⁶

1. What type of house is on the property – low set, highset, double storey, split level, etc?
2. Is the house on stumps or slab-on-ground?
3. Approximately how high is the habitable floor level above surrounding ground level?
4. Is the ground level at the house higher than the street level?
5. What date and time was the rain heaviest?
6. What time did the heavy rain stop?
7. When did the property get inundated (date)?
8. What time did the inundation of the property (yard) commence?
9. What time did water come into the house, garage, shed, etc?
10. What date and time did the water level in the property peak?
11. At its peak, how deep was the water inside the house, garage, shed, etc?
12. At its peak, how deep was the water in the yard?
13. [From w]hich direction did the water come into the property?
14. Was the water inundating the property 'clean' or 'dirty'?
15. Was there any and if so what damage caused by rainwater through the roof or by overflowing gutters?

Their purpose was to identify whether damage to a policy-holder's property had been caused by flood (excluded under household policies) or involved stormwater (covered by household policies) or whether further information was required. The questions were not designed to take policy-holders 'through everything that [had] occurred' at their properties.²³⁷

The Commission was told that the questions were developed in consultation with a hydrologist.²³⁸ CGU asked the hydrologist by telephone on 5 January 2011 to 'prepare a set of questions to assist CGU [claims officers] to identify the source of inundation to a customer's residential property'. The hydrologist proposed 14 questions by email later that day. CGU's technical manager added an extra question to those proposed by the hydrologist to form the set which was used by staff.²³⁹

The Commission sought the opinion of independent hydrologists as to the extent to which responses to the set of questions could be relied upon to ascertain whether damage at a property had been caused by flood or stormwater.

It received advice that responses to the set questions could be useful in providing a preliminary indication, but could not alone have been relied on to ascertain the cause of inundation.²⁴⁰

There is no evidence that CGU used a policy-holder's responses to the questions alone to determine a claim. It did not occur in the cases the Commission examined and CGU indicated to the Commission it did not occur in any case. The insurer said that in cases determined on the telephone (without a site inspection), decisions were based on responses to the set questions, aerial photography, flood mapping provided by the Insurance Council and area hydrology reports: this is reflected in instructions given to staff, as discussed in the next section, *Guidance to staff*.

It is not, however, evident on the material provided to the Commission that the policy-holders in those cases were asked all 15 questions. Responses to 12 questions are recorded in a set of file notes in one case;²⁴¹ fewer responses are recorded in the two other cases.²⁴² It may be that the policy-holders were asked 15 questions and the responses are not reflected, or were not recorded, in the notes (a topic discussed in *12.6.2 Files notes and recording calls*).

It is noted, however, that the Australian Securities and Investments Commission wrote to CGU in April 2011 notifying the insurer of concerns raised about its 'Desk Top Triage Process' which it understood 'involved asking up to five short questions of the policy holder and referring to a "Google map" or "[N]ear [M]ap" image... in order to decide a claim'.²⁴³ An internal record of a review CGU performed in February 2011 also refers to a 'belief from some customers' that they had only been asked five questions.²⁴⁴ This does not necessarily indicate that policy-holders were not asked all of the set questions: a letter CGU wrote to the Australian Securities and Investments Commission in June 2011 stated:²⁴⁵

Whilst the questions themselves did not change throughout the process, it became apparent relatively early during the events that, some of the responses to questions were often put as narrative rather than as specific responses to specific questions. Some customers also only recalled being asked a few questions when in fact CGU staff had covered all 15 questions during the initial discussion. CGU's procedures were accordingly changed so that our claims officers ensured that each question was made more explicit and distinct.

Guidance to staff

The triage process was carried out by a team of ten staff assembled specifically to deal with the flood claims.²⁴⁶ The team began operating on or about 20 January 2011²⁴⁷ and first used the triage process on or about 24 January 2011. Determinations of flood claims began to be made at this time.²⁴⁸ CGU described the process as 'robust',²⁴⁹ 'very thorough'²⁵⁰ and 'very accurate'.²⁵¹ Its national claims manager said assessments were based on 'reliable information' and the company was 'very confident' of the ability of its staff to make decisions without site assessments.²⁵² The expertise of, and guidance given to, staff was thus of some interest to the Commission.

The Commission was told it was a team of experienced staff (but was not informed of the experience the team had in dealing with flood claims) and that the team was trained in the triage process.²⁵³ The national claims manager indicated in oral evidence that the team was instructed to make use of the desktop data to determine whether 'an accurate decision' could be made, and to seek further information, typically by way of site assessment, if one could not be made. Guidance was given to staff by the team's manager and technical manager's 'walking [them] through' the desktop data. The set of questions also provided guidance.²⁵⁴

After the national claims manager gave evidence, the Commission sought details of the training staff received by requiring CGU to produce 'records of training' relevant to the process of assessing claims. CGU was also required to produce 'copies of any instructions, directions, or guidance' given to staff. Assuming all such documents were provided in response to the Requirement, there is nothing to add on the topic of training: nothing resembling training records was provided to the Commission.

It appears the team was not given much more in the way of instruction (written or otherwise) than that indicated by the national claims manager. Of the documents produced, a 'Queensland floods claims reference document' dated 17 January 2011 provided instructions on the allocation and processing of claims. It did not include any instructions as to how household claims were to be assessed. The only relevant instruction was: 'Do not allocate an assessor or builder. All potential flood [claims] needs [sic] to be allocated into the correct worklist... before we determine the appropriate assessment method'.²⁵⁵ Another document headed 'Validation process Brisbane and surrounding areas [sic]' emailed to members of the team on 24 January 2011, set out the following procedure:²⁵⁶

1. CMC to validate claim...
2. Review flood maps, Near maps and hydrology report

3. Call customer as per scripting
4. Confirm coverage and make decision on phone
5. Fill out spreadsheet
6. If claim denied, send denial...
7. Finalise file, If [customer] disputes, file can be re-opened
8. If [customer] calls back to dispute decision, reopen claim and refer to [the team manager].

The reference to 'scripting' presumably means the standard set of questions. This document, steps 2 to 4 in particular, confirms the process the team followed in assessing claims. The only other relevant instruction given to the team was advice (given on 25 January 2011) on when water rising from drains, and rainwater unable to enter full drains, constituted 'flood'.

Further instructions were given to staff following a review of the assessment process in mid-February 2011. The circumstances which led to the review and the instructions given to staff are discussed below (see *Events concerning Sallyanne Doyle's claim*). The three documents referred to above apparently represent the totality of the instructions, directions and guidance relevant to the assessment of claims given to staff before mid-February 2011. Given that the members of the team were required to 'confirm coverage and make [a] decision on [the] phone', the dearth of detailed written instructions is surprising. In particular, there is nothing in the instructions which gives any guidance as to the conclusions staff could draw from a policy-holder's responses to the set questions, how staff could apply the technical information contained in an area hydrology report to the information given by a policy-holder, or when staff could consider information 'conclusive' or make an 'accurate decision'. Nor do they contain any reference to the appointment of assessors for site assessments (discussed in the next section).²⁵⁷ It would appear that claims officers were to apply their own judgment with little written direction or guidance. The Commission is not in a position to say, however, whether the lack of written instructions and records of training had any bearing on the determination of claims.

Site assessments

The circumstances in which site inspections by loss assessors were offered to policy-holders or sought by CGU are also unclear. The company's chief executive officer, Mr Peter Harmer, indicated in a statutory declaration that an assessor would be appointed if a policy-holder disagreed with the outcome of the assessment made as a result of the triage process.²⁵⁸ He confirmed this in oral evidence, but also said site inspections were 'clearly offered' to policy-holders when a determination was made, whether policy-holders disagreed or not. This was a part of the 'scripts' staff used.²⁵⁹ He added that improvements were made, in February 2011, as to how that option was communicated to policy-holders. Mr Harmer qualified this aspect of his evidence by saying that it was something about which CGU's national claims manager was better placed to inform the Commission.²⁶⁰

The national claims manager said that site assessments were sought where the 'desktop data' was 'inconclusive' or where it was uncertain whether a claim would be covered (and also at the internal review stage if a site assessment had not been conducted).²⁶¹ If a policy-holder indicated damage might have been caused by stormwater, this 'introduced an element of doubt' and further information would be sought 'as a matter of course',²⁶² 'invariably' by way of a site assessment. However, he also emphasised that because of the limited availability of assessors, staff had to be selective in assigning assessors to claims.²⁶³

Neither the national claims manager's nor Mr Harmer's evidence is reflected in the instructions given to staff on 24 January 2011 or any other set of instructions: as discussed above, the instructions give no clue as to when staff were to assign an assessor to a claim. However, a document dated 16 February 2011, which recorded changes made as a result of feedback from policy-holders (detailed below),²⁶⁴ provides some indication of the circumstances in which assessors were appointed. It states that, as at 16 February 2011, site assessments for personal insurance claims were conducted only where there was 'insufficient evidence to support a decision' or where a policy-holder provided 'objective information' that suggested damage was not the result of flood. This supports the national claims manager's evidence as to when site assessments were offered.

A site assessment did occur in the case of each of the three policy-holders who gave evidence. There is no dispute that one policy-holder was, on 27 January 2011, advised that an assessor would be appointed in the phone call in which the set questions were asked. The evidence as to the appointment of assessors was, however, contentious in the cases of two policy-holders.

One of the policy-holders gave an account of a telephone conversation on 2 February 2011, during which she was asked the set questions. This was consistent with descriptions of the triage process.²⁶⁵ During that call, she said, she was told her claim was being denied.²⁶⁶ She ‘made a fuss’,²⁶⁷ and protested that a decision had been made without an assessor inspecting her property.²⁶⁸ The next day, she was advised an assessor would attend.²⁶⁹ (She produced handwritten notes which she said she made at the time to support her account.²⁷⁰) CGU disputed that account: its records indicated that the policy-holder was told during the conversation on 2 February 2011 that assessors would be appointed and told later that day that the assessors would be Crawford and Company.²⁷¹ However, the file note of the conversation also states, ‘advised [policy-holder] flood water, [policy-holder] was adamant not flood damage’. This suggests the policy-holder was told floodwater had caused damage to her property, and that she then argued the damage had not been caused by floodwater.

The state of the evidence does not allow this particular factual dispute to be resolved; nor is it considered necessary to do so. It should be added, however, that the policy-holder had asserted that water had flowed up through the sewerage system, which had occurred a number of times before,²⁷² and the insurer’s request for a site assessment stated: ‘Please assess and report on cause of damage as insured has stated that there have been issues over recent years with the council in regards to sewerage. Need to ascertain if flood/storm damage or sewerage issues’.²⁷³ (This aspect of the case is discussed in 12.7.3 *Loss assessors’ reports*.) This is consistent with the national claims manager’s evidence as to the circumstances in which site inspections were sought.

Ms Sallyanne Doyle was asked the set questions in a telephone call on 1 February 2011. After answering the questions, Ms Doyle was told that her claim would be declined because flooding from the Brisbane River had caused the damage to her West End property. Ms Doyle strongly disagreed with this assessment and argued with the claims officer, for about 30 minutes, that stormwater had caused damage to her property.²⁷⁴ On any view of CGU’s evidence as to its approach, these circumstances would have resulted in a site inspection being offered: either because she had disagreed with the insurer’s assessment or because she had raised the possibility that stormwater damage had occurred. However, an assessor was not appointed. The claims officer did, at the end of the conversation, invite Ms Doyle to get her tenant, who was present at the property at the relevant time (Ms Doyle was not), to provide information to CGU.²⁷⁵

The national claims manager explained that, as he understood it, the claims officer did not assign an assessor to the claim, because, in this particular case, she needed an ‘additional degree of confidence’ that it was appropriate to do so.²⁷⁶ The difference in this case, he said, was that Ms Doyle was not providing a firsthand account.²⁷⁷

However, the note of the conversation contained in the CGU’s records conveys something different. It states:²⁷⁸

[Policy-holder] is adamant that water run off went through the property prior to the flood waters.
 [Policy-holder] confirmed the drains rose, I confirmed this is flood from river.
 [Policy-holder] then advised no the water ran down street and into her home.
 [Policy-holder] talked for about 30 minutes about how the water entered.
 Explained that this is consistent with flood as advised by the hydrologist etc. [Policy-holder] did not agree and would not accept it.
 [E]ventually as conversation was not adding value to the claim: asked if I could speak with tenant also to gather further information. [Policy-holder] agreed she will have real estate contact me with tenant details.

This note appears to be consistent with Ms Doyle’s evidence, that the claims officer said the tenant could provide information merely as a means of bringing to an end a ‘long’ and ‘tortuous’ conversation, as a result of which both Ms Doyle and the claims officer were exhausted.²⁷⁹ The Commission does not, however, have evidence from the claims officer. After the conversation, the claims officer sent an email to Ms Doyle’s broker (which was not passed on to Ms Doyle), which said:²⁸⁰

We have discussed the claim with the insured Sally. While the information considered indicates the property has suffered damage as a result of flood the insured is of the opinion that storm water caused damage to the property prior to the flood. CGU will be considering this claim further and await contact details for the tenant to gather more information surrounding the circumstances of the event.

Ms Doyle explained that she did not take any steps to put her tenant in contact with claims officer, because she felt so discouraged after the call on 1 February 2011. She believed the claim had been denied and did not think that information from the tenant would make any difference.²⁸¹

Ms Doyle did, however, call back the following day and, in another lengthy conversation with the claims officer, repeated her view that stormwater had caused damage to her property.²⁸² There was no discussion about the appointment of an assessor. Ms Doyle did not recall any further discussion about getting information from the tenant.²⁸³ The claims officer made a note of the conversation. It concludes: 'She [Ms Doyle] will get property manager to email me regarding the gathering of further info. [P]ossibly need to appoint an assessor, await further info.'²⁸⁴ The second sentence is a note to the team manager, not a record of something said to Ms Doyle during the conversation. This is the first time appointment of an assessor was raised as a possibility. It is unclear if the first sentence is also an internal note or reflects part of the conversation.²⁸⁵

The records show that on 5 February 2011, the claims officer 'recommended' the appointment of an assessor, after the insurer received a written complaint from Ms Doyle, via her broker (which was also sent to state and federal politicians and journalists).²⁸⁶ The claim was referred to the team manager, who, according to a note dated 8 February 2011, considered whether an assessor should be appointed. The note also states that CGU was waiting for Ms Doyle to 'forward further information'. The information was not provided, but the team manager approved the appointment of an assessor on the morning of 10 February 2011. An external assessor was initially appointed and an email to that effect was sent to Ms Doyle's broker that morning,²⁸⁷ but later that day, the decision was made to assign an internal assessor instead because of concerns about delays the external assessor was experiencing.

Prior to the email on 10 February 2011, no indication had been given to Ms Doyle or her broker that an assessor might be appointed. Ms Doyle's broker (who apparently had not seen the email) contacted CGU on the afternoon of 10 February 2011 and was informed the claim had not been denied and an assessor had been appointed. The broker advised Ms Doyle that CGU was continuing to 'review the claim' but did not mention the appointment of an assessor.²⁸⁸ Ms Doyle did not read an email sent by CGU on 10 February 2011 advising her of the decision to appoint the assessor.²⁸⁹ It was on 11 February 2011, when another CGU staff member contacted her to schedule the inspection, that she first learned that an assessor had been appointed.²⁹⁰

These circumstances suggest that the decisions (on 1 February 2011) to receive further information from Ms Doyle's tenant and then (on 10 February 2011) to appoint an assessor, were related to Ms Doyle's persistence (perhaps intransigence) rather than her suggestion that damage had been caused by stormwater. The national claims manager's evidence as to when site inspections occurred is not reflected in the circumstances of this case, although it was more generally borne out.

Mr Harmer's account as to when site inspections were offered was similarly inconsistent with what happened in Ms Doyle's case. His evidence on this topic does correspond with a letter from CGU's General Counsel to the Australian Securities and Investments Commission, dated 13 May 2011;²⁹¹ but is not reflected in any other evidence. The letter indicates that site assessments were sought if 'coverage was unclear or where the customer disagreed with the outcome of the desk top assessment'. A subsequent letter to ASIC, however, dated 30 June 2011 (which responded to a request for further information), states that until 'CGU reviewed its position on or around [22 February 2011]²⁹²... a site assessment option was not conveyed to customers where a clear decision had been made to decline cover on the basis of a flood exclusion... Site assessments were still always conducted where there was doubt about the cause of the loss (e.g. uncertainty about whether the loss was caused by stormwater or flood)'.²⁹³ The author of the letters confirmed in a statutory declaration that site assessments were not 'explicitly offered' to policy-holders where CGU considered flood 'to be the cause of the loss, up until [a] change in communicating the claims process was made on 22 February 2011'.²⁹⁴ This contradicts Mr Harmer's evidence. It is consistent with the document which recorded the changes made after a review of CGU's processes on or about 16 February 2011.

That review, which led to changes to CGU's processes, occurred as a result of a meeting between Ms Doyle and CGU's chief executive officer (Mr Harmer), corporate affairs manager and general manager of claims on 14 February 2011. For that reason, Ms Doyle's claim warrants further attention. There is an additional reason for focussing on Ms Doyle's case: the professional conduct of the insurer's chief executive officer was called into question as a result of an incident between Ms Doyle and Mr Harmer on 22 February 2011; an issue relevant to the insurer's performance which required examination.

Events concerning Sallyanne Doyle's claim

14 February 2011 meeting

On 11 February 2011, Ms Doyle received a call from CGU's corporate affairs manager about an article published in *The Courier-Mail* on 10 February 2011.²⁹⁵ The article reported that Ms Doyle was organising a demonstration outside CGU's Brisbane office on 18 February 2011.²⁹⁶ The corporate affairs manager requested that Ms Doyle meet her and the general manager of claims; Ms Doyle agreed. The meeting took place at Ms Doyle's property at West End on 14 February 2011. Mr Harmer was in Brisbane that day and also attended the meeting. He was aware of *The Courier-Mail* article and wanted to understand Ms Doyle's concerns.²⁹⁷

Most of the communication at the meeting was between Mr Harmer and Ms Doyle. Their respective accounts of the meeting did not differ greatly. Both agreed the meeting was amiable.²⁹⁸ Ms Doyle expressed her concerns about CGU's assessment process and felt optimistic after the meeting that improvements might be made.²⁹⁹

Process changes

The meeting led to a review of CGU's processes.³⁰⁰ Mr Harmer said the point he gathered from the meeting was that Ms Doyle had not heard or had not understood that a site assessment was available to her, or the option had not been communicated to her effectively.³⁰¹ He suggested that Ms Doyle had not appreciated that she had the option of a site assessment; she had not fully 'absorbed' the information which had been given to her.³⁰² This evidence was curious: as set out above, the option of a site inspection was not communicated to Ms Doyle at all before 10 February 2011; and she was aware from 11 February 2011 that an assessor had been appointed (so there can be no question that she understood on 14 February 2011). At no stage before 11 February 2011 had Ms Doyle not heard or failed to understand that a site inspection was available to her: it simply was not offered to her. It is difficult to believe that Mr Harmer did not appreciate this. In light of the facts, his evidence does not make sense.

In any case, the issue, as far as Mr Harmer was concerned – at least as he explained it to the Commission – related to communication: the availability of site assessments had not been clearly communicated. As a result, 'the way in which [the insurer] communicated [the] claims assessment process' to policy-holders was reviewed.³⁰³ Mr Harmer asked that 'the scripts' be rewritten and training be conducted to ensure that staff offered a site assessment if a customer 'was in any way dissatisfied with the determination'.³⁰⁴ However, the national claims manager said that, in fact, the changes made as a result of the meeting with Ms Doyle did not involve amendment of any script. Rather, changes were made to the process. One of the changes was to ensure that customers understood that a site assessment was available if they had any 'grievance with the process' or saw 'merit in a site assessment'.³⁰⁵

The document which records the 'process changes' made as a result of a 'process review' on 16 February 2011 indicates that changes were made extending the circumstances in which site assessments were to be conducted.³⁰⁶ Site assessments would occur for all claims which were yet to be determined. An internal email dated 17 February 2011 confirms that 'after the recent media attention', site assessments would be conducted for remaining flood claims (of which there were about 150 personal claims in Brisbane and Ipswich).³⁰⁷ Site assessments would also occur for all 'disputed/escalated claims', that is, those the subject of a complaint or dispute, and where a customer asserted damage was the result of stormwater run-off or water rising from stormwater drains.³⁰⁸

This indicates that more was involved than changes to communication: the process changes related principally to the availability of site assessments themselves, with necessary changes to what was communicated to policy-holders. They were not merely changes to how an existing option was communicated, as Mr Harmer indicated in evidence and in a media statement made on 22 February 2011, in which he stated that the company had 'reviewed and made changes to how we communicate our claims assessment processes to customers'. He also said he wished to make it clear that site assessments were available 'to all customers should they want one'.

Changes to what staff told customers about site assessments would have followed necessarily from an extension of the circumstances in which site assessments were to occur. Precisely what staff were to tell customers after 16 February 2011 is not known. The document dated 16 February 2011 indicates that staff were to be given 'updated scripting'; but if a script was updated, it has not been provided to the Commission.³⁰⁹ There are no written instructions which reveal what staff were to say to customers about site assessments (or at least none have been provided in response to a Requirement to produce copies of instructions, directions or guidance relevant to the changes made in February 2011). Nor are there any records of training given to staff (which were also specifically sought by the Commission). The national claims manager indicated in oral evidence that the process changes and

Mr Harmer's media statement were explained to the flood team.³¹⁰ Other than that, there is no evidence of the details of the training to which Mr Harmer referred.

22 February 2011 telephone conversation

Mr Harmer's media statement was made in response to the demonstration led by Ms Doyle outside CGU's offices on 18 February 2011. After the demonstration, a meeting, which had been arranged on 14 February 2011, was held between Ms Doyle and other policy-holders (and a lawyer from Legal Aid Queensland) and the corporate affairs manager, general manager of claims and other CGU executives. Mr Harmer was unable to attend. The group of policy-holders made a number of requests at the meeting. Ms Doyle indicated there were three: that site assessments occur as a matter of course in all cases of major loss; that 'there be some recognition' that CGU's assessment process was 'inadequate' and compensation for mismanagement of claims; and that CGU give financial assistance to customers whose claims had been denied under the flood exclusion.³¹¹ Mr Harmer referred to additional demands, that CGU acknowledge that its assessment process was 'illegal' and issue a public apology for it.³¹² The CGU representatives agreed to provide a response by 23 February 2011. Mr Harmer communicated the response to Ms Doyle by telephone on 22 February 2011, at about 3.00 pm. What transpired during this call was the subject of contention.

Ms Doyle was at work when she received the call from Mr Harmer. He informed her that a media statement would be published that afternoon and he wanted to 'walk her through it'. Ms Doyle took notes (which she no longer has) as he did so. She said Mr Harmer discussed each request in turn.³¹³ He explained that CGU would continue to use the triage process and a customer could ask for a site assessment if he or she wanted one. He said the company would not make ex-gratia payments or pay compensation for inadequate assessment processes because he did not accept the processes were inadequate.³¹⁴ Ms Doyle said words to the effect of: 'So that's no to everything we asked for'.³¹⁵ At this point, Ms Doyle said, the tone and content of the conversation changed. Mr Harmer said, in a 'deliberate voice': 'I have copies of tapes of conversations between you and CGU. I have listened to those tapes and I know you misled the media.' This took Ms Doyle by surprise; she asked: 'What?' Mr Harmer repeated: 'I have tapes of conversations between you and CGU. I've listened to those tapes and I know you misled the media about the reasons for you being provided an assessor visit.' Ms Doyle said: 'Well, I suppose it is open season on CGU now', to which Mr Harmer replied: 'Well, you do what you need to do,' and the conversation ended.³¹⁶

Ms Doyle said she felt that Mr Harmer had threatened her.³¹⁷ The next day, she requested, by email to her broker and the claims officer who was handling her claim, copies of recordings of her conversations with CGU.³¹⁸ The claims officer replied that 'in some cases, not all, the calls are recorded for training and quality assurance purposes only' and asked Ms Doyle to provide details of the calls, such as the dates and times and lengths of the calls and the names of the people to whom she had spoken. Ms Doyle responded:³¹⁹

It would seem that, at least some of the phone conversations I am requesting are in existence and have been referred to by your CEO Peter Harmer in a conversation I had with him yesterday afternoon, Tuesday Feb 22 at approximately 3pm. Mr Harmer has, he advises me, been in receipt of and listened to taped conversations of me, presumably talking to you regarding the outcome of my claim.

Over a week later, on about 4 March 2011, Ms Doyle received a letter from Mr Harmer, dated 1 March 2011, about her request for copies of call recordings.³²⁰ The letter said:

When we last spoke by phone on 22 February, I indicated that CGU was working towards individual site assessment at your property prior to you contacting the media about your claim. At the time, I made reference to this being reflected in call recordings. Unfortunately, I made a mistake, and it was the file notes of the call made by the claims officer that support this sequence of events.

Call recordings are not made of customer calls to the Brisbane Flood Claims Team... due to technology limitations and, as a result, no recording was made of this particular call. I apologise for any confusion I have caused.

Mr Harmer accepted in evidence he had 'given Ms Doyle some misleading information' in the conversation on 22 February 2011³²¹ – to which he had referred in the letter – but he denied that he told Ms Doyle he had call recordings, and that he had listened to them.³²² He also denied saying to her that she had 'misled the media'.³²³ He accepted, however, that he was, at the time of the conversation, concerned about the report in *The Courier-Mail* on 10 February 2011³²⁴ (and possibly other media reports³²⁵) and he expressed this to Ms Doyle in the conversation.³²⁶

His concern, he explained in evidence, was that the ‘article did not convey the true position’ because it did not reflect that Ms Doyle’s claim had not been denied and the insurer had sought further information from Ms Doyle’s tenant and a site assessment had been offered to her.³²⁷ He ‘quite possibly’ felt that Ms Doyle had contributed to the nature of the reporting.³²⁸ He said he discussed with her the fact that the article did not report that she had been offered a site inspection.³²⁹ The article itself did not contain any details of Ms Doyle’s claim. While it reported that Ms Doyle was organising a demonstration against CGU, it did not state that her claim had been denied (although perhaps that inference was open) or that she had not been offered a site inspection, or mention her concerns about CGU’s assessment process. The article otherwise reported her perceptions, as a social worker, of the effects on people whose claims had been denied.

Mr Harmer gave an account of the conversation in a statutory declaration which responded to information Ms Doyle had given the Commission before she appeared as a witness.³³⁰ That information was substantially the same as the evidence given by Ms Doyle.³³¹ In evidence, Mr Harmer said his statutory declaration did not give a verbatim account of the conversation but ‘reasonably reflected’ his recollection of it.³³² When he said this, Mr Harmer was aware of the evidence Ms Doyle had given when she appeared as a witness the day before; he had, in fact, authorised a media statement which commented on Ms Doyle’s evidence.³³³ It became clear in the course of Mr Harmer’s evidence, as additional details were elicited, that his statement did not, in fact, reasonably reflect his recollection of the conversation. His account appears to be as follows.

Mr Harmer informed Ms Doyle about the media release and said he would ‘walk her through it’.³³⁴ He discussed CGU’s responses to the policy-holders’ demands. He told Ms Doyle CGU had ‘adjusted [its] process and implemented additional training’ in response to her feedback.³³⁵ At the end of that discussion, Ms Doyle said words to the effect of, ‘So, you are not giving us any of [the] demands’. Mr Harmer explained that CGU had made changes to its process but could not agree to the other demands. Ms Doyle then responded: ‘Don’t you guys want to do business in Queensland? Don’t you care how your brand is going to be trashed up here in this part of the world?’ Mr Harmer then expressed his concern about the media report. He said: ‘It’s very disappointing when not all of the facts get into the public domain’.³³⁶ and added that *The Courier-Mail* article did not mention that Ms Doyle’s claim had not been denied and that CGU had been waiting on Ms Doyle to provide her tenant’s contact details ‘to be able to conduct a site inspection and gain an eyewitness account’.³³⁷ Ms Doyle disputed what Mr Harmer said. She said something to the effect of: ‘That’s just not the case’.³³⁸ to which Mr Harmer responded by saying that CGU had call recordings which could be checked to establish the true situation.³³⁹ Mr Harmer agreed that the tone of the conversation had changed, but he denied he had used a threatening tone.³⁴⁰ The conversation came to a conclusion by Ms Doyle’s commenting that CGU was not ‘giving [the protestors] anything’. She said: ‘Well, I guess it’s open season on CGU.’ Mr Harmer replied: ‘Well, you will have to do what you will have to do.’³⁴¹

Mr Harmer’s account that he said there were call recordings which could be checked is not reflected in the letter he sent Ms Doyle dated 1 March 2011. The letter stated that Mr Harmer had indicated to Ms Doyle on 22 February 2011, that the fact that CGU had been working towards a site assessment at her property before she contacted the media, was ‘reflected in call recordings’. He accepted in oral evidence that he did say to Ms Doyle that CGU had been working towards site assessment at her property, as stated in the letter. That sentence was an accurate reflection of what he had said in the conversation on 22 February 2011.³⁴² However, the next sentence, that he had made ‘reference to this being reflected in call recordings’, was not. That, he said, was a poor use of language. He had not said in the telephone conversation that the facts he asserted were reflected in the call recordings, but rather that the recordings – which he incorrectly assumed existed – could be checked to ascertain whether his or Ms Doyle’s version was correct.³⁴³ He became aware that, in fact, calls had not been recorded after Ms Doyle’s request was brought to his attention. (He said the claims officer made him aware of the request, by email.³⁴⁴ Mr Harmer was, however, copied into the email Ms Doyle sent to the claims officer on 23 February 2011.)³⁴⁵ He wrote the letter to correct this ‘misleading information’ he had given Ms Doyle.³⁴⁶

Mr Harmer’s account corresponded with Ms Doyle’s except on the critical part of the conversation. His letter to Ms Doyle is consistent with Ms Doyle’s version. Ms Doyle presented as a credible and reliable witness. There is no reason to doubt that she gave her evidence honestly. CGU did not test Ms Doyle’s account in cross-examination, but did point out some differences between Ms Doyle’s evidence, on the one hand, and an earlier statement and questionnaire she provided to the Commission, on the other. The Commission does not consider the differences significant.

Ms Doyle's account is recorded in a typed note she made in late March 2011, based on handwritten notes she made at the time of the events (which no longer exist).³⁴⁷ But for two incorrect dates (one of which, when drawn to her attention, Ms Doyle accepted was a mistake),³⁴⁸ Ms Doyle's email to the claims officer on 23 February 2011 contained an otherwise accurate record of her claim. It seems unlikely that Ms Doyle was mistaken when she recorded in that email that Mr Harmer had said to her, the day before, that he had 'been in receipt of and listened to taped conversations'. Taking all of the evidence into account, the Commission is comfortably satisfied that Ms Doyle's account reflects the exchange with Mr Harmer on 22 February 2011. Mr Harmer's conduct was, on this occasion, unprofessional. It seems to have been designed to intimidate Ms Doyle, with an element of bluff (about the existence of recordings). The Commission accepts that it may have been the product of annoyance at what he perceived as an incomplete account of her dealings with the company in the media, rather than any calculated attempt to deter her from persisting with her claim or the more general demands she and others were making.

Comments on the desktop assessment process

The desktop assessment process was designed to deal with flood claims quickly and practically. It may well have done so in many cases: a substantial number of claims was accepted using the process. The controversial aspect of the process – which informed the Commission's investigation – was the absence of site inspections in cases (which related to significant destruction of people's homes and loss of property) which were declined.

Assessment of inundation-related claims without inspection of the damage or features of the particular site carries a risk that the complexity of some cases, or some individual circumstances, will be overlooked. Ms Doyle's claim demonstrated the potential for that to occur, insofar as it appeared the claims officer made a decision during the telephone call on 1 February 2011 that the claim would be declined without proper consideration of the possibility of stormwater damage. CGU continued to assess the claim because Ms Doyle did not accept that decision. On further investigation, a hydrologist considered there may have been some minor stormwater damage, which would have been covered under the policy; but then, after further investigation again, the hydrologist concluded damage had not been caused by stormwater. The initial assessment, on 1 February 2011, therefore turned out to be correct, but the process the claims officer used did not involve proper consideration of the individual circumstances of the claim. It raises the possibility that other claims, of policy-holders not as assertive or persistent as Ms Doyle, could have been determined without proper investigation of individual circumstances.

As part of the review that occurred in February 2011, however, CGU reviewed 497 claims that had been denied by that time, including those denied without a site inspection, to ensure that the decisions had been based on sufficient information. The decisions were also reviewed against hydrology information CGU had received since the claims were denied. None of the decisions was changed.³⁴⁹ Of the 126 claims which have been reviewed in the internal dispute resolution process, only three decisions have been overturned and a site inspection occurred in each of them. (The decisions in those cases were overturned for reasons unrelated to the insurer's determination of the cause of damage.)

A number of cases, however, are still before the ombudsman – including the three the Commission examined. It must be added, however, that the expert hydrologists the Commission engaged, reviewed one of the cases and considered the information CGU had used to determine the claim adequate. The site-specific hydrology report used in another case was also reviewed and said to be supported by strong evidence.

ASIC indicated to the Commission that, in its view, the triage process appeared to be 'acceptable' because:

there is no evidence that assessing a claim under the 'Desk top triage' process has adversely affected the outcome of any individual claimant. It also appears to comply with obligations under section 4 of the General Insurance Code of Practice.

This view was based on an explanation given by CGU in correspondence dated 13 May 2011 in response to ASIC's inquiries. ASIC added that if any 'claimants had been disadvantaged by the process ASIC would be more likely to consider it a systemic issue'.³⁵⁰

One claim which CGU denied without a site assessment has been overturned by the ombudsman.³⁵¹ The ombudsman's determination contains some relevant observations. The ombudsman expressed 'concern' that the insurer had not sent a loss assessor to inspect to the property. Had an assessor done so, there would have been 'more detail on the topography and more general information on what occurred'. The 'failure to assess the claim' meant the insurer was unable to refute information from the policy-holders that the damage had occurred to the part of

the property furthest from the waterway which the insurer concluded had caused the damage; the insurer could not establish that the flood exclusion applied. The following comment is made in the determination:

The Panel notes a site specific report is not always required and an insurer may rely on a general hydrology report in certain circumstances. However, in doing so, it must still address the specific circumstances of the loss, such as conducting an assessment of the property and gathering evidence to clarify exactly what occurred and when, as well as providing details of the insured address and the topography of the area.

The Commission agrees with this comment and, as stated in the section on site inspections by loss assessors, considers that a site inspection should generally form part of a proper assessment of cause of damage at a particular property before a claim is declined. Otherwise, the comments made in the section on site-specific hydrology reports are relevant in this context.

The Commission accepts that CGU's process was improved by the changes made as a result of the review in February 2011. It notes also that CGU home, contents and landlord policies will include automatic flood cover from February 2012, removing the need for such a process of determination.³⁵²

12.7.5 RACQ Insurance Limited

A number of RACQ Insurance's policy-holders complained about delay in the handling of claims. The insurer accepted that delay occurred.³⁵³

The delay is explained, generally, by the large number of claims RACQ Insurance received, the complexity of some cases and the nature of the insurer's assessment process.³⁵⁴ Hydrological advice was needed for every claim which involved inundation of property,³⁵⁵ in order to determine whether the inundation was caused by 'flash flood and/or stormwater run-off' ('a sudden flood caused by heavy rain that fell no more than 24 hours prior to the flash flood or stormwater run-off')³⁵⁶ or 'flood' ('rising water which enters your home as a result of it running off or overflowing from any origin or cause')³⁵⁷. That advice was received from a hydrology firm, Water Technology, in the form of 'hybrid' hydrology reports, which covered regional areas but also took into account individual properties of policy-holders within each region.³⁵⁸ The hybrid reports differed from the area hydrology reports other insurers used in that they assigned a cause of inundation (flood or flash flood or stormwater run-off) to specific properties.

The reports were delivered to RACQ Insurance's solicitors, who considered the reports before providing them to the insurer with legal advice as to whether claims were payable.³⁵⁹ If Water Technology advised that additional information was needed for some properties, further investigation was then undertaken.³⁶⁰ In some cases, RACQ Insurance requested that Water Technology carry out further investigation. As those investigations were completed, and as more claims were received, Water Technology provided further reports to RACQ Insurance. The insurer determined a claim when it was satisfied that a report provided sufficient information on which to make a decision.³⁶¹

RACQ Insurance said that a number of difficulties caused delays in this process.³⁶² One such difficulty was obtaining information and data from local and state authorities.³⁶³ It was in this context that RACQ Insurance explained the re-assessment of 247 claims in Ipswich which had been previously declined.³⁶⁴ On 2 August 2011, when the insurer announced that it had approved the claims, its media release stated that the decision had been made after 'finally' receiving access to 'new hydrological information' it had been seeking 'since early February'. The new information had been released by Brisbane City Council and upon receiving it, RACQ Insurance had acted 'as soon as possible'.³⁶⁵

The 'new information' was in fact Brisbane City Council's Mike-11 hydraulic model of the Brisbane and Bremer Rivers, which the council had made available to RACQ Insurance on 17 May 2011. RACQ Insurance accepted that its media release of 2 August 2011 may have created the impression that other people were responsible for the delay in accepting the claims,³⁶⁶ but that, the insurer said, was not intentional.³⁶⁷ Any such impression so far as the Brisbane City Council was concerned would certainly have been unfair; delay in the model's provision, at least over the period from 5 April 2011 to 17 May 2011, was the result of RACQ Insurance's failure to return first a user agreement, and then a purchase order.

The Commission examined the circumstances of RACQ Insurance's decisions to decline claims between February 2011, when the use of the Mike-11 model was first sought, and 17 May 2011, when access to the model was provided, to establish whether RACQ Insurance had acted reasonably. To understand the position, it is necessary

to appreciate the state of the expert reporting to RACQ Insurance. In a report provided in March 2011, Water Technology, which RACQ Insurance had engaged to investigate ‘inundation events’ in the Ipswich region, had explained that without the Mike-11 modelling, the effect of ‘tailwater’ from the Brisbane River upstream of the Ipswich gauge could not be established.³⁶⁸ However, there were locations upstream where the levels of the Bremer River were unlikely to have been affected by the tailwater; they had been identified in a ‘Schedule C’ to the report. There were properties inundated in the lower reaches of the Bremer River where that river’s levels had been elevated by the Brisbane River tailwater; those properties were identified in a document titled ‘Schedule B Part 1’. Of those properties there was a sub-group where in addition to the tailwater effect, a different mechanism might have produced flooding; that sub-group, identified on ‘Schedule B Part 3’, needed further investigation, with a site-specific approach. Then there was another group of properties which appeared to be outside the identified river inundation zone which might or might not have been affected by the elevated Brisbane River tailwater; they were listed on ‘Schedule B Part 2’.

The significance of the effect of the Brisbane River tailwater was that Water Technology had concluded that flooding in the Brisbane River was attributable to releases from Wivenhoe Dam. Water was discharged from the dam to accommodate inflows into the dam due to rainfall; if that rainfall had commenced more than 24 hours before the releases, claims for damage caused by the resulting dam releases into the Brisbane River and consequent elevation of Bremer River levels would not be payable under RACQ Insurance’s household policy. Without the tailwater, Water Technology said, the Bremer River would have been largely contained within its banks.³⁶⁹ On that basis, and with the information contained in Water Technology’s report, which was provided to RACQ Insurance’s solicitors on 9 March 2011,³⁷⁰ the insurer declined claims under the flood exclusion on various dates between 18 March 2011 and 30 June 2011.³⁷¹

Water Technology said in its March report that it had made requests to Brisbane City Council, Ipswich City Council and Seqwater for access to the Mike-11 model, but, as at the date its report was written, had received no response. RACQ Insurance’s solicitors followed up on those requests but were not able to obtain the model from Ipswich City Council or Seqwater. The solicitors asked the Brisbane City Council for the use of Mike-11 on 28 February 2011.³⁷² The council replied, indicating that the request had been referred to the ‘appropriate area’ ‘as a priority’. The council would ‘endeavour’ to respond within 20 working days, and noted the urgency of the request.³⁷³ On 7 March, the insurer’s solicitors wrote to Brisbane City Council again and reiterated the urgency.³⁷⁴ The council responded on 10 March 2011 in similar terms to its letter dated 28 February 2011;³⁷⁵ it would endeavour to provide a response and acknowledged the urgency of the request. At this stage, RACQ Insurance had not received any indication that the model would be made available, but nor had any indication been given that its request would be refused.³⁷⁶ One hundred and forty-two of the Ipswich claims later re-assessed and accepted were declined in mid- to late March 2011.

On 5 April 2011, Brisbane City Council agreed to provide access to the model. It forwarded to RACQ Insurance’s solicitors, by email, a user agreement, requesting that it be signed and returned, together with a purchase order.³⁷⁷ (The Commission notes that the council’s provision of the model was a sensible step in the public interest.) The agreement was not signed by the principal of Water Technology until 29 April 2011; it was returned to Brisbane City Council on 3 May 2011, but without a purchase order. The insurer’s reason for the delay in returning the agreement was the pressure of work at the time on RACQ Insurance, its solicitors and Water Technology.³⁷⁸ In the interval between the council’s agreement to provide the model and the return of the agreement, 100 of the Ipswich claims which were eventually re-assessed were declined.³⁷⁹ Another claim was declined on 10 May 2011.

On 16 May 2011, Brisbane City Council requested the provision of ‘a purchase order number for this job... required by our finance department to initiate the project’. On 17 May 2011, Brisbane City Council provided RACQ Insurance with the means of accessing the model.³⁸⁰ Three claims were declined on that date.³⁸¹

When it obtained access to Brisbane City Council’s model, Water Technology carried out further investigations and analysis and provided supplementary reports to RACQ Insurance’s solicitors on 6 June 2011 and 14 June 2011. In the end, the result of having the model, and conducting new hydrological analysis, was that the impact of the Brisbane River tailwater was determined to be substantially less than what it was thought to be in the first analysis undertaken.³⁸² The report of 6 June 2011 recommended acceptance of claims made by nine policy-holders in the Ipswich suburbs of One Mile and Churchill, which were upstream of the Ipswich gauge. Decisions on those claims had been deferred; it was now concluded that the contribution of any Brisbane River tailwater to flooding at the relevant properties was insignificant. The report of 14 June 2011 explained that Water Technology had used

the Mike-11 model, together with some more detailed terrain information obtained from DERM, and Seqwater's March flood event report, to simulate the flood over the period between 8 January 2011 and 14 January 2011 and to produce a new set of inundation lines. After RACQ Insurance received the report, it re-assessed a large number of Ipswich claims; the end result was that the 247 previously declined claims were accepted. The cost of the re-assessment was in the region of \$20 million.³⁸³ RACQ Insurance did not deduct previously made compassionate payments from the insurance payouts of the 197 policyholders who had received them.³⁸⁴

RACQ Insurance justified its decision to proceed to decide claims over the March-May period on the ground that Water Technology's March report made 'reasonable conclusions based on the best information available at the time',³⁸⁵ and provided a 'reasonable basis for' declining the claims, notwithstanding Water Technology's 'desire to obtain further information'.³⁸⁶ The decision was appropriate, the insurer's witnesses said, given it was not known whether the model would be made available and, if it did become available, whether it would change Water Technology's initial conclusions.³⁸⁷

The Commission accepts that for the large majority of the claims of the schedule, it was reasonable for RACQ Insurance to proceed with decisions. They related to properties inundated by the Bremer River in the stretches downstream of the Ipswich gauge, where the river approaches the junction with the Brisbane River. The relevant areas included Barellan Point, Basin Pocket, Booval, Bundamba, East Ipswich, Karalee, Moores Pocket, North Booval, Riverview, and Tivoli.³⁸⁸ The Water Technology report in March had presented the position as clear in relation to those areas; it asserted that they 'had been impacted by high Brisbane River tailwater levels', subject to the need for site-specific investigations for the small group where another mechanism might have operated. There was no real reason to suppose that for claims in respect of properties downstream of the Ipswich gauge, the Mike-11 model was likely to make a difference. Timely decision-making was undoubtedly a primary consideration.³⁸⁹ (As discussed in section 12.2.2, the duty of utmost good faith requires that an insurer not delay in determining claims.) There was, the insurer explained, a 'pressing need' to make decisions on claims in the Ipswich area.³⁹⁰

But for at least 28 properties in suburbs upstream of the Ipswich gauge, such as Brassall, West Ipswich, Woodend and Leichardt, the decision to refuse claims in the second half of March and in April is not explained by reliance on Water Technology's March report. It had said quite clearly that the hydrologists were not able to identify the upstream effect of the tailwater without the Mike-11 model. RACQ Insurance pointed out that it could not have been confident of the use to which Brisbane City Council's version of the model could be put for Ipswich. The insurer's chief executive officer said that Water Technology had hoped to obtain data relating to the Bremer River catchment and its configuration as part of the council's model but did not expect the level of detail provided.³⁹¹ The general manager, personal insurance claims, for the company similarly said that it was a 'pleasant surprise' to obtain the details of the Bremer catchment.³⁹² But it seems that there was some level of expectation that the Brisbane City Council model would assist. In the user agreement submitted to the Brisbane City Council on RACQ Insurance's behalf, the 'proposed use of the model' was described as 'To assist [RACQ Insurance's solicitors] and RACQ Insurance in determining inundation mechanisms in Ipswich and Brisbane regions'.³⁹³

In respect of the properties flooded by the Bremer upstream of the Ipswich gauge, the Commission has weighed the evidence about the need for timely decision-making and the element of uncertainty about what the model could offer. It does not consider, on the available evidence, that it was reasonable for RACQ Insurance, once it had embarked on an application for the Mike-11 model, to deny that group of claims. And it is worth observing that none of those policy-holders was told when their claims were denied that better information might become available or that Water Technology was carrying out further investigations. RACQ Insurance did not consider giving them the option of waiting on the possibility of new information coming to hand.

12.8 Information to policy-holders whose claims were denied

12.8.1 Provision of reasons

The General Insurance Code of Practice says that insurers will give a policy-holder whose claims are denied written reasons for the decision.³⁹⁴

The extent to which insurers provided reasons in their letters to policy-holders varied. Some insurers' letters gave an explanation for the decision and referred to the information on which the insurer had relied in reaching the

decision.³⁹⁵ Other insurers' letters, however, did little more than state that the claim was denied because damage had been caused by flood, which was not covered by the policy. The explanation given in CGU's standard letter was limited to the following:³⁹⁶

We have carefully reviewed your claim and based on your advice and information available to us, we conclude that the loss for which you have claimed was caused by flood.

The standard letter did not specify the advice the policy-holder had given or the information that was available to CGU. CGU said that the standard letters followed detailed telephone conversations with policy-holders,³⁹⁷ but that was not evident in one case the Commission examined. In that case, CGU told the Commission it had relied on a range of information to determine the policy-holder's claim: the policy-holder's responses to a set of questions, an area hydrology report, an assessor's report, flood extent mapping provided by the Insurance Council of Australia, aerial photography and Google Maps.³⁹⁸ The note of the conversation in which CGU advised the policy-holder her claim had been denied does not refer to all of this information. It indicates that CGU told the policy-holder that her claim had been denied on the basis of the loss assessor's report, which had recently been received.³⁹⁹ This may not have been an isolated case of CGU's giving a policy-holder an incomplete explanation. An internal record of a review CGU performed in February 2011 indicates that some customers were not being told of all the information which the insurer had used to decide their claims.⁴⁰⁰ CGU conceded that the standard letters it used could be improved.⁴⁰¹

Another insurer, RACQ Insurance, provided scant reasons to policy-holders whose claims were denied under the flood exclusion. A policy-holder was informed by phone, typically, that the claim had been denied because the insurer had determined that flooding had caused the damage to his or her property, and the policy did not cover flood.⁴⁰² The standard letter confirming the decision did not provide any greater explanation. It stated that RACQ Insurance's investigations had been completed and determined that flood was the cause of damage which was not covered by the policy.⁴⁰³ The letter set out the definition of 'flood' but did not refer to the relevant clauses of the policy which provided and excluded cover. No attempt was made to explain the basis for the conclusion that the damage was caused by flood. Nor did the letters apprise policy-holders of the information on which RACQ Insurance had relied, from which the policy-holder might glean the basis for the conclusion. The letter did advise policy-holders who had any queries or needed more information, to call RACQ Insurance, and provided a telephone number for this purpose.

RACQ Insurance did not regard the letters as being deficient in any respect.⁴⁰⁴ The insurer said the letter was consistent with the company's usual practice and provided all the information that was necessary. It asserted that including any more particular information would have been onerous and extended the time taken to assess claims and advise policy-holders of decisions.⁴⁰⁵

While the Commission acknowledges, given the magnitude of the tasks which insurers had to perform, that some standardisation of communications was essential, it considers that standard letters which do not give any sense of why the cause of inundation was flood, and therefore excluded from cover, do not assist policy-holders to understand the reason for rejection of their claims. A statement in a letter that the property damage was caused by flooding from the river, and not by stormwater, and that river flooding was excluded from the policy's coverage, would have been more informative and would give a policy-holder some sense of why his or her claim was rejected.

If standard letters such as those discussed in the preceding paragraphs are to be regarded as meeting the code's obligation to give reasons, they deprive that obligation of any meaningful content. They are not helpful, particularly when the complexity of flood claims and policy terms is considered, and given also that the code intends that a policy-holder will have the opportunity to review the information on which his or her insurer relied in assessing the claim.⁴⁰⁶

At a minimum, letters telling policy-holders that their claims have been denied should advise them of the information on which the insurer relied to reach the decision. The letters should also advise policy-holders that they can request copies of that information, and how to do so.

12.8.2 Provision of information

Section 3.4.3 of the Code of Practice is the only section in the code which imposes an obligation on insurers to make material available to a policy-holder in the assessment stage. It states that:

You will have access to information about you which we have relied on in assessing your claim and an opportunity to correct any mistakes or inaccuracies. In special circumstances or where a claim is being or has been investigated, we may decline to release information and reports but we will not do so unreasonably. In these circumstances, we will give you reasons and you will have the right to request a review of our decision through our complaints handling procedures. We will provide our reasons in writing upon request.⁴⁰⁷

There is a corresponding provision in the section in the Code dealing with complaints handling procedures.⁴⁰⁸

Some insurers provided policy-holders with copies of the information on which they had relied with the letter confirming decisions to deny claims.⁴⁰⁹ Other insurers only provided material on request.⁴¹⁰ That approach is consistent with the code, which does not require insurers to offer, unsolicited, copies of information on which they rely in assessing claims. The code also states that insurers may refuse to provide copies of material if 'special circumstances' apply; for example, if the material is 'subject to privacy laws' or 'protected from disclosure by law'.

In its submission to the Natural Disaster Insurance Review, the ombudsman stated that 'as a general rule with the Queensland floods, the insurers have provided early access to the information and in particular hydrology information relied upon. Where this information has not been provided this has led to a considerable level of complaints'.⁴¹¹

RACQ Insurance withheld its hydrology reports, for a time, from policy-holders, their lawyers and the Financial Ombudsman Service, on the grounds of legal professional privilege and protection of privacy.⁴¹² The insurer maintained its refusal to release the reports until the ombudsman indicated, that if the reports were not disclosed, adverse inferences might be drawn against the insurer in the ombudsman's resolution of disputes. The reports were provided to the ombudsman in mid-July 2011.

RACQ Insurance had, in lieu of the full hydrology reports, given policy-holders who requested copies of reports, summaries of the conclusions expressed in the reports in 'plain English'. For any matter before the ombudsman, RACQ Insurance provided to the ombudsman and policy-holder statements by its hydrologist, instead of the full hydrology report.⁴¹³

The ombudsman is considering whether RACQ Insurance's actions in withholding the hydrology reports give rise to a systemic issue.⁴¹⁴ The insurer's position is that it was, at all relevant times, entitled to claim legal professional privilege, and that there had been no breach of the code.⁴¹⁵

The right to claim legal professional privilege is fundamental,⁴¹⁶ and is not abrogated in any way by the *Insurance Contracts Act 1984* or the code. The Commission makes no finding that RACQ Insurance was not entitled to claim privilege.

On the other hand, insurers are not obliged to claim privilege. There are good reasons for an insurer, in both its own interests and that of its policy-holders, to consider the wisdom of standing on privilege so as to refuse disclosure of information relied on in its decision-making. Hydrology reports, in particular, are fundamental to a policy-holder's understanding of the refusal of a claim based on a distinction between flood and storm-water inundation; and to enabling him or her to make an informed decision as to whether to pursue internal and/or external review.⁴¹⁷ Their prompt disclosure may assuage policy-holders' doubts about whether their claims have been properly rejected, avoiding dispute.

The Commission notes that, on 10 October 2011, the Insurance Council Board agreed in principle to an amendment of the code to the effect that insurers will make hydrology and other expert reports used to determine claims available to policy-holders within ten business days of receiving the reports. The Commission generally supports the proposed amendment, but it has not seen its precise terms and does not know how it would apply to the circumstances of the case mentioned above.

The Commission also notes that clause 3.4.3 gives policy-holders the right to request a review of an insurer's decision to refuse to release copies of information, but does not impose any obligation on insurers to inform policy-holders of their right to do so. The code should be amended to correct the omission.

Recommendations

- 12.3 Letters notifying policy-holders that their claims have been denied should, at a minimum, state the information upon which the insurer has relied in making the decision. These letters should also advise policy-holders that copies of the information will be made available upon request (in accordance with clause 3.4.3 of the General Insurance Code of Practice) and indicate how policy-holders can make a request.
- 12.4 The Insurance Council of Australia should consider an amendment to Part 3 of the code which requires insurers to notify policy-holders of the information on which they relied in assessing claims.
- 12.5 The Insurance Council of Australia should amend clause 3.4.3 of the General Insurance Code of Practice so that it requires insurers to inform policy-holders of their right to request a review of an insurer's decision to refuse to provide access to information on which it relied in assessing claims.

12.9 Internal dispute resolution

The obligation on insurers to offer internal dispute resolution as part of their claims handling procedures is discussed in *12.2.2 The Insurance Contracts Act 1984*.

The Commission received evidence from insurers detailing their internal dispute resolution procedures.⁴¹⁸ As would be expected, there were differences in some of the detail of the procedures, but the key aspects of the process were consistent across insurers; a description follows.

If an insurer denies (or partially denies) a claim, a policy-holder is entitled, on request, to an independent review of the decision through the insurer's internal dispute resolution procedure. On internal review, an internal dispute officer considers all the information contained in the policy-holder's file (including expert reports) and requests any further information required. The decision made upon internal review is binding and cannot be challenged by the insurer. If the claim is denied at internal review, the insurer must outline the reasons for the decision and advise that the policy-holder is entitled to have the decision reviewed by the Financial Ombudsman Service.

In some cases the Commission considered, further evidence was obtained on internal review in the form of site-specific hydrology reports.⁴¹⁹ By way of example, in one case, a site-specific hydrology inspection and report were commissioned when the policy-holder disputed the finding that the cause of the inundation was flood because of the location of his property.⁴²⁰ In another case, the insurer obtained a supplementary site-specific hydrology report after the policy-holder provided further information to the insurer, including an engineer's report and flood maps, which raised doubts as to the cause of the inundation.⁴²¹

The Commission received evidence from an AAMI policy-holder who complained that during the internal review process, he provided a written submission to AAMI which was not passed onto a hydrologist for further opinion. The initial claim was denied on the strength of a site-specific hydrology report in which the hydrologist concluded that the cause of the property's inundation was overflow from a local creek, and was, in consequence, flood, excluded under the policy.⁴²² The hydrologist concluded that the level of stormwater would have been insufficient to inundate the property above floor level.⁴²³

The policy-holder wrote to AAMI challenging that conclusion: he queried the validity of the hydrologist's assumptions, particularly questioning the adequacy of the rainfall data, and the conclusions made in consequence of reliance on that data.⁴²⁴ He also suggested that a three metre stormwater drain in the vicinity, a photograph of which he attached, was significant and should have featured in the report (which it did not). The hydrology report attached an annotated aerial photograph described as depicting '[d]rainage features in the vicinity of the subject property'. The stormwater drain does not appear to be depicted within it.

The internal review officer was aware that seeking a further report from the hydrologist would delay the review by approximately six to eight weeks. He considered that course not justified because he had formed the view that:⁴²⁵

- The information in the AAMI's policy-holder's submission had already been considered by the hydrologist (he assumed that the hydrologist must have had regard to the stormwater drain, although

the hydrologist did not expressly mention it in the hydrology report),⁴²⁶ was directly contradicted by information in the hydrologist's report, or was not of a kind likely to result in the hydrologist's changing his mind.

- The evidence was of sufficient strength to make a decision on the available material without seeking a further report from the hydrologist.

The internal review officer had some training in reading hydrology reports, but was not an expert in matters of hydrology and was not in a position to determine whether the factual issues raised by the policy-holder were relevant to the hydrologist's opinion as to cause of inundation.⁴²⁷ That he was not qualified to determine such issues seems implicit in his letter to the policy-holder, which stated that he was guided by the expert qualified opinion of the hydrologist.⁴²⁸ Nevertheless, he did not seek such guidance when presented with the policy-holder's specific challenge to the hydrologist's report.⁴²⁹ And while the Commission accepts that there were delays in obtaining site-specific reports of up to eight weeks or more, it seems unlikely that it would have taken six to eight weeks for the hydrologist to advise whether the additional information provided by the AAMI policy-holder might affect his determination. There was no evidence of a pressing need to conclude the internal review in advance of the time it would take to receive and consider further hydrology advice.

The Commission is not in a position to say whether the additional information would have altered the result of the claim. However, as a matter of prudence and fairness, where a policy-holder provides information which appears relevant to the cause of inundation, claims officers and internal review officers should refer that information to any reporting hydrologist for consideration.

(Endnotes)

- 1 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p1].
- 2 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [Recommendations 1, 8 and 11; see also p29: para 2.4 and 2.5].
- 3 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [Recommendation 25; see also p74: para 9.7].
- 4 See Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p103: para 13.31-13.32 and Recommendation 34; and p104-105: para 13.37-13.46 and Recommendation 36].
- 5 'Reforming flood insurance: A proposal to improve availability and transparency'. The Natural Disaster Insurance Review did not recommend the 'opt-out' option. It advocated automatic flood cover over automatic flood cover with an 'opt-out' option for purchasers (Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p29: para 2.5; p31: para 2.13-2.15].
- 6 Statement of Paul Fahey (CommInsure – Response to question 30), 23 September 2011 [Appendix A]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 125].
- 7 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011, Exhibit 3 [p28].
- 8 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011, Exhibit 3 [p27].
- 9 *Pye v Metropolitan Coal Co Ltd* (1934) 50 CLR 614, 625.
- 10 To be a 'proximate cause' the cause must be 'direct, real or commonsense, dominant, effective or operative'. A cause can be the proximate cause, whether or not it is the closest cause in time: D Derrington and R Ashton, *The Law of Liability Insurance*, Lexis Nexis Butterworths, 2005 (2nd edition) [p490-491]; see *Elilade Pty Ltd v Nonpareil Pty Ltd* [2002] FCA 909 [para 55].
- 11 *HIH Casualty & General Insurance Ltd v Waterwell Shipping Inc* (1998) 43 NSWLR 601, [p612: para B]; P Telford, *Of floods and driving rains: Hams v CGU Insurance Ltd* (2003) 18(3) ILB 31.
- 12 *Elilade Pty Ltd v Nonpareil Pty Ltd* [2002] FCA 909 [para 52-53].
- 13 Commonwealth Treasury, *Reforming flood insurance: A proposal to improve availability and transparency*, Consultation paper, November 2011 [p3].

- 14 Section 51(xiv) *Constitution of the Commonwealth of Australia*.
- 15 It commenced on 1 January 1986.
- 16 Preamble, *Insurance Contracts Act 1984*.
- 17 *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1 [p12]; [2007] HCA 38 [para 15]; *Murphy v Allstate Insurance Company* (1976) 17 Cal 3d 937; P 2d 984; D Derrington and R Ashton, *The Law of Liability Insurance*, Lexis Nexis Butterworths, 2005 (2nd edition) [p237].
- 18 P Mann, *Annotated Insurance Contracts Act*, Lawbook Co., 2003 (4th edition) [p38: para 13.10.3]; see also, *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1 [p42].
- 19 *Moss v Sun Alliance Ltd* (1990) 55 SASR 145 [p154].
- 20 Sections 11A-11E, *Insurance Contracts Act 1984*.
- 21 Section 1017G, *Corporations Act 2001*.
- 22 Australian Securities and Investments Commission, *Regulatory Guide 165 Licensing: Internal and external dispute resolution, April 2011*.
- 23 Australian Securities and Investments Commission, *Regulatory Guide 165 Licensing: Internal and external dispute resolution, April 2011* [p24: RG 165.98-RG 165.106].
- 24 Exhibit 587, General Insurance Code of Practice [section 7.7]. See also sections 7.8 to 7.23.
- 25 Foreword, General Insurance Code of Practice.
- 26 Section 1.19 of the General Insurance Code of Practice states: 'The objectives of this code will also be pursued and its provisions applied having regard to the fact that a contract of insurance is a contract involving the utmost good faith which requires each party to the contract to act towards the other party with the utmost good faith in respect of any matter arising under the contract.'
- 27 Exhibit 587, General Insurance Code of Practice [section 3.2].
- 28 Exhibit 587, General Insurance Code of Practice [section 6.9].
- 29 Exhibit 587, General Insurance Code of Practice [section 3.4].
- 30 Exhibit 587, General Insurance Code of Practice [p15].
- 31 Exhibit 587, General Insurance Code of Practice [sections 4.1, 4.3].
- 32 Exhibit 587, General Insurance Code of Practice [section 4.2].
- 33 Exhibit 587, General Insurance Code of Practice [sections 6.6-6.9].
- 34 Financial Ombudsman Service, *Terms of Reference*, 10 January 2010 (as amended by 1 January 2012) [para 8.1-8.9].
- 35 One witness giving evidence at a public hearing commended his insurer's performance (Transcript, Graham Spackman, 29 September 2011, Emerald [p3403: line 40]).
- 36 The eight insurers defined 'household claims' as follows.
 - AAMI defined 'household claims' as 'claims for damage to home and contents items covered by the following AAMI home and contents policies' relating to residential properties: Home Building Insurance Policy; Home Contents Insurance Policy; Fire and Theft Contents Insurance Policy; Landlord Insurance Policy; Strata Title Landlord Insurance Policy.
 - Allianz Australia Insurance Limited defined 'household claims' as 'building or contents claims on policies that provide cover for domestic home buildings and contents' including 'domestic home buildings and contents written under landlords and rural products'.
 - CGU Insurance Limited defined 'household claims' as 'all home buildings, home contents (including valuables), and landlords claims'.
 - CommInsure defined 'household claims' as residential and investment policies providing home buildings and home contents cover.
 - NRMA Insurance defined 'household claims' as 'all home buildings, home contents, landlord buildings and landlord contents claims'.
 - QBE Insurance (Australia) Limited defined 'household claims' as 'all claims related to home building &/or home contents risks'.
 - RACQ Insurance Limited's defined 'household claims' as claims made under its 'household insurance policy'.
 - Suncorp Metway Insurance Limited defined 'household claims' as 'claims for damage to

- home and contents items covered by the following Suncorp home and contents policies' relating to residential properties: Classic Home & Contents; 55UP Home & Contents; Platinum Home & Contents; Investor Home & Contents.
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- 37 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [para 41].
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- 38 See correspondence from the Australian Securities and Investments Commission to CGU Insurance Limited, dated 20 April 2011, and CGU's response, dated 13 May 2011, provided by CGU in response to a Commission Requirement, 14 October 2011.
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- 39 Correspondence from CGU Insurance Limited to the Australian Securities and Investments Commission, dated 30 June 2011, provided by CGU in response to the Commission Requirement, 14 October 2011; Statutory Declaration of Dion Gooderham (CGU Insurance Limited), 21 November 2011 [p5: para 30-32].
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- 40 Correspondence from the Australian Securities and Investments Commission to CGU Insurance Limited, dated 3 August 2011, provided by CGU in response to a Commission Requirement, 14 October 2011.
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- 41 Statement of Gregory Kirk (Australian Securities and Investments Commission), 5 October 2011, Annexure 4G.
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- 42 Correspondence between Financial Ombudsman Service and CGU Insurance Limited, various dates, provided by CGU in response to a Commission Requirement, 14 October 2011.
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- 43 Correspondence from the Financial Ombudsman Service to CGU Insurance Limited, dated 14 July 2011, provided by the Financial Ombudsman Service. Under its terms of reference, the Financial Ombudsman Service 'must identify systemic issues and refer [them] to the relevant Financial Services Provider [in this case, an insurer] for remedial action'. It must also report systemic issues to ASIC. A systemic issue is 'an issue that will have an effect on other persons...beyond the parties to the Dispute'. The correspondence dated 14 July 2011 states, 'A dispute has been referred to me as raising a possible systemic issue. I will be responsible for investigating the matter'. The letter states elsewhere: 'This possible systemic issue was investigated recently...'.

- 44 Correspondence from the Financial Ombudsman Service to CGU Insurance Limited, dated 26 August 2011, provided by CGU in response to a Commission Requirement, 14 October 2011.
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- 45 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [para 15, 16].
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- 46 Transcript, James Merchant, 6 October 2011, Brisbane [p3816: line 25 – p3819: line 45].
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- 47 Consistent with its terms of reference, the Commission defined the 2010/2011 floods as the floods that occurred in Queensland in December 2010 and January 2011.
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- 48 The total number of residential and commercial claims across 'all classes' encompassed residential building, residential contents, domestic motor, domestic other, commercial property, commercial vehicles, business interruption and commercial other claims. Domestic and commercial 'other' claims include a variety of small insurance classes, including landlords insurance, farm and rural insurance and marine insurance (Statutory Declaration of Robert Whelan, 2 December 2011 [para 12-13]). The data does not include mining and heavy manufacturing claims (Statutory Declaration of Robert Whelan, 2 December 2011 [para 11]).
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- 49 The Insurance Council of Australia defined the 'Queensland floods' as including:
- inundation in regional Queensland (including Ipswich) from 21 December 2010 to 14 January 2011
 - inundation in the Lockyer Valley and Toowoomba from 10-11 January 2011
 - inundation in the Brisbane local government area from 21 December 2010 to 14 January 2011 (Statutory Declaration of Robert Whelan, 2 December 2011 [para 3-4]).
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- 50 The Insurance Council took 'residential claims' to mean residential building claims only, including claims for non-body corporate policies and visualised as claims arising from standalone or duplex properties in domestic use (Statutory Declaration of Robert Whelan, 2 December 2011 [para 23]).
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- 51 The companies which were included were: Insurance Australia Group, Allianz Australia Insurance Limited, Auto & General Insurance, Catholic Churches Insurance, FM Global Insurance, Progressive Direct, Westpac Insurance,

- YouI, Suncorp, Ansvr Insurance, Calliden Insurance, Comminsure, Lloyds, QBE Insurance (Australia) Limited, Zurich, Aioi Insurance, Assetinsure, Guild Insurance, CUNA Mutual, Great Lakes Insurance, RACQ Insurance Limited and Westfarmers Insurance (Statutory Declaration of Robert Whelan, 2 December 2011 [para 7, 9]).
- 52 Statutory Declaration of Robert Whelan, 2 December 2011 [para 10].
- 53 Figure 12(a) includes withdrawn claims for all insurers but RACQ Insurance Limited, which did not include withdrawn claims in its data. Withdrawn claims totalled 2,916 claims (13 per cent of N). Insurers counted composite home and contents claims differently. Four insurers – AAMI, QBE Insurance (Australia) Limited, RACQ Insurance Limited and Suncorp Metway Insurance Limited – counted composite home and contents claims as a single claim. The other insurers – Allianz Australia Insurance Limited, CGU Insurance Limited, NRMA Insurance and CommInsure – recorded composite claims as two separate claims: one home building claim and one contents claim. So, for every home and contents claim recorded by the first group of insurers, two claims were recorded by the second group – inflating the totals of the second group when compared with the first.
- 54 ‘Storm’ is defined in RACQ Insurance Limited’s Household Insurance Policy as ‘A violent disturbance of the atmosphere associated with strong winds including a cyclone, lightning, heavy rain, hail or snow, but not continuous bad weather by itself’ (Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [Exhibit 3: p29]).
- 55 In September 2011, QBE Insurance (Australia) Limited indicated that it received approximately 4000 claims from the 2010/2011 floods, a far greater number than indicated in Figure 1 (Statutory Declaration of Shaun Standfield, 22 September 2011 (QBE Insurance (Australia) Limited), Annexure B [para 18]). AAMI indicated that from the flooding in central and south east Queensland it received 1736 claims, of which approximately 1200 were paid and settled (Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011 [p9: para 39]).
- 56 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p37: para 194]. QBE Insurance (Australia) Limited received approximately 7000 claims from Cyclone Yasi and 4500 claims from the Victorian Storms (Statutory Declaration of Shaun Standfield, 22 September 2011 (QBE Insurance (Australia) Limited), Annexure B [para 18]). AAMI received over 3050 claims for Cyclone Yasi (Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [para 81]). NRMA Insurance received over 1000 (Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 79]).
- 57 Residential and commercial claims.
- 58 Insurance Council of Australia, Current Disaster Statistics as at January 2012, available at: www.insurancecouncil.com.au/industry-statistics-data/disaster-statistics.
- 59 Figure 12(b) excludes all outstanding and withdrawn claims. Seven of the eight insurers recorded claims accepted in part as ‘accepted’ claims. Allianz Australia Insurance Limited records partially accepted claims differently: these claims were counted in its data as ‘declined’ claims.
- 60 As for Figure 12(b), Figure 12(c) excludes all outstanding and withdrawn claims. Seven of the eight insurers recorded claims accepted in part as ‘accepted’ claims. Allianz Australia Insurance Limited records partially accepted claims differently: these claims were counted in its data as ‘declined’ claims.
- 61 All percentages are rounded upwards to the nearest whole percentage point. As for figures 12(b) and 12(c), Figure 12(d) excludes all outstanding and withdrawn claims. Seven of the eight insurers recorded claims accepted in part as ‘accepted’ claims. Allianz Australia Insurance Limited records partially accepted claims differently: these claims were counted in its data as ‘declined’ claims.
- 62 The terms of cover were: ‘Storm and rainwater including stormwater runoff from areas surrounding the site, or water escaping from any water main, drain, pipe, street gutter, guttering or surface. Storm means violent wind (including a cyclone or tornado’.
- ‘Flood’ was defined in AAMI’s home building insurance policies and home contents insurance policies as:
- ‘the inundation or covering of normally dry land by water which:

- escapes or overflows from, or
- cannot enter (because it is full or has overflowed), or
- is prevented from entering (because other water has already escaped or been released from it) the normal confines of any watercourse or lake, including any that may have been modified by human intervention, or reservoir, canal, dam or stormwater channel.

Flood does not mean stormwater runoff from areas surrounding the site or water escaping from any water main, pipe, street gutter, guttering or surface.'

- 63 Allianz Australia Insurance Limited policies provided cover for 'storm, rainwater or run-off' where 'storm' was defined as 'violent wind (including cyclones and tornadoes), thunderstorms and hail which may be accompanied by rain or snow'; 'rainwater' was defined as 'rain falling naturally from the sky onto the buildings and/or ground'; and 'run-off' was defined as 'rainwater that has collected on or has flowed across normally dry ground...' Other policies provided cover for 'storm, rainwater, hail or wind', or 'storm (including cyclone or hurricane) and/or rain, which may be accompanied by... hail', or 'storm, tempest, rainwater, wind, hail or tornado, cyclone'.

The declined claims shown in figures 12(c) and 12(d) were declined under the flood exclusion or some other policy exclusion (such as wear and tear, or subsidence, for example). The definition of 'flood' in Allianz Australia Insurance Limited's generic domestic home policy was: 'the inundation of normally dry land by water that has escaped or has been released from the normal confines of any natural watercourse, lake or lagoon whether or not altered or modified or of any reservoir, canal or dam'.

Some policies excluded loss or damage caused by 'flood water combined with run-off and/or rainwater'.

- 64 Claims accepted by CGU Insurance Limited were accepted on the basis of one of the following events (depending on the policy): 'storm, rainwater or wind'; 'storm (including cyclone or hurricane) and/or rain...'; 'storm, tempest, rainwater, wind, hail, tornado, cyclone or hurricane'. The most common definition of 'flood' in CGU Insurance Limited's policies was: 'the covering of normally dry land by water

escaping or released from the normal confines of a watercourse or lake, whether or not it is altered or modified. Flood also includes water escaping from the confines of any reservoir, channel, canal or dam'.

Slightly different definitions were used in two policies. One was: 'the inundation of normally dry land by water escaping from any watercourse, lake, canal, dam or reservoir. Flood does not include inundation from rainwater that cannot flow into a stormwater drain because the drain is blocked or backed up'.

- 65 NRMA Insurance's policies defined 'storm' as 'a violent wind, cyclone, tornado, thunderstorm or hail... or a sudden, excessive run-off of water as a direct result of a storm in your local area. It does not include persistent rain by itself'. 'Flood' was defined as: 'the covering of normally dry land by water escaping or released from the normal confines of a watercourse or lake, whether or not it is altered or modified. Flood also includes water escaping from the confines of any reservoir, channel, canal or dam'.
- 66 'Flood', or 'River flood' was generally defined as: 'the inundation of normally dry land by water escaping from any watercourse, lake, canal, dam or reservoir'; or as 'when water that is normally contained in a water catchment system increases because of rainfall or snow melt (whether in the immediate region or elsewhere) or is deliberately released by an authority, and the water overflows onto land that is not normally covered by water into your home'.
- 67 Defined as: 'A sudden flood caused by heavy rain that fell no more than 24 hours prior to the flash flood or stormwater run-off.'
- 68 Defined as: 'Rising water which enters your home as a result of it running off or overflowing from any origin or cause.'
- 69 'Flash flood' was defined as: 'The overflow of any lake, river, creek, stormwater channel, canal or any other watercourse (whether natural, altered or man made), caused by a storm, where the flooding occurs within 24 consecutive hours of the storm having commenced.'

CommInsure also covered damage caused by 'storm', defined as:

A violent wind (including cyclones), sometimes combined with thunder, heavy falls of rain, hail or snow; or

- Thunderstorms or hailstorms, sometimes accompanied by heavy falls of rain or snow.
- It is not persistent bad weather or heavy or persistent rain by itself.
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- 70 Defined as: 'The inundation of normally dry land by water which has overflowed, escaped or been released from a lake, river, creek, storm water channel, canal or any other watercourse whether natural, altered or man made.'
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- 71 Figure 12(e) excludes all claims received by Suncorp. Figure 12(e), like figures 12(b) to 12(d), excludes all outstanding and withdrawn claims. Six of the seven insurers recorded claims accepted in part as 'accepted' claims. Allianz Australia Insurance Limited records partially accepted claims differently: these claims were counted in its data as 'declined' claims.
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- 72 Submission by the Financial Ombudsman Service Limited to the Natural Disaster Insurance Review, July 2011 [p13].
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- 73 Seven of the eight insurance providers treated disputes resolved by way of mutual agreement as being resolved in favour of the insured. CGU Insurance did not have any claims that were resolved by way of mutual agreement.
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- 74 Total disputed claims across the eight insurers was 1331, as shown in Figure 12(f). Total decided claims across the eight insurers was 19833, as shown in figures 12(b) to 12(d).
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- 75 Section 35 of the *Insurance Contracts Act 1984* requires an insurer to clearly inform a policyholder, before the insurance contract is entered into, of the terms of the contract that differ from the standard terms of a prescribed contract under the *Insurance Contract Regulations 1985*. A contract for home buildings and home contents insurance is a prescribed contract under the regulations. The regulations prescribe that such contracts include flood insurance. Under s 35 of the Act, if an insurer fails to clearly inform a policyholder that flood is excluded from cover, the insurer is not entitled to rely on the exclusion.
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- 76 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p110: para 14.13].
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- 77 *Moss v Sun Alliance Aust Ltd* (1990) 55 SASR 145; *B H Gutteridge & Anor v Commonwealth of Australia* (unreported), Supreme Court of Queensland, Ambrose J, 25 June 1993.
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- 78 Exhibit 587, General Insurance Code of Practice [section 3.1].
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- 79 Exhibit 587, General Insurance Code of Practice [section 3.2.5].
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- 80 Exhibit 587, General Insurance Code of Practice [section 3.3].
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- 81 Exhibit 587, General Insurance Code of Practice [section 4.3].
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- 82 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p24: para 1.35]. This statement was based on unpublished data the Insurance Council of Australia provided to the Review Panel.
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- 83 Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 23 September 2011, Annexure B [para 18].
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- 84 For example, two claims were determined in two months: Raymond Byron (2 months): see Exhibit 591, Third Affidavit of Graham Dale (RACQ Insurance Limited), 14 September 2011 [para 8]; Michael Gourley (2 months): see Exhibit 898, Ninth Affidavit of Graham Dale (RACQ Insurance Limited), 19 October 2011, Exhibit 5.
- Six claims were determined in two to three months: Robert Clements (2 months, 5 days): see Exhibit 649, Letter from Allianz Australia Insurance Limited to Robert Clements, 18 March 2011 and Statement of Garry Townsend (Allianz Australia Insurance Limited), 16 September 2011 [para 3.6]; Attachment 1.2; Gary Lobley (2 months, 2 weeks): see Exhibit 878, Statement of James Higgins (AAMI), 13 October 2011 [para 8 and 10-15]; Kristy Sihvola (2 months, 3 weeks): see Exhibit 891, First Affidavit of Graham Dale (RACQ Insurance Limited), 1 September 2011 [para 6 and 26]; Lynn Doyle (2 months, 3.5 weeks): see Exhibit 626, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011 [para 4 and 6]; Leslie Cameron (2 months, 3.5 weeks): see Exhibit 897, Seventh Affidavit of Graham Dale (RACQ Insurance Limited), 13 October 2011, Exhibit 5; Dennis Ward (3 months): see Exhibit 879, Statement of James Higgins (AAMI), 3 October 2011 [para 8].
- Three claims were determined in three to four months: Sharron Campbell (3 months, 1 week): see Exhibit 719, Statutory Declaration of Matthew Jarrett (NRMA Insurance), 22 September 2011 [para 18 and 33]; Sallyanne Doyle (3 months, 2 weeks): see Exhibit 717, Statutory Declaration of James Merchant (CGU

- Insurance Limited), 3 October 2011 [para 9 and 59]; Julian and Rebecca Chambers (4 months): see Exhibit 843, Statement of James Higgins (AAMI), 7 October 2011 [para 8].
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- 85 Three claims were determined in four to five months: Colin Sharp (4 months, 2 weeks): see Exhibit 851, Eighth Affidavit of Graham Dale (RACQ Insurance Limited), 15 October 2011, Exhibit 3; Thomas Fischer (4 months, 3.5 weeks): see Exhibit 593, Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 14 September 2011, Attachment 2; Josephine Sledge (4 months, 3.5 weeks): see Exhibit 896, Sixth Affidavit of Graham Dale (RACQ Insurance Limited), 13 October 2011 [para 13 and 104].
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- 86 QBE Insurance (Australia) Limited received the report for Toowoomba on 18 February 2011; the report for the Brisbane River Catchment on 9 March 2011; the report for the Brisbane Local Government Area 9 March 2011; the report for Ipswich on 22 March 2011; the report for the Lockyer Valley on 29 March 2011; and report for the Somerset Local Government Area on 27 April 2011 (Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 23 September 2011, Annexure B [para 12.3.3]).
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- 87 QBE Insurance (Australia) Limited indicated that it took, on average, 35 business days to determine claims arising from the 2010/2011 floods, but that if a site-specific hydrology report were not required, claims would generally be determined in less than 35 business days. If a site-specific report were obtained, determinations may have taken more than 35 business days (Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 23 September 2011, Annexure B [para 18]).
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- 88 Exhibit 1026, Statement of Mark Richards (AAMI), 8 November 2011 [para 13].
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- 89 Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [para 17].
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- 90 See, for example, Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [para 173-182]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 167-187]; Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 23 September 2011 [para 17]; Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 76]; Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [para 17]; Statement of Paul Fahey (CommInsure), 23 September 2011, Appendix A [p19]; Exhibit 742, Statutory declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [para 12.3.3 ,17].
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- 91 Figure 12(g), includes outstanding claims, but does not include withdrawn claims. All percentages are rounded upwards to the nearest whole percentage point. All references to 'days' includes business days only. 'Months' means calendar months.
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- 92 Exhibit 873, Statement of James Higgins (Suncorp Group Limited), 30 September 2011 [para 6-9].
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- 93 Excluding withdrawn claims.
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- 94 As for Figure 12(g), Figure 12(h) includes outstanding claims, but does not include withdrawn claims. All percentages are rounded upwards to the nearest whole percentage point. All references to 'days' includes business days only. 'Months' means calendar months. The timeframes in Figure 8 are not definitive because different insurers took different approaches to what constituted a 'decision' date. Five of the seven insurers – CGU Insurance Limited, NRMA Insurance, CommInsure, Allianz Australia Insurance Limited and QBE Insurance (Australia) Limited – provided data indicating the time taken to determine liability and also communicate the decision to policy-holders. Generally policy-holders were informed of the decision on the same day it was made, or only a short time afterwards. One insurer (Allianz Australia Insurance Limited), however, said that the time between making a decision to decline a claim and notifying the policy-holder of the decision, could be as many as eight days. RACQ Insurance Limited's data did not encompass when decision dates were communicated to policy-holders. It indicated when the General Manager for Personal Insurance Claims made decisions about liability and conveyed those decisions to the claims officers. The insurer said, however, decisions were generally communicated to policy-holders soon after they were made.
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- 95 This excludes withdrawn claims but includes outstanding claims.
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- 96 For example, 96 per cent of Allianz Australia Insurance Limited claims decided in 10 days or less were accepted and 85 per cent of Allianz Australia Insurance Limited claims decided

within one month were accepted; 95 per cent of RACQ Insurance Limited claims decided in 10 days or less were accepted and 93 per cent of RACQ Insurance Limited claims decided within one month were accepted; 94 per cent of CommInsure claims decided in 10 days or less were accepted and 61 per cent of claims decided within one month were accepted; 70 per cent of CGU Insurance Limited claims decided in 10 days or less were accepted and 64 per cent of claims decided within one month were accepted.

- 97 Figure 12(i) excludes outstanding and withdrawn claims. Five of the six insurers recorded claims accepted in part as 'accepted' claims. Allianz Australia Insurance Limited records partially accepted claims differently: these claims were counted in its data as declined claims. RACQ Insurance Limited was instructed to treat 247 Ipswich claims, which were originally declined but later accepted in bulk in August 2011, as accepted claims. For details, see section on Ipswich re-assessment.

As for figures 12(g) and 12(h):

- All percentages are rounded upwards to the nearest whole percentage point.
- All references to 'days' includes business days only. 'Months' means calendar months.
- The timeframes in Figure 8 are not definitive because different insurers took different approaches to what constituted a 'decision' date. Five of the seven insurers – CGU Insurance Limited, NRMA Insurance, CommInsure, Allianz Australia Insurance Limited and QBE Insurance (Australia) Limited – provided data indicating the time taken to determine liability and also communicate the decision to policy-holders. Generally policy-holders were informed of the decision on the same day it was made, or only a short time afterwards. One insurer (Allianz Australia Insurance Limited), however, said that the time between making a decision to decline a claim and notifying the policy-holder of the decision, could be as many as eight days. RACQ Insurance Limited's data did not encompass when decision dates were communicated to policy-holders. It indicated when the General Manager for Personal Insurance Claims made decisions about liability and conveyed those decisions to the claims officers. The insurer said, however,

decisions were generally communicated to policy-holders soon after they were made.

- 98 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p115, para 14.36; p116, para 14.40-14.43; Recommendations 39 and 40].
- 99 Insurance Council of Australia, Media Release: 'QLD Insurance Claims Assessments Near Completion', 10 May 2011.
- 100 Figure 12(j) includes outstanding claims, but does not include withdrawn claims. All percentages are rounded upwards to the nearest whole percentage point. All references to 'days' includes business days only. 'Months' means calendar months.
- 101 Figure 12(k) excludes outstanding and withdrawn claims. All percentages are rounded upwards to the nearest whole percentage point. All references to 'days' includes business days only. 'Months' means calendar months.
- 102 The Commission did not compare the data AAMI provided with that of other insurers concerning finalisation of claims because it was not able to be satisfied, at the time of writing, that the data was comparable.
- 103 The Insurance Council of Australia took 'residential claims' to mean residential building claims only, including claims for non-body corporate policies and visualised as claims arising from standalone or duplex properties in domestic use (Statutory Declaration of Robert Whelan, 2 December 2011 [para 23]).
- 104 As at 24 November 2011. Across residential and commercial claims, 86 per cent of claims had been 'closed' and 14 per cent remained 'open'. See Insurance Council of Australia, General insurance claims response – 2010/2011 Queensland floods and cyclone, 24 November 2011 [p2-3]. The Insurance Council of Australia's report is available online at www.insurancecouncil.com.au. NRMA Insurance indicated to the Commission that 97 per cent of all accepted claims had been finalised as at 1 December 2011. RACQ Insurance Limited informed the Commission that, as at 30 September 2011, it had finalised 91 per cent of household claims arising from the 2010/2011 floods (Exhibit 893, Updated Table – RACQ Insurance Limited Finalisation Table as at 30 September 2011).
- 105 The Insurance Council of Australia did not seek further clarification as to how individual insurers interpret and record 'open' or 'closed'

claims. The Commission's experience was that different insurers record the finalisation date of claims at different times: some when the decision is finalised internally and others when the decision is communicated to the customer and the customer's file is closed on the insurer's records system. There is some potential, based on the Commission's experience, that some insurers interpreted 'closed' claims as encompassing more or fewer claims than other insurers.

- 106 Figure 12(l) includes outstanding claims, but does not include withdrawn claims. All percentage points are rounded upwards to the nearest whole percentage point. 'Months' means calendar months.
- 107 Figure 12(m) includes outstanding claims, but does not include withdrawn claims. All percentage points are rounded upwards to the nearest whole percentage point. 'Months' means calendar months.
- 108 CGU Insurance Limited indicated that manual processing of invoices generally took three business days.
- 109 See, for example: Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [para 36]; Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 22 September 2011 [para 36]; Statement of Paul Fahey (CommInsure), 23 September 2011, Appendix A [p28-36]; Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 132-33]; Exhibit 871, Statement of James Higgins (Suncorp Metway Insurance Limited), 14 September 2011 [para 230-238]; Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [para 255-263]; Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [para 34]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 266-272].
- 110 Figure 12(n) includes outstanding claims, but does not include withdrawn claims. All percentage points are rounded upwards to the nearest whole percentage point. 'Months' means calendar months. In this figure, 'finalised' claims only include claims that have been closed. It does not include claims where partial or progress payments have been made.

- 111 The duty of utmost good faith does require insurers to settle claims promptly (*Moss v Sun Alliance Aust Ltd* (1990) 55 SASR 145).
- 112 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p115: para 14.37].
- 113 Exhibit 879, Statement of James Higgins (AAMI), 3 October 2011, Annexure 2; Exhibit 1030, Statement of Jamie Dobbs (Vero Insurance), 7 October 2011, Annexure 1; Exhibit 674, Statement of James Higgins (Suncorp Metway Insurance Limited), 27 September 2011 [para 60]; Exhibit 877, Statement of James Higgins (Suncorp Metway Insurance Limited), 14 September 2011 [para 20-25]; Exhibit 591, Third Affidavit of Graham Dale (RACQ Insurance Limited), 14 September 2011; Exhibit 894, Fourth Affidavit of Graham Dale (RACQ Insurance Limited), 16 September 2011.
- 114 Exhibit 587, General Insurance Code of Practice [sections 6.2, 6.6].
- 115 Exhibit 587, General Insurance Code of Practice [sections 6.3, 6.7].
- 116 Exhibit 587, General Insurance Code of Practice [section 4.3].
- 117 Exhibit 587, General Insurance Code of Practice [section 6.10].
- 118 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p117-118: para 14.50-14.59; Recommendation 42].
- 119 Figure 15 includes outstanding claims, but does not include withdrawn claims. All references to 'days' includes business days only. 'Months' means calendar months. All percentages are rounded upwards to the nearest whole percentage point.
- Seven of the eight insurers measured the time taken to finalise internal reviews from the date the request for a review was made. RACQ Insurance Limited measured the time taken to finalise internal reviews from the date the policy-holder provided substantive submissions, rather than the date that the policy-holder indicated that he or she would be disputing a decision. However, insurers used slightly different 'completion' dates. AAMI, Allianz Australia Insurance Limited, CommInsure, CGU Insurance Limited, NRMA Insurance and Suncorp Metway Insurance Limited used the date on which the decision was communicated to the policy-holder. QBE

Insurance (Australia) Limited also did so, but where an extension was agreed with the insured, it used the agreed date as the end date. RACQ Insurance Limited used the date that the review was completed internally, though it indicated that the customer was usually advised on the same day. Figure 15 must be read with these slight differences in mind. In addition, in Suncorp Metway Insurance Limited's case, the disputes were not about the insurer's decisions about cause of inundation. The exclusion of Suncorp Metway Insurance Limited's data, however, has little effect on the results shown in Figure 15.

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- 120 See, for example: Leslie Cameron (5 business days): see Exhibit 897, Seventh Affidavit of Graham Dale (RACQ Insurance Limited), 13 October 2011 [para 40, 44-45]; Sally Doyle (6 business days): see Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011 [para 59 and 76]; Gary Lobley (7 business days): Exhibit 878, Statement of James Higgins (AAMI), 13 October 2011 [para 49 and 53]; Colin Sharp (8 business days): see Exhibit 851, Eighth Affidavit of Graham Dale (RACQ Insurance Limited), 15 October 2011 [para 46 and 50]; Kristy Sihvola (10 business days): see Exhibit 891, First Affidavit of Graham Dale (RACQ Insurance Limited), 1 September 2011 [para 42 and 51]. Michael Gourley (15 business days): Exhibit 898, Ninth Affidavit of Graham Dale (RACQ Insurance Limited), 19 October 2011 [Exhibit 5]. One matter (Nick Laszlo) was finalised in 16 business days: see Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011 [para 53, 61].
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- 121 Transcript, Thomas Fischer, 22 September 2011, Brisbane [p3009: lines 25-45]; Exhibit 593, Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 14 September 2011, Annexure B [para 8].
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- 122 Statement of Gary Townsend (Allianz Australia Insurance Limited), 16 September 2011 [para 5.1 and 5.5]; Exhibit 658, Email from Robert Clements to Allianz, 11 August 2011; Transcript, Robert Clements, 27 September 2011, Brisbane [p3269: line 35]; Exhibit 647, Statement of Robert Clements, 13 September 2011 [para 9].
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- 123 Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p110; para 14.14]. The Australian Securities and Investments Commission noted, in a different context, that advising a policy-holder calling to make a claim that the claim is likely to

be denied can have the effect of dissuading him or her from proceeding with the claim (Report 245: Review of general insurance claims handling and internal dispute resolution procedures, August 2011 [p25: para 133-137]). In dealing with the claims arising from the 2010/2011 floods, some insurers advised policy-holders when they called to claim that their policy did not cover damage caused by flood. The Commission expresses no view as to whether or not it is better for an insurer to advise a policy-holder calling to make a claim that their claim is likely to be denied. Provided that advice is given in good faith, and that a policy-holder is informed that if a claim is lodged, it will be fully assessed, the Commission acknowledges that some policy-holders would prefer to have this early indication of likelihood of denial of claim, rather than being lulled into a sense of false hope.

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- 124 This information is current as at 30 November 2011 (correspondence from Insurance Council of Australia to the Commission, 30 November 2011). The change arose from consultation between the Insurance Council of Australia, the ASIC and consumer advocates at the end of 2010 about ASIC's Regulatory Guide 165 on Dispute Resolution (see ASIC's Report 245: Review of general insurance claims handling and internal dispute resolution procedures, August 2011 [p25: para 137] and correspondence from Insurance Council of Australia to the Commission, 30 November 2011).
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- 125 This was also raised with the Natural Disaster Insurance Review, Inquiry into flood insurance and related matters, September 2011 [p24: para 1.35; p110: para 14.14]).
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- 126 Exhibit 587, General Insurance Code of Practice [section 3.2.3].
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- 127 Exhibit 587, General Insurance Code of Practice [section 4.3].
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- 128 Exhibit 871, Statement of James Higgins (Suncorp Metway Insurance Limited), 14 September 2011 [para 175]; Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [para 204]; Transcript, James Higgins (Suncorp Metway Insurance Limited/AAMI), 25 October 2011, Brisbane [p4319: line 46].
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- 129 RACQ Insurance Limited informed the Commission that during 2010 its 'Teleclaims' call centre received around 35 000 calls per month. In January 2011, the call centre received 60 090 calls

- and 71 463 calls in February 2011. It said this volume of calls was 'unprecedented' (Exhibit 896, Sixth Affidavit of Graham Dale (RACQ Insurance Limited), 13 October 2011 [para 47]).
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- 130 RACQ Insurance Limited informed the Commission that calls took longer to answer during December 2010 and January and February 2011. The highest average wait time was in February: 264 seconds (Exhibit 896, Sixth Affidavit of Graham Dale (RACQ Insurance Limited); see also Transcript, Graham Dale (RACQ Insurance Limited), Brisbane, 27 October 2011 [p4449: line 16].
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- 131 See, for example, Transcript, Sharron Campbell, 5 October 2011, Brisbane [p3682: lines 45-53].
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- 132 Transcript, Sharron Campbell, 5 October 2011, Brisbane [p3683: lines 1-8].
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- 133 Transcript, Graham Spackman, 29 September 2011, Emerald [p3403: lines 48-55].
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- 134 Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited, 22 September 2011, Annexure B [para 19]; Attachment 7.
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- 135 Submission by the Financial Ombudsman Service Limited to Natural Disaster Insurance Review, July 2011 [p10-11].
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- 136 Exhibit 587, General Insurance Code of Practice [section 3.2.3].
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- 137 Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 81]; Transcript, Dominic Dower (NRMA Insurance), 6 October 2011, Brisbane [p3836: line 39].
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- 138 Exhibit 659, Email from Allianz Australia Insurance Limited to Robert Clements, 16 August 2011; Statement of Garry Townsend (Allianz Australia Insurance Limited), 16 September 2011 [para 5.5].
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- 139 See, for example, Exhibit 673, Statement of Cresta Richardson, 15 September 2011 [para 8].
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- 140 Exhibit 674, Statement of James Higgins (Suncorp Metway Insurance Limited), 27 September 2011 [para 43]; Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4559: line 45 – p4560: line 5]; Transcript, Dominic Dower (NRMA Insurance), 6 October 2011, Brisbane [p3825: line 22 – p3826: line 3].
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- 141 Exhibit 843, Statement of James Higgins (AAMI), 7 October 2011 [para 22]; Annexure 2; Transcript, Sharron Campbell, 5 October 2011, Brisbane [p3676: lines 19-40].
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- 142 Transcript, Judith Dobrowa, 27 September 2011, Brisbane [p3282: lines 1-39]; Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3657: lines 8-21].
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- 143 Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 91]; Transcript, Dominic Dower (NRMA Insurance), 6 October 2011, Brisbane [p3832: line 23]; Statement of Paul Fahey (CommInsure), 12 September 2011, Appendix A [p36].
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- 144 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4477: lines 50-60; p4478: lines 22-48].
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- 145 Transcript, James Merchant (CGU Insurance Limited), 6 October 2011, Brisbane [p3818: line 47 – p3819: line 8].
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- 146 Exhibit 843, Statement of James Higgins (AAMI), 7 October 2011 [para 34]; Annexure 2. The insurer determined that the policy-holder had not been given incorrect information.
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- 147 Transcript, James Higgins (AAMI), 25 October 2011, Brisbane [p4345: line 43; p4248: lines 40-56]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p10: para 47; p23: para 122]; Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011 [p4454: lines 11-52].
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- 148 See, for example, Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4453: 10 – p4454: line 1]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p11: para 52]; Exhibit 824, First Affidavit of Bradley Heath (RACQ Insurance Limited), 23 September 2011 [p3: para 14]; Transcript, Dominic Dower (NRMA Insurance), 6 October 2011, Brisbane [p3834: line 55; p3835: line 20]; Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [p14: para 17]. In some cases, AAMI did not rely on hydrology reports (Transcript, James Higgins (AAMI), 25 October 2011, Brisbane [p4324: lines 28-50]).
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- 149 NRMA Insurance obtained reports which related to particular properties and to particular streets (Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [p14: para 64]).
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- 150 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4452: lines 12-15; p4478: line 50 – p4479: line 10]; Exhibit 892, Statutory Declaration of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p12: para 58 – p13: para 61; p20: para 108; p22: para 116 – p24: para 123; p29: para 149-150].
- 151 The reports of the Insurance Council of Australia hydrology panel are available on the Insurance Council's website: www.insurancecouncil.com.au.
- 152 Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [p26: para 145; p28: para 158-159]; Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [p11: para 12.3.1, 12.3.3; p12: para 12.3.5]. QBE Insurance (Australia) Limited also obtained reports for regions which were not covered by the Insurance Council's reports (Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 22 September 2011, Annexure B [p6: para 12.3.1; p7: para 12.3.3]).
- 153 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p12-13: para 12.3.1]; Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011, Appendix A [p12: para 56 – p13: para 63].
- 154 Statement of Paul Fahey (CommInsure), 23 September 2011, Appendix A [p10, 15-16].
- 155 See, for example, Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [p11: para 12.3.3]; Statement of Paul Fahey (CommInsure), 23 September 2011, Appendix A [p16].
- 156 For example, one insurer took a 'staged approach' to determining what information was required, considering whether site-specific hydrology was required once it had reviewed the general hydrology information (Exhibit 1024, Statement of Jane Pires (AAMI), 8 November 2011 [p1-2: para 7]). See 12.7.2 *Site-specific hydrology reports* for more information as to when this second stage would be adopted.
- 157 Transcript, Dominic Dower (NRMA Insurance), 6 October 2011, Brisbane [p3829: line 39].
- 158 As at 1 November 2011, NRMA Insurance had received a total of 2955 household claims, including 584 claims which were withdrawn and 1 claim which had not been determined.
- Withdrawn claims are excluded from the figure cited in the text. For more information, see 12.4 *The picture as a whole*.
- 159 Transcript, James Merchant (CGU Insurance Limited), 6 October 2011, Brisbane [p3813: line 17].
- 160 As at 1 November 2011, CGU Insurance Limited had received a total of 3897 household claims, including 1076 claims which were withdrawn and 284 claims which had not been determined. Withdrawn claims are excluded from the figure cited in the text. For more information, see 12.4 *The picture as a whole*.
- 161 Statement of Paul Fahey (CommInsure), 23 September 2011, Appendix A [p16].
- 162 As at 1 November 2011, CommInsure had received a total of 1644 household claims, including 171 claims which were withdrawn and 11 claims which had not been determined. Withdrawn claims are excluded from the figure cited in the text. For more information, see 12.4 *The picture as a whole*.
- 163 Exhibit 1025, Statement of Peter Unwin (AAMI), 8 November 2011 [p1: para 4]. See also, Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011 [p9-10: para 40].
- 164 As at 1 November 2011, AAMI had received a total of 1,560 household claims, including 176 claims which were withdrawn and 164 claims which had not been determined. Withdrawn claims are excluded from the figure cited in the text. For more information, see 12.4 *The picture as a whole*.
- 165 Exhibit 1024, Statement of Jane Pires (AAMI), 8 November 2011 [p1: para 4].
- 166 Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [p6: para 5; p12-13: para 12.3.5.1]; Statement of Paul Fahey (CommInsure), 23 September 2011, Appendix A [p16]; Exhibit 892, Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p12-13: para 58-61; p39: para 202]. Transcript, James Higgins (AAMI), 25 October 2011, Brisbane [p4319: line 19].
- 167 Exhibit 1024, Statement of Jane Pires (AAMI), 9 November 2011 [p1-2: para 7]. See also Exhibit 843, Statement of James Higgins (AAMI), 7 October 2011 [p11: para 54]: 'it was exceptionally difficult, if not impossible, to obtain site-specific reports.'

- 168 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigations into Causes of Property Inundation: Overview of Insurance Reports*, 5 November 2011 [p8: para 11-13]; Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigations into Causes of Property Inundation: Review of Insurance Reports*, 6 November 2011 [p10-11: para 29-30]; Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p3: para 6 and 8].
- 169 Sinclair Knight Mertz advised that where storm events had an intensity of less than the 2-Year ARI, it is considered most unlikely that they would have been sufficient to exceed the local drainage system (Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p3: para 9]).
- 170 RACQ Insurance Limited's household policy provided cover for 'flash flood and/or stormwater run-off' which was defined as: 'A sudden flood caused by heavy rain that fell no more than 24 hours prior to the flash flood or stormwater run-off'. CommInsure also provided cover for 'flash flood', defined as: 'The overflow of any lake, river, creek, stormwater channel, canal or any other watercourse (whether natural, altered or man made), caused by a storm, where the flooding occurs within 24 consecutive hours of the storm having commenced.'
- 171 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p4-5: para 13; p8: para 22].
- 172 Insurance Council of Australia Hydrology Panel, *Flooding in the Brisbane River Catchment January 2011: Volume 3, Flooding in Ipswich City LGA*, 20 February 2011 [p98]. The report is available on the Insurance Council of Australia's website: www.insurancecouncil.com.au.
- 173 See, for example, Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [p6: para 5]; Statutory Declaration of Shaun Standfield, 22 September 2011 (QBE Insurance (Australia) Limited), Annexure B [para 12.3.5.1-12.3.5.2].
- 174 See, for example, Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [p28: para 160]; Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011 [p9-10: para 40]; Transcript, James Higgins (AAMI), 25 October 2011, Brisbane [p4310: lines 47-55]; Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 22 September 2011, Annexure B [para 12.3.5].
- 175 Transcript, James Higgins (AAMI), 25 October 2011, Brisbane [p4311: lines 8-22].
- 176 Transcript, Dominic Dower (NRMA Insurance), 6 October 2011, Brisbane [p3829: lines 20-25].
- 177 Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 70].
- 178 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p8-10: para 23-38]. For details of the particular matters, see Statement of Garry Townsend (Allianz Australia Insurance Limited), 16 September 2011; Exhibit 843, Statement of James Higgins (AAMI), 7 October 2011; Exhibit 878, Statement of James Higgins (AAMI), 13 October 2011.
- 179 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p4: para 10 – p5: para 15]. For details of the particular matter, see Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011.
- 180 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigations into Causes of Property Inundation: Overview of Insurance Reports*, 5 November 2011 [p8: para 11-13].
- 181 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p23: para 122].
- 182 Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [para 147-150 and 160]; Transcript, James Higgins (AAMI), 25 October 2011, Brisbane [p4311: lines 1-6; p4315: line 42; p4316: line 3]; Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p12: para 12.3.1; p14: 12.3.5]; Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 65 and 70] and Transcript, Dominic Dower, 6 October 2011, Brisbane [p3829: lines 20-43]. See also Exhibit 719, Statutory Declaration of Matthew Jarrett (NRMA Insurance), 22 September 2011 [para 25]; Statement of Paul Fahey (CommInsure),

- 23 September 2011, Appendix A [p16-17]; Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 22 September 2011, Annexure B [para 12.3.5]; Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011, Annexure B [para 12.3.3 and 12.3.5.2].
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- 183 Transcript, Dominic Dower, 6 October 2011, Brisbane [p3829: lines 20-43]. See also Exhibit 719, Statutory Declaration of Matthew Jarrett (NRMA Insurance), 22 September 2011 [para 25].
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- 184 Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [p28: para 160].
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- 185 Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 22 September 2011, Annexure B [para 12.3.5.1].
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- 186 Exhibit 593, Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 14 September 2011; Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011; Exhibit 626, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011; Exhibit 879, Statement of James Higgins (AAMI), 28 September 2011; Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011; Exhibit 719, Statutory Declaration of Matthew Jarrett (NRMA Insurance), 22 September 2011 [para 25-26].
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- 187 Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011 [p3: para 11]; Transcript, James Higgins (AAMI), 25 October 2011, Brisbane [p4311: line 31].
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- 188 Exhibit 879, Statement of James Higgins (AAMI), 28 September 2011 [p6: para 21-22].
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- 189 Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 66 and 115]; Statement of Garry Townsend (Allianz Australia (Insurance) Limited), 12 September 2011 [para 12.3.5.2]; Statement of Paul Fahey (CommInsure), 23 September 2011, Appendix A [p16].
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- 190 Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 22 September 2011, Annexure B, Attachment 4; Water Technology, Supplementary report, 14 September 2011; Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 11; Annexure 18; Exhibit 719, Statutory Declaration of Matthew Jarrett (NRMA Insurance), 22 September 2011, Annexure A [p141-150]; Statement of Garry Townsend (Allianz Australia Insurance Limited), Attachment 5.2; Exhibit 843, Statement of James Higgins (AAMI), 7 October 2011, Annexure 3; Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011, Annexure 8.
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- 191 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigations into Causes of Property Inundation: Review of Insurance Reports*, 6 November 2011 [p11: para 31].
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- 192 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigations into Causes of Property Inundation: Review of Insurance Reports*, 6 November 2011 [p9: para 27; p13: para 32].
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- 193 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigations into Causes of Property Inundation: Review of Insurance Reports*, 6 November 2011 [p9: para 28; p11: para 31; p13: para 33].
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- 194 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigations into Causes of Property Inundation: Review of Insurance Reports*, 6 November 2011 [p7: para 26].
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- 195 The Financial Ombudsman Service, Circular: Flood Edition, Issue 7, Update 1, November 2011, available at http://fos.org.au/centric/home_page/publications/the_circular.jsp. In a number of cases, the ombudsman has ruled that insurers were liable to pay part of a policy-holder's claim because he was persuaded that stormwater run-off had initially caused damage before flood water inundated the property. See the following determinations, for example, which are available on the Financial Ombudsman Service's website: case numbers 241994, 243793, 242183, 241145, 235302, 239580, 239578, 239186 and 235758.
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- 196 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p21-22: para 115; p27: para 138, 140]; Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [p25: para 135, 139; p26: para 144; p31: para 178]; Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 22 September 2011, Annexure B [para 12.1.1]; Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [para 12 and 12.1]. NRMA Insurance used its internal loss assessors (Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 51]).
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- 197 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p21-22: para 115]; Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [p25: para 140]; Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 23, 54]; Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 22 September 2011, Annexure B [para 12.1.2].
- 198 Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [p25-26: para 143; p31-32: para 179]; Transcript, James Higgins (AAMI), 25 October 2011, Brisbane [p4312: line 31; p4317: line 35].
- 199 Statement of Paul Fahey (CommInsure), 23 September 2011, Annexure A [p4].
- 200 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p11: para 12.2.3, 12.2.4]; Transcript, James Merchant, 6 October 2011, Brisbane [p3807: lines 10-45]. Loss assessors were not appointed if the insurer considered that a policy-holder's responses to a standard set of questions, aerial photography, flood mapping and an area hydrologist 'conclusively' established the cause of damage.
- 201 See, for example, Exhibit 593, Statutory Declaration of Shaun Standfield (QBE Insurance (Limited) Australia), 14 September 2011, Annexure B; Attachment 1; Exhibit 879, Statement of James Higgins (AAMI), 28 September 2011, Annexure 5; Exhibit 878, Statement of James Higgins (AAMI), 13 October 2011, Annexure 4; Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011, Annexure 4; Statement of Garry Townsend (Allianz Australia Insurance Limited), 16 September 2011, Attachment 2.3.
- 202 Statement of Garry Townsend (Allianz Australia Insurance Limited), 12 September 2011 [p9: para 12, 12.1.3; p14: para 17].
- 203 Statement of Garry Townsend (Allianz Australia Insurance Limited), 16 September 2011, Attachment 2.3 [p3].
- 204 Statement of Garry Townsend (Allianz Australia Insurance Limited), 16 September 2011 [p8: para 3.8-3.9].
- 205 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p8: para 23 – p9: para 28].
- 206 Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [p25: para 141].
- 207 Transcript, James Higgins, 25 October 2011, Brisbane [p4312: line 5].
- 208 Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011, Annexure 6.
- 209 Transcript, James Higgins, 25 October 2011, Brisbane [p4310: line 50].
- 210 Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011, Annexure 4 [p2]; Exhibit 878, Statement of James Higgins (AAMI), 13 October 2011, Annexure 4; Exhibit 843, Statement of James Higgins (AAMI), 7 October 2011, Annexure 6 [p2].
- 211 Exhibit 879, Statement of James Higgins (AAMI), 28 September 2011, Annexure 5 [p3].
- 212 Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011, Annexure 7; Transcript, James Higgins, 25 October 2011, Brisbane [p4307: line 41].
- 213 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p9: para – p23: para 38].
- 214 CGU Insurance Limited, Notice to Loss Adjusters – January 2011, provided in response to the Commission Requirement, 14 October 2011.
- 215 Statutory Declaration of James Merchant (CGU Insurance Limited), 25 November 2011 [p2: para 10.1; p3: para 13-14]; Transcript, James Merchant, 6 October 2011, Brisbane [p3820: line 2; p3821: lines 8-11].
- 216 Statutory Declaration of James Merchant (CGU Insurance Limited), 25 November 2011 [p2: para 10.3].
- 217 CGU Insurance Limited, Notice to Loss Adjusters – January 2011, provided in response to the Commission Requirement, 14 October 2011.
- 218 Statutory Declaration of James Merchant (CGU Insurance Limited), 25 November 2011 [p2: para 11-12; p3: para 21].
- 219 Statutory Declaration of James Merchant (CGU Insurance Limited), 25 November 2011 [p3: para 14-15, 17-18].

- 220 Statutory Declaration of James Merchant (CGU Insurance Limited), 25 November 2011 [p2: para 10.4; p3: para 21].
- 221 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 4.
- 222 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 9.
- 223 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011 [p2: para 6.7]; Annexure 2.
- 224 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011 [p2-3: para 7].
- 225 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 2 [p5].
- 226 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p6: para 17-18].
- 227 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p6: para 17].
- 228 Statutory Declaration of Dion Gooderham (CGU Insurance Limited), 21 November 2011 [p4: para 23]. The term ‘triage process’ was used in correspondence between the Australian Securities and Investments Commission and CGU Insurance Limited (see CGU Insurance Limited’s response to the Commission Requirement, 14 October 2011), and in the Commission’s public hearings (see, for example, Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p6: para 27]; Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3638: lines 47-53]; Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p4: para 19-20]; Transcript, Peter Harmer, 6 October 2011, Brisbane [p3779: lines 27-30].
- 229 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p11: para 12.2.3, 12.2.4]; Transcript, James Merchant, 6 October 2011, Brisbane [p3807: lines 10-45].
- 230 Transcript, James Merchant, 6 October 2011, Brisbane [p3813: line 16].
- 231 Transcript, James Merchant, 6 October 2011, Brisbane [p3807: line 1].
- 232 The national claims manager said in his statutory declaration, dated 22 September 2011, that approximately 190 claims were declined without a site inspection having been carried out (Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p11: para 12.2.1]). He confirmed this in oral evidence (Transcript, James Merchant, 6 October 2011, Brisbane [p3802: lines 1-7]). CGU Insurance Limited informed the Commission on 18 January 2012 that this information was not correct. It lawyers advised that, ‘following further investigation... it appears that the 190 estimate is the number of site assessments that were conducted prior to the process change on or about 17 February 2011. The number of household claims declined without a site assessment is approximately 340’.
- 233 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p7: para 34]; Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3639: line 6].
- 234 Statutory Declaration of Dion Gooderham (CGU Insurance Limited), 21 November 2011 [p4: para 25.1; p5: para 29.1].
- 235 Statutory Declaration of James Merchant (CGU Insurance Limited), 25 November 2011 [p1: para 3].
- 236 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 7.
- 237 Transcript, James Merchant, 6 October 2011, Brisbane [p3805: lines 48-53; p3815: lines 13-22]; Statutory Declaration of James Merchant (CGU Insurance Limited), 25 November 2011 [p1: para 4.1].
- 238 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p10: para 11].
- 239 Statutory Declaration of James Merchant (CGU Insurance Limited), 25 November 2011 [p1: para 4].
- 240 Sinclair Knight Merz, *Brisbane River 2011 Flood Event – Investigation into Causes of Property Inundation: Review of Four Insurance Matters*, 14 December 2011 [p6: para 19 – p8: para 21].
- 241 Exhibit 715, Statement of Sallyanne Doyle, 3 October 2011, Attachment 4.

- 242 Exhibit 626, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 1 [p3]; Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 2 [p2-3].
- 243 Correspondence from the Australian Securities and Investments Commission to CGU Insurance Limited, dated 20 April 2011, provided by CGU Insurance Limited in response to the Commission Requirement, 14 October 2011.
- 244 CGU Insurance Limited, QLD Flood Claims Process Review – 16th Feb 2011, provided in response to the Commission Requirement, 14 October 2011.
- 245 Correspondence from CGU Insurance Limited to the Australian Securities and Investments Commission, dated 30 June 2011, provided by CGU Insurance Limited in response to the Commission Requirement, 14 October 2011.
- 246 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011 [p8: para 6].
- 247 See Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011, Annexure 3. A file note dated 22 January 2011 states that the policy-holder's broker 'was already told on 18/1 that the flood team would be up and running on 20/1...'
- 248 Statutory Declaration of Dion Gooderham (CGU Insurance Limited), 21 November 2011 [p5: para 29].
- 249 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p11: para 12.2].
- 250 Transcript, James Merchant, 6 October 2011 [p3804: line 22].
- 251 Transcript, James Merchant, 6 October 2011 [p3806: line 41].
- 252 Transcript, James Merchant, 6 October 2011 [p3806: line 57].
- 253 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p8: para 6]; Transcript, James Merchant, 6 October 2011, Brisbane [p3804: lines 30-42].
- 254 Transcript, James Merchant, 6 October 2011, Brisbane [p3807: lines 10-32].
- 255 CGU Insurance Limited, Queensland Floods Claims Reference Document, provided in response to the Commission Requirement, 14 October 2011. It appears from a note of a telephone conversation between a CGU Insurance Limited staff member and a policy-holder's broker that, as at 18 January 2011, CGU Insurance Limited was not appointing assessors to inspect properties the subject of claims (Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011, Annexure 3 [p1]).
- 256 CGU Insurance Limited, 'Validation process Brisbane and surrounding area's [sic]', provided in response to the Commission Requirement, 14 October 2011.
- 257 A file note in CGU Insurance Limited's records for one policy-holder, dated 1 February 2011, states:
- '-await call from [policy-holder]
- ~ask flood scripting – check with [policy-holder] which house is hers on near map
- ~if clearly flood – advise [policy-holder] no cover & arrange decline letter
- ~determine if assessing is required.'
- (Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 2.)
- 258 Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p3: para 14.3].
- 259 Transcript, Peter Harmer, 6 October 2011, Brisbane [p3780: line 25].
- 260 Transcript, Peter Harmer, 6 October 2011, Brisbane [p3780: lines 5-55].
- 261 Exhibit 742, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 3 [p11: para 12.1.2, 12.2.4]. This information was given in response to a question in a Requirement, issued on 2 September 2011, which asked: 'At what stage of the claims handling process were site assessments/inspections carried out?' Mr Merchant's answer to this question did not include the information Mr Harmer gave in evidence.
- 262 Transcript, James Merchant, 6 October 2011, Brisbane [p3807: line 37; p3815: line 20].

- 263 Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011 [p9: para 81]; Transcript, James Merchant, 6 October 2011, Brisbane [p3806: line 50; p3809: line 40 – p3810: line 5].
- 264 CGU Insurance Limited, QLD Flood Claims Process Review – 16th Feb 2011, provided in response to the Commission Requirement, 14 October 2011.
- 265 Transcript, Judith Dobrowa, 27 September 2011, Brisbane [p3284: lines 27-32].
- 266 Transcript, Judith Dobrowa, 27 September 2011, Brisbane [p3282: line 12; p3284: line 27; p3293: line 32; p3294: line 29].
- 267 Transcript, Judith Dobrowa, 27 September 2011, Brisbane [p3293: line 50; p3294: line 30].
- 268 Transcript, Judith Dobrowa, 27 September 2011, Brisbane [p3284: lines 27, 55].
- 269 Transcript, Judith Dobrowa, 27 September 2011, Brisbane [p3294: line 30].
- 270 Exhibit 664, Notes made by Judith Dobrowa.
- 271 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 2.
- 272 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 2; Exhibit 663, Transcript of conversation between CGU Insurance Limited consultant and Judith Dobrowa.
- 273 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 4.
- 274 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p3: para 14-16]; Attachment 4.
- 275 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p3-4: para 16].
- 276 Transcript, James Merchant, 6 October 2011, Brisbane [p3809: line 55]. See also Transcript, James Merchant, 6 October 2011, Brisbane [p3810: line 50; p3811: lines 5-10].
- 277 Transcript, James Merchant, 6 October 2011, Brisbane [p3808: lines 7-32].
- 278 Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011, Annexure 3 [p3-4].
- 279 Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3636: line 1; p3637: lines 3-20, 45-50; p3658: line 20].
- 280 Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011 [p3: para 25]; Annexure 12.
- 281 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p4: para 16-17]; Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3637: lines 10-22; p3657: lines 45-51].
- 282 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p4: para 18]; Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011 [p3: para 26]; Annexure 3.
- 283 Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3666: line 55 – p3667: line 17].
- 284 Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011, Annexure 3. See also Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011 [p3: para 26].
- 285 The second note of the conversation, the one provided to Ms Doyle in March 2011, does not refer to any discussion about getting further information from the property manager or tenant: Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011, Attachment 4. Mr Merchant gave evidence that Ms Doyle said that ‘she would provide [CGU Insurance Limited] with details of her tenant so that further information could be gathered about the claim’: Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011 [p3: para 26].
- 286 Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011, [p4: para 27-28]; Annexure 3; Annexure 13; Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011, Annexure 1.
- 287 Exhibit 717, Statutory Declaration of James Merchant (CGU Insurance Limited), 3 October 2011, Annexure 3; Annexure 15. See also para 30-32.
- 288 Exhibit 715, Statement of Sallyanne Doyle [p5: para 24]; Attachment 12.
- 289 Exhibit 715, Statement of Sallyanne Doyle [p5: para 23]; Attachment 11.
- 290 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p5: para 25]; Transcript,

- Sallyanne Doyle, 5 October 2011, Brisbane [p3638: lines 1-22].
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- 291 Correspondence from CGU Insurance Limited to the Australian Securities and Investments Commission, dated 13 May 2011, provided by CGU Insurance Limited in response to the Commission Requirement, 14 October 2011.
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- 292 Statutory Declaration of Dion Gooderham (CGU Insurance Limited), 21 November 2011 [para 33.2 and 42].
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- 293 Correspondence from CGU Insurance Limited to the Australian Securities and Investments Commission, dated 30 June 2011, provided by CGU Insurance Limited in response to the Commission Requirement, 14 October 2011.
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- 294 Statutory Declaration of Dion Gooderham (CGU Insurance Limited), 21 November 2011 [p7: para 44].
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- 295 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p5: para 26].
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- 296 Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011, Annexure 2.
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- 297 Transcript, Peter Harmer, 6 October 2011, Brisbane [p3783: lines 18-30].
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- 298 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [para 30]; Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3638: line 55]; Transcript, Peter Harmer, 6 October 2011, Brisbane [p3783: lines 56-58].
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- 299 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p7: para 30].
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- 300 Transcript, Peter Harmer, 6 October 2011, Brisbane [p3780: line 30].
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- 301 Transcript, Peter Harmer, 6 October 2011, Brisbane [p3780: line 25]. In his statutory declaration, dated 3 October 2011 (Exhibit 716), Mr Harmer said, at page 6, paragraph 27: 'Ms Doyle told us that we had not made it clear to her that an assessor would be appointed by CGU Insurance Limited if the customer did not agree with our assessment of their claim and sought for the claim to be assessed'.
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- 302 Transcript, Peter Harmer, 6 October 2011, Brisbane [p3781: line 2].
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- 303 Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p5: para 26].
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- 304 Transcript, Peter Harmer, 6 October 2011, Brisbane [p3780: line 30]; Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p6: para 27].
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- 305 Transcript, James Merchant, 6 October 2011, Brisbane [p3805: lines 34, 55; p3806: lines 15-20].
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- 306 CGU Insurance Limited, QLD Flood Claims Process Review – 16th Feb 2011, provided in response to the Commission Requirement, 14 October 2011.
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- 307 CGU Insurance Limited, email dated 17 February 2011, provided in response to the Commission Requirement, 14 October 2011.
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- 308 CGU Insurance Limited, QLD Flood Claims Process Review – 16th Feb 2011, provided in response to the Commission Requirement, 14 October 2011.
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- 309 The Commission was concerned to see all scripts used by CGU Insurance Limited staff dealing with flood claims. Two scripts were exhibited to Mr Merchant's main statutory declaration (Exhibit 742): one used by claims lodgement staff (Annexure 5 to his statutory declaration) and the standard set of questions (Annexure 7 to his statutory declaration). Mr Merchant confirmed in evidence that these were the only scripts used: Transcript, 6 October 2011, Brisbane [p3806: lines 21-28]. The document dated 16 February 2011 refers to 'customer scripting when communicating the decision to deny the claim'. If this is a reference to another script, it has not been provided to the Commission and Mr Merchant did not mention it when asked if all scripts had been provided to the Commission.
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- 310 Transcript, James Merchant, 6 October 2011, Brisbane [p3805: line 30].
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- 311 Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p7-8: para 34]; Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3640: lines 24-42].
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- 312 Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p5: para 25]; Transcript, Peter Harmer, 6 October 2011, Brisbane [p3785: line 15].
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- 313 Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3640: line 47].
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- 314 Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3640: lines 24-48]; Exhibit 715,

	Statement of Sallyanne Doyle, 5 October 2011 [p8: para 36].	332	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3785: lines 20-30].
315	Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p8: para 36].	333	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3785: line 31].
316	Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3641: lines 14-35]; Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p8: para 37].	334	Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p4: para 21.1]; Transcript, Peter Harmer, 5 October 2011, Brisbane [p3787: line 13].
317	Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p9: para 38].	335	Transcript, Peter Harmer, 5 October 2011, Brisbane [p3787: line 25].
318	Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p9: para 39]; Attachment 3.	336	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3792: lines 5-17; p3796: lines 5-15].
319	Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p9: para 39-40]; Attachment 3.	337	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3796: lines 9-13].
320	Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p10: para 42]; Attachment 4.	338	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3795: line 50; p3796: line 18].
321	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3790: lines 15, 37].	339	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3787: lines 48-55; p3788: line 55; p3791: lines 8-15; p3796: line 33]; Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p4: para 21.3].
322	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3791: line 6; p3794: lines 28, 43]; Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p4: para 21.3].	340	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3797: lines 42-51].
323	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3787: line 1].	341	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3796: line 35; p3792: line 55].
324	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3785: lines 48-58].	342	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3788: lines 20-30].
325	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3786: line 5].	343	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3789: lines 8, 30-35].
326	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3786: line 30]; Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p5: para 21.4].	344	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3790: lines 28-50]; Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p6: para 35].
327	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3785: line 53; p3786: lines 15-20; p3795: lines 35-45].	345	Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011, Attachment 3.
328	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3786: line 25].	346	Transcript, Peter Harmer, 6 October 2011, Brisbane [p3790: line 37].
329	Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p5: para 21.4].	347	Exhibit 715, Statement of Sallyanne Doyle, 5 October 2011 [p6: para 29]; Attachment 5; Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3641: line 37 – p3642: line 16].
330	Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011 [p4: para 25].	348	Transcript, Sallyanne Doyle, 5 October 2011, Brisbane [p3643: lines 1-24].
331	Exhibit 716, Statutory Declaration of Peter Harmer (CGU Insurance Limited), 3 October 2011, Annexure 1.		

- 349 Statutory Declaration of Dion Gooderham (CGU Insurance Limited), 21 November 2011 [p9: para 58].
- 350 Statement of Gregory Kirk, 5 October 2011, Annexure 4; Statement of Michael Saadat, 21 October 2011 [p3: para 9 – p4: para 12].
- 351 Determination 239347. The ombudsman has found in favour of CGU Insurance Limited policy-holders in four other cases, two on the basis that the insurer could not prove it clearly informed the policy-holder of the exclusion; and two on the basis that stormwater run-off had initially inundated the property.
- 352 CGU Insurance Limited, Media Release: ‘CGU to provide automatic flood cover in home, contents and landlords policies and improved customer experience’, 9 December 2011.
- 353 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4451: lines 18-38; p4456: lines 6-15]; Exhibit 895, Fifth Affidavit of Graham Dale (RACQ Insurance Limited), 21 September 2011, Exhibit 8.
- 354 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 167-170, 199]; Transcript, Graham Dale, 28 October 2011, Brisbane [p4549: line 4; p4558: lines 15-31].
- 355 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4453: 10 – p4454: line 2]; Exhibit 824, First Affidavit of Bradley Heath (RACQ Insurance Limited), 23 September 2011 [para 14].
- 356 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011, Exhibit 3 [p28].
- 357 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011, Exhibit 3 [p27].
- 358 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4452: lines 10-15; p4478: lines 50 – p4479: line 10]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 58-60, 108, 116-123, 149-150].
- 359 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011 [p4453: line 20 – p4454: line 52; p4474: lines 10-30]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 47, 143-144].
- 360 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4454: lines 44-46; p4479: lines 7-48]; Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4556: lines 40-55].
- 361 Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4542: line 50 – p4544: line 55].
- 362 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 167-187]; Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4451: lines 28-38].
- 363 Exhibit 892, Second affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 172-173].
- 364 Exhibit 892, Second affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 172-183]; Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4462: lines 48-52].
- 365 Exhibit 901, RACQ Media Release dated 2 August 2011.
- 366 Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4512: line 54 – p4513: line 3].
- 367 Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4513: lines 29-35].
- 368 Exhibit 824, First Affidavit of Bradley Heath (RACQ Insurance Limited), 23 September 2011 [Exhibit 3: p36].
- 369 Exhibit 824, First Affidavit of Bradley Heath (RACQ Insurance Limited), 23 September 2011 [Exhibit 3: p33].
- 370 Exhibit 824, First Affidavit of Bradley Heath (RACQ Insurance Limited), 23 September 2011 [para 21 and 38-39].
- 371 Exhibit 824, First Affidavit of Bradley Heath (RACQ Insurance Limited), 23 September 2011 [Exhibit 2: p6-11].
- 372 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [Exhibit 4: p120-122].
- 373 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [Exhibit 4, p127]. See also: Exhibit 902, Bundle of correspondence.

- 374 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [Exhibit 4, p150]. See also: Exhibit 902, Bundle of correspondence.
- 375 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [Exhibit 4, p157]. See also: Exhibit 902, Bundle of correspondence.
- 376 Transcript, Graham Dale, 28 October 2011, Brisbane [p4514: line 58 – p4515: line 45].
- 377 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [Exhibit 4, p170]. See also exhibit 902, Bundle of correspondence.
- 378 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [para 43(o)-(p)]. See also Transcript, Graham Dale, 28 October 2011, Brisbane [p4563: lines 5-40].
- 379 Thirty-five claims were declined on 7 April 2011, 60 on 15 April 2011 and 5 on 21 April 2011 (Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011, Exhibit 2).
- 380 Exhibit 902, Bundle of correspondence.
- 381 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011, Exhibit 2.
- 382 Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4540, lines 1-10].
- 383 Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4541: lines 50-57].
- 384 Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4540: line 41 – p4541: line 8].
- 385 Transcript, Graham Dale, 27 October 2011, Brisbane [p4464: line 53 – p4466: line 20; p4467: line 50; p4468: lines 5-56].
- 386 Transcript, Graham Dale, 27 October 2011, Brisbane [p4465: lines 24-51]. In his second affidavit, the insurer's general manager, personal insurance claims, acknowledged that Water Technology 'required more complete data' in order to 'accurately estimate' the effect of the Brisbane River on the flooding in Ipswich, and that the modelling Water Technology had done was based on the '(limited) information then at its disposal'. He said the report adopted a 'cautious approach with respect to the data then available to it' (Exhibit 892, Second Affidavit of Graham Dale, 19 September 2011 [para 175, 178]). See also Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [para 17(a)].
- 387 Transcript, Graham Dale, 27 October 2011, Brisbane [p4464: line 53 – p4465: line 51; p4467: lines 28-50; p4468: lines 7, 48-55]; Exhibit 892, Second Affidavit of Graham Dale, 19 September 2011 [para 178]; Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [para 19-20, 23].
- 388 Exhibit 824, First Affidavit of Bradley Heath (RACQ Insurance Limited), 23 September 2011 Exhibit 2 [p6-11].
- 389 Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4547: line 50].
- 390 Exhibit 824, First Affidavit of Bradley Heath, 23 October 2011 [para 20].
- 391 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011 [para 26].
- 392 Transcript, Graham Dale, 28 October 2011, Brisbane [p4563: line 47].
- 393 Exhibit 824, First Affidavit of Bradley Heath, 23 September 2011, Exhibit 4 [p193].
- 394 Exhibit 587, General Insurance Code of Practice [section 3.4.5(a)]. The same expectation applies when insurers notify policy-holders of the outcome of disputes (Exhibit 587, General Insurance Code of Practice [section 6.9]). These standards are presently subject to section 4.3 of the Code which has the effect of relieving insurers of their obligations under the Code when dealing with a high volume of claims as a result of a natural disaster (Exhibit 587, General Insurance Code of Practice [section 4.3]).
- 395 See, for example, Exhibit 593, Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 14 September 2011, Attachment 7. See also Exhibit 873, Statement of James Higgins (AAMI), 14 September 2011 [para 167, 171].
- 396 See, for example, Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 5.
- 397 Transcript, James Merchant (CGU Insurance Limited), 6 October 2011, Brisbane [p3817: line 31].
- 398 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011 [para 7].

- 399 Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011, Annexure 2.
- 400 CGU Insurance Limited, QLD Flood Claims Process Review – 16th Feb 2011, provided in response to the Commission Requirement, 14 October 2011.
- 401 Transcript, James Merchant (CGU Insurance Limited), 6 October 2011, Brisbane [p3818: lines 35-40].
- 402 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [p31: para 158]; Exhibit 17 [p367, 369]; Exhibit 897, Seventh Affidavit of Graham Dale (RACQ Insurance Limited), 13 October 2011, Exhibit 33 [p864-865]; Exhibit 851, Eighth Affidavit of Graham Dale (RACQ Insurance Limited), Exhibit 26 [p317]; Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4482: lines 19-36]. The script another insurer used when informing a policy-holder that his or her claim had been denied, by contrast, stated that the assessment of the claim had involved ‘a physical assessment of [the] property’ and a review of ‘aerial photos taken during the flood, utilising a QLD Government website mapping areas that were impacted by flooding, along with an external hydrology report specific to your property’ (Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [p356]).
- 403 See, for example, Exhibit 898, Ninth Affidavit of Graham Dale (RACQ Insurance Limited), 19 October 2011, Exhibit 17 [p190-191]; Exhibit 897, Seventh Affidavit of Graham Dale (RACQ Insurance Limited), 13 October 2011, Exhibit 22 [p184-185]; Exhibit 851, Eighth Affidavit of Graham Dale (RACQ Insurance Limited), Exhibit 19 [p203-204].
- 404 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4486: lines 1-40]. The insurer similarly defended the standard letter which advised policy-holders of the outcome of internal reviews. That letter did not give reasons for a decision to maintain the initial denial of the claim (Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4500: line 55]). It stated no more than the review had been completed and the result of it. The insurer’s general manager of claims could not think of any other information which might be included in the letter for a policy-holder’s benefit. More detailed reasons were given, however, if a lawyer had made a submission to the insurer on a policy-holder’s behalf.
- 405 Transcript, Graham Dale, 28 October 2011, Brisbane [p4547: line 55 – p4548: line 20; p4548: line 55 – p4549: line 10].
- 406 Exhibit 587, General Insurance Code of Practice [section 3.4.3].
- 407 The footnote in the code then sets out some examples of special circumstances. They are ‘where information is subject to privacy laws, where information is protected from disclosure by law, or where the release of the information may be prejudicial to us in relation to a dispute about your claim’.
- 408 Exhibit 587, General Insurance Code of Practice [section 6.1.4].
- 409 QBE Insurance (Australia) Limited provided copies of all relevant material on which it had relied (Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 23 September 2011, Annexure B [para 15-16] and Exhibit 593, Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited, 14 September 2011, Annexure B [para 7.4]). AAMI provided a copy of the loss assessor’s report and any site-specific hydrology report with letters to policy-holders confirming denial of their claims. Where an Insurance Council hydrology report was relied on, AAMI informed the policy-holder and told the policy-holder that it was available on the Insurance Council’s website (Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [para 170]). NRMA Insurance provided a copy of the hydrology report (general area or site-specific) which it commissioned and relied on to make the claim decision. Policy-holders were advised on how to access documents relied on which were in the public domain (Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 100] and see Transcript, Dominic Dower (NRMA Insurance), 6 October 2011, Brisbane [p3834: line 50 – p3835: line 56]).
- 410 Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4485: line 3 – p4486: line 13]; Transcript, Graham Dale (RACQ Insurance Limited), 28 October 2011, Brisbane [p4546: line 42]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 158 and

- 276]; see also Exhibit 662, Statutory Declaration of James Merchant (CGU Insurance Limited), 22 September 2011 [para 8] and Transcript, Judith Dobrowa, Brisbane, 27 September 2011 [p3286: lines 35-43].
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- 411 Submission by the Financial Ombudsman Service to the Natural Disaster Insurance Review, July 2011 [p15]. The submission does not state the insurer or insurers in respect of whom such complaints were made. The Commission is not otherwise aware of the identity of the insurer/s to which this submission relates.
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- 412 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 160-164]; Transcript, Graham Dale (RACQ Insurance Limited), 27 October 2011, Brisbane [p4489: line 1 – p4491: line 51]; Transcript, Graham Dale, 28 October 2011, Brisbane [p4550: lines 8-57].
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- 413 Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 163].
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- 414 Under its terms of reference, the Financial Ombudsman Service ‘must identify systemic issues and refer [them] to the relevant [insurer] for remedial action’. It must also report systemic issues to ASIC. A systemic issue is ‘an issue that will have an effect on other persons... beyond the parties to the Dispute’.
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- 415 Affidavit of Bradley Heath (RACQ Insurance Limited), 28 November 2011, Exhibit 4.
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- 416 *The Daniels Corporation International Pty Ltd v Australian Competition and Consumer Commission* (2002) 213 CLR 543 at 563 per McHugh J.
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- 417 A similar sentiment is expressed by the ombudsman in its submission to the Natural Disaster Insurance Review, at page 12:
- Delays by some insurers in exchanging information in particular hydrologists reports, or requiring multiple reports prior to making a claim decision has caused significant disputes between consumer, advisors and insurers. The provision of information relied upon need to be strengthened to ensure all information relied upon is exchanged with a consumer so that consumer/advisor can make an informed decision as to whether to dispute a claim decision or not.
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- 418 For example, Exhibit 745, Statutory Declaration of Dominic Dower (NRMA Insurance), 23 September 2011 [para 102-118]; Exhibit 872, Statement of James Higgins (AAMI), 14 September 2011 [para 229-235]; Exhibit 892, Second Affidavit of Graham Dale (RACQ Insurance Limited), 19 September 2011 [para 237-240]; Statement of Paul Fahey (CommInsure), 23 September 2011, Appendix A [p22-24].
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- 419 Exhibit 878, Statement of James Higgins (AAMI), 13 October 2011 [para 60-61]; Statement of Garry Townsend (Allianz Australia Insurance Ltd), 16 September 2011 [para 5.2]; Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 14 September 2011, Annexure B [para 6.4 and 10.2].
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- 420 Statement of Garry Townsend (Allianz Australia Insurance Ltd), 16 September 2011 [para 5.1-5.2]; Attachment 3.3.
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- 421 Statutory Declaration of Shaun Standfield (QBE Insurance (Australia) Limited), 14 September 2011, Annexure B [para 12].
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- 422 Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011, Annexure 9.
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- 423 Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011, Annexure 8.
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- 424 Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011, Annexure 10.
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- 425 Exhibit 1027, Statement of Robert Hazell (AAMI), 8 November 2011 [para 12].
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- 426 Letter from Corrs Chambers Westgarth Lawyers, 11 January 2012.
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- 427 Exhibit 1027, Statement of Robert Hazell (AAMI), 8 November 2011 [para 6, 10].
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- 428 Exhibit 874, Statement of James Higgins (AAMI), 13 October 2011, Annexure 11.
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- 429 Exhibit 1027, Statement of Robert Hazell (AAMI), 8 November 2011 [para 11].
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