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Introduction

The past year has been one of significant law reform for New Zealand's insurance sector. While you're undoubtedly aware of the major legislative changes on the horizon, the practical implications for day-to-day operations are still unfolding, and that's where the real impact lies.

The new Contracts of Insurance Act 2024 represents the most substantial overhaul of insurance contract law in decades. But it's a number of more recent government announcements, including as to the regulation of the building industry and the enforcement regime for environmental prosecutions, as well as a number of judicial decisions that are reshaping the regulatory landscape. What might appear as straightforward legislative updates look set to create ripple effects across claims handling, compliance frameworks, and risk assessment processes.

Take the Supreme Court's recent decision in Routhan v PGG Wrightson – on the surface, a case about negligent misstatement. But dig deeper, and it is in fact a case redefining how damages are calculated across various liability contexts, with implications that could reach across multiple lines of coverage.

This publication brings together the legal developments that matter most to your industry right now. We've focused on the practical interpretation of these changes – from the operational reality of new privacy obligations to the enhanced enforcement powers emerging in environmental law, we explore what these shifts mean for insurers, brokers, and risk managers navigating an increasingly complex regulatory environment.

The insurance sector has always been built on understanding and managing uncertainty. As the legal framework continues to evolve, our insurance team is prioritising helping clients decode new requirements and adapt their practices accordingly.

The insights that follow reflect not just our analysis of the law as written, but our experience in seeing how these changes play out in practice. Whether you're reviewing policy terms, adjusting claims procedures, or planning for compliance requirements, we hope these practical perspectives prove valuable as you adapt to the changing landscape.

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Routhan v PGG Wrightson

Supreme Court Clarifies Scope of Duty and Damages in Negligent Misstatement Claims

In Routhan v PGG Wrightson, the Supreme Court clarified how damages are to be assessed in negligent misstatement claims. The Court considered whether New Zealand should adopt the approach from the UK case of South Australia Asset Management Corp v York Montague Ltd (SAAMCO), including the "scope of duty" principle and the so-called SAAMCO "cap" on liability.

While confirming that professionals are not liable for every downstream loss, the Court extended liability beyond overpayment of the purchase price to include certain expenditure incurred post-purchase in reliance on the misstatement.

Background

In 2010 the Kaniere Family Trust, controlled by the Routhan family (**Routhans**), intended to purchase a 105-hectare dairy farm near Hokitika for $2.8 million. An earlier real estate brochure had advertised that the farm's three-year average production was 103,000 kgMS per season. As production was central to profitability, the Routhans asked PGG Wrightson Real Estate (**PGG**) to verify this figure. However, PGG did not do so, despite representing that it had by preparing a Rural Information Sheet on behalf of the vendor showing the milk production figures.

The PGG Proposal included the following disclaimer:

[PGG] is acting solely as the selling agent for the vendor, and is not responsible for the accuracy and completeness of information supplied by the vendor either directly or via [PGG], whether contained in an information memorandum or otherwise. [PGG] has not verified such information and [PGG] is not liable to any party, including the purchaser for the accuracy or completeness of such information……

In practice, production never reached 103,000 kgMS. The Routhans spent considerable money on fertiliser, re-pasturing and feed systems to improve milk production. However this was not successful and in 2020 Rabobank forced a sale of the farm. It sold for $1.5 million and a run-off block for $761,000, wiping out the Trust's equity in the properties.

The Routhans argued that but for the negligent misstatement (the historic production figure), the Routhans would not have purchased the farm. They sued PGG in negligence and under the Fair Trading Act 1986 seeking $3 million in damages which reflected the position they would have been in had they bought an alternative farm that met the represented production levels.

High Court decision

Dunningham J in the High Court found PGG liable for negligent misstatement and misleading conduct under the Fair Trading Act. The Court accepted that the Routhans would not have purchased the farm but for the misrepresentation. Her Honour treated the losses broadly as causal consequences of the misstatement. Damages of $2.122 million were awarded, for lost equity and capital improvements, less a 20% deduction for contributory negligence.

Court of Appeal decision

PGG appealed. The Court of Appeal agreed that PGG's negligent misstatement induced the purchase but drastically reduced damages to $300,000. In doing so, the Court applied the principles from SAAMCO, which provides that in cases of negligent misstatement causing pure economic loss, a professional is liable only for losses for which they assumed responsibility.

The House of Lords in SAAMCO drew a distinction between advice cases, where a professional assumes responsibility for the decision as a whole and all foreseeable losses may be recoverable, and information cases, where the professional supplies limited data and liability is confined to the consequences of that information being wrong.

In information cases, damages are typically capped at the difference between the asset's value as represented and its true value — a limit later described by the Supreme Court as the "SAAMCO cap."

PGG had only provided information around production figures, and not advice. The Court held the proper measure of loss here was the difference between the price paid and the farm's true market value at the date of purchase only.

Supreme Court decision

The case went to the Supreme Court, which was divided three–two.

The majority (Glazebrook and Miller JJ, with Kós J concurring in the result) awarded damages for both the overpayment at purchase and limited post-purchase expenditure directly attributable to PGG's breach of duty (fertiliser and pasture renewal). In considering

which post-purchase losses were directly attributable, it considered the remoteness of the damage compared against the scope of the duty. In doing so it confirmed that SAAMCO forms part of New Zealand law but only insofar as it is a "cross check" in respect of any damages awarded, to identify whether loss caused by a defendant's breach falls within the scope of their duty of care.

Glazebrook and Miller JJ also cautioned that the "advice" and "information" categories from SAAMCO can be too rigid. Instead, the scope of a professional's duty should be assessed by reference to the risk the professional actually assumed. PGG assumed responsibility not only for the risk of overpayment but also for the risk that the represented production figures could not be achieved. Expenditure reasonably incurred in attempting to reach that level of production therefore fell within the scope of PGG's duty and was recoverable.

Justice Kós agreed with the outcome but expressed doubt about whether SAAMCO has any useful place in New Zealand law at all.

Chief Justice Winkelmann and Ellen France J dissented. They would have upheld the Court of Appeal's application of the SAAMCO cap, holding that the risk assumed by PGG was confined to the price paid for the farm. Although the PGG agent assisted with the transaction, he did not advise the Routhans on whether to purchase or on the operation of the farm. Therefore, losses beyond the overpayment lay outside the scope of his duty.

All three courts rejected PGG's asserted reliance on the disclaimer. General wording cannot absolve liability for a specific negligent misstatement.

Comments

The case illustrates how liability for negligent information can extend beyond overpayment to expenditure incurred in seeking to achieve a represented outcome. The fact that PGG was not advising on farm operations did not shield PGG from liability. At the same time, the Court's refusal to reinstate the High Court's broader award confirms that SAAMCO principles remain an important limit on professional liability. Professionals are not guarantors of their clients' commercial ventures.

The disclaimer outcome reinforces that courts will construe such clauses narrowly. Generic wording is unlikely to protect professionals; effective disclaimers must be precise, unambiguous and clearly directed at the risk in issue.

However, with the Supreme Court divided on most of the key issues, uncertainty remains. Insurers should expect claimants to continue testing the limits of recoverable loss in negligent misstatement cases.

When defective components cause property damage

Lessons from Capral for general liability insurers

The Federal Court of Australia – Full Court (FCAFC) decision in Insurance Australia Limited t/as CGU Insurance v Capral Limited [2025] FCAFC 46 offers critical guidance for general liability insurers navigating claims involving defective products incorporated into insured property. The case clarifies how courts may distinguish between mere supply of defective goods and actual property damage under general liability policies.

Defective plate, damaged vessels

Capral Limited (**Capral**) imported and on sold aluminium plates as marine-grade plate (**Plate**) to ten customers, which was used in the construction of vessels. The Plate was found to be sub-standard, lacking corrosion resistance and failing to meet certification requirements. Customers had already welded Plate to vessel hulls, rendering them non-compliant and unfit for the market. Customers needed to remove the Plate or reconstruct the vessels to proceed to market. Capral settled claims with its customers and sought indemnity from its insurer, CGU Insurance (**CGU**).

What constitutes "Property Damage"?

The central question was whether the amounts Capral became liable to pay to its customers were "Compensation for… Property Damage" as a result of an "Occurrence" subject to the terms of Capral's insurance policy (**Policy**) with CGU.

The Policy defined "Property Damage" as meaning:

- physical injury or damage to or physical loss of or destruction of tangible property including loss of use at any time resulting therefrom;
- loss of use of tangible property which has not been physically injured, damaged or destroyed provided such loss of use is caused by or arises out of physical damage of other tangible property.

CGU argued Capral was "*attempting to persuade the Court to read a policy responding to 'any claim for Property Damage' as one responding to claims that goods sold are not fit for purpose: claims, in substance, that those goods were inferior to that promised… the remediation of non-compliant plate may have caused damage to the Customers' property, that went only to the quantification of the Customers' claims and, more particularly, formed no part of the basis for those claims*".

The FCAFC rejected this, stating:

"*The welding of the Plate into partially constructed Vessels altered the physical state of those Vessels in a way which was harmful, progressively causing damage to the Vessels. The welding of defective Plate into partially complete Vessels did not progressively "improve" them as they became increasingly watertight.*

The damage which was caused to the partially constructed Vessels had to be rectified. The customers therefore claimed for the materials and labour required to carry out the repairs. These were claims for property damage within the meaning of the Policy."

Implications for Insurers

1. **Incorporation can trigger coverage:** Insurers must assess whether a defective product has been incorporated into insured property in a way that impairs its value or function. In Capral the FCAFC determined that the primary judge was correct in finding that supply of defective product is not property damage in and of itself, but only "*once the defective product is physically incorporated into larger tangible property that the possibility of property damage arises*". The distinction is between having the ability to supply a replacement before it is incorporated versus liability depending on the nature of the property with which the product has come into contact with once incorporated.
2. **Damage vs defective product:** Coverage analysis should focus on the nature of the harm, not the label of the claim. The FCAFC determined it is not a question of whether the claim should be categorised as a claim for defective goods rather than for property damage, but whether the claim came within the words of the insuring clause. Claims made by customers had physical damage to tangible property as their basis.
3. **Incorporation may not "improve" the property:** Insurers should consider whether incorporation results in the need for rectification work. This points away from incorporation "improving" the insured property and instead, damaging the insured property. In *Capral* the Court rejected the argument that the Plate improved incomplete hulls by making them more watertight. The process of welding the Plate progressively damaged the hulls, culminating in a need to repair the damage.
4. **Settlement language is relevant:** The language used in settlement agreements can influence the interpretation of a claim. In Capral each settlement deed referred to the customer having made claims for "property damage", supporting it was "*for" property damage* under the Policy.

Questions to consider

Has the defective product been physically incorporated into another item?

Has there been physical alteration of the insured property?

Did that physical alteration impair the usefulness or value of the insured property?

Is rectification required due to the incorporation?

A parallel example: AAI Limited v The Owners – Strata Plan No 91086 [2025] FCAFC 6

The decision in *AAI Limited* provides a parallel illustration of how courts assess property damage when defective materials are physically integrated into buildings.

In that case, Fairview Architectural Pty Ltd supplied aluminium composite panels (**Panels**) which were affixed using framework to the exterior of high-rise buildings of the respondent. The Owners brought proceedings against Fairview following fires in the residential towers. The fires were found to have been accelerated/worsened by the presence of the Panels.

The FCA made orders that AAI be joined as second respondent. The FCA also ordered leave to bring and continued proceedings against AAI pursuant to (NSW) Civil Liability (Third Party Claims Against Insurers) Act 2017. AAI sought to appeal the two orders.

The FCA found that it was at least arguable that the affixation of the panels effected an immediate physical alteration or change to the buildings which impaired their usefulness as residential buildings and as such caused property damage to those buildings. The FCA's conclusion that it was arguable that the policy response was not attended by sufficient doubt to warrant a grant of leave to appeal.

Getting ready for the Contracts of Insurance Act

For more than a century, the law relating to insurance contracts has developed in a piecemeal way, with important rules scattered across a number of pieces of legislation and case law.

The Christchurch Earthquakes of 2010 and 2011 served as a catalyst for reform of New Zealand's insurance law, with industry consultation initiated in 2018. The Contracts of Insurance Act 2024 (**COIA**) was finally passed on the 14th of November 2024. The commencement date remains subject to confirmation by an Order in Council, with implementation required no later than 15 November 2027.

The Act will revolutionise the statutory basis for insurance law and consolidate all relevant rules and principles into one statute. COIA will cover all insurance contracts (although some provisions are consumer insurance-specific and others non-consumer insurance specific), including life insurance policies and marine insurance.

Key features of the COIA

Contracting out

Under s166, the provisions of COIA may not be contracted out of. Unlike in the UK, this applies in all cases, consumer or otherwise.

Reinsurance

The Act does not cover reinsurance (s6(3)). This creates significant differences between insurers' and reinsurers' obligations for example liability for late payment and reliance upon late notifications of losses.

Duty of utmost good faith

The common law principle of 'duty of utmost good faith' is codified by the COIA (both for the insurer and insured). Section 59 follows the Insurance Act 2015 (UK) in divorcing utmost good faith from pre-contract disclosure and from the remedy of avoidance.

Insureds' duty of disclosure

The existing requirement is that all insureds (both consumers and businesses) must, before entering into an insurance contract, disclose to the insurer all material information. COIA now flips the responsibility onto the insurer to ask questions of the insured to obtain the required information.

Consumers are required to "take reasonable care not to make a misrepresentation" when answering these questions and COIA sets out matters to be taken into account when determining whether reasonable care has been taken.

Business (or non-consumers) are required to make a "fair representation of risk" to the insurer, this means disclosing every material circumstance that the insured knows or ought to know, or that would give the insurer sufficient information to put it on notice that it needs to make further inquiries and doing so reasonably clearly and accessibly, that is substantially correct in fact or believed in good faith.

The principle that the knowledge of brokers is to be treated as knowledge of the insurer has been carried over into the COIA for consumer and non-consumer presentation of risk. As a result, the Act imposes duties on intermediaries and remedies for insurers.

Timing of payments

The Act introduces an implied term into every contract of insurance that the insurer must pay any sums due in respect of a claim made under the policy within a 'reasonable

time'. What constitutes a reasonable time will turn upon what is required to investigate and assess the claim.

Timing of claims

Carried over from section 9 of the Insurance Law Reform Act 1977, an insurer cannot decline a claim on the basis it was not notified within the time set out in the policy. However, "claims-made" policies may be declined in certain circumstances.

Genetic testing

The Act includes provisions allowing for regulations to be made either to prohibit or control the conduct of insurers in connection with genetic testing. This could cover insurers requiring someone to undergo genetic testing, to disclose any results of genetic testing, or to confirm whether they have already undergone genetic testing.

Before recommending any regulations, it is expected that the Minister will conduct a full policy development and consultation process.

Third party claims against insurers

The Act updates the provisions (from section 9 of the Law Reform Act 1936) relating to circumstances where a third party can make a claim directly against an insurer, bypassing the policyholder. A third party will be permitted, with leave of the court, to claim directly from the insurer if the insured party is insolvent or dead.

Increased risk exclusions

Section 11 of the Insurance Law Reform Act 1977 is also carried over into COIA, providing that an insurer cannot decline a claim because of an exclusion where that exclusion did not cause or contribute to the loss. The insured will not be bound by an increased risk exclusion if the insured proves that the loss "was not caused, or contributed to, by the happening of the event or the existence of the circumstance referred to in the increased risk exclusion."

Contracts of Insurance (Repeals and Amendments) Act 2024

The Contracts of Insurance (Repeals and Amendments) Act 2024 was passed alongside the COIA. This Act was passed to repeal or reform a number of statutes. Key areas of reform include changes to the unfair contracts regime in the Fair Trading Act and amendments to the Financial Markets Conduct Act 2013. It is expected that the provisions of this Act will be brought into effect earlier than the full three years allowed for.

The next steps

Insurers and brokers will need to prepare for COIA before it comes into effect. This will include:

- Reviewing and updating disclosure processes, including implementing separate processes for consumer and non-consumer insurance;
- Updating documentation to explain the new disclosure duties and the consequences for non-compliance;
- Ensuring that proposal forms for consumer insurance cover all material points, and are sufficiently specific and clear to ensure that all required information is obtained;
- Ensuring that there are suitable systems between insurers and brokers to make sure that all required information is passed between them; and
- Checking that policy terms are consistent with COIA, and do not contain avoidance rights that are wider than or inconsistent with the Act.

Conclusion

This comprehensive reform of New Zealand insurance law will require significant action by insurers to ensure their policies and procedures align with the new regime. We are already almost one-year through the three-year implementation period (assuming the date isn't brought forward), so preparations should be underway soon.

UK Court of Appeal rules on fair presentation

The duty of fair presentation for non-consumer insurances, set out in the Contracts of Insurance Act 2024 (not yet in force), borrows heavily from the UK Insurance Act 2015. The decisions of UK courts are important guidance as to how the 2024 Act should be construed. The decision of the UK Court of Appeal in Delos Shipholding SA v Allianz Global Corporate and Speciality SE [2025] EWCA Civ 1019 is the first detailed consideration at an appellate level of the meaning of "knowledge" for the purposes of the duty of fair presentation.

Background

Delos, a member of the NGM Group controlled by the Moundreas family, was the owner of the Vessel Win Win. The sole Director, President, Secretary and Treasurer of Delos was Evangelos Bairactaris (EB), a Greek maritime lawyer and registered member of the Piraeus Bar. It was established in the evidence before the trial judge, Dias J, that EG was no more than a nominee of the Moundreas family. He was contractually obliged to act on their instructions and he neither exercised independent judgment nor made decisions. He was described by Males LJ as "a vehicle, as a matter of administrative convenience, for carrying out decisions made by NGM and the Moundreas family, by signing documents (typically documents drafted by his law firm in its capacity as the NGM Group's external lawyers) in accordance with their instructions."

In February 2019, in a dramatic change of policy, the Indonesian maritime authorities began to arrest vessels for unauthorised anchoring in Indonesian territorial waters. On 17 February Win Win was detained. Negotiations for her release began immediately, but were terminated in April 2019 when it became apparent that a bribe was required. Win Win was not released until 2020.

The insurance and the dispute

Win Win was insured against war and political risks. The Policy was renewed for the period 1 July 2018 to 30 June 2019. The sum insured was based on an agreed value of US$37.5 million. There was a deemed constructive total loss by way of deprivation of possession without likelihood of recovery if the "Vessel shall have been the subject of … detainment … for a continuous period of [six] months …" There was an exclusion for "Arrest, restraint or detainment under customs or quarantine regulations and similar arrests, restraints or detainments …"

The dispute and the judgment of Dias J

The insurers accepted that Win Win had been a constructive total loss within the detention clause, but they denied liability on four grounds: (1) the detention was not fortuitous because the Master had voluntarily anchored in Indonesian territorial waters while aware of the risks; (2) there had been a failure to sue and labour; (3) the Policy exclusion applied; and (4) the Policy could be avoided for material non-disclosure in breach of the duty of fair presentation. On this final point, the Insurers pointed to criminal charges brought in Greece in March 2018 against EB, accusing him of organised crime and drug trafficking. EB denied the charges and he had not been prosecuted. However, the Insurers claimed that the charges were material facts and should have been disclosed.

In proceedings brought by the owners, Dias J rejected these defences. There had been a fortuity

and Delos had acted reasonably in attempting to secure the release of Win Win and refusing to pay a bribe. The exclusion on its proper construction did not apply. Finally, there had not been a breach of the duty of fair presentation because Delos did not have the knowledge required for disclosure. The owners' claim for damages for late payment (under the UK equivalent of CIA 2024, s 66) was, however, dismissed.

The Insurers sought permission to appeal on two issues: the meaning of the exclusion; and whether the Claimants had the relevant knowledge of the charges against EB for the purposes of the duty of fair presentation. The appeal was dismissed by the Court of Appeal.

The exclusion may be dealt with briefly. It was not disputed that the seizure had not been "under customs or quarantine regulations", and the only question was whether the seizure was for "similar" reasons. That was not the case. There was no similarity between seizure for smuggling or public health grounds and the present seizure which was simply an exercise in maritime sovereignty.

Fair presentation

Under CIA 2024, replicating the UK Insurance Act 2015, a policyholder is required to disclose what the policyholder knows and what the policyholder ought to know.

By section 38 of the 2024 Act, so far as relevant to the present case, a corporate policyholder knows "only what is known to one or more of the individuals who are .. part of the insured's senior management …" The term "senior management" is defined by section 36((2)(c) as "those individuals who play significant roles in the making of decisions about how the policyholder's activities are to be managed or organised." The Court of Appeal held that there was no actual knowledge imputed to Delos within these provisions. EB, despite his titles, did not constitute senior management of Delos. It was necessary to identify the policyholder's activities, to identify the individuals who made decisions about how those activities were to be managed and organised, and to consider the significance of each individual's role in such decision-making. Delos was the owner and operator of Win Win and EB simply did as he was told. Although he signed documents, he made no decisions about them. Importantly, the Court of Appeal rejected proposition that the sole director of a corporate insured with no employees would always be part of the company's senior management.

As regards what a policyholder ought to know, section 40(1) of CIA 2024 provides that a policyholder ought to know "what should reasonably have been revealed by a reasonable search of information available to the policyholder (whether the search is conducted by making enquiries or by any other means)." The common law required disclosure only of what the policyholder actually knew or chose to ignore, so that the "reasonable search" is an important innovation and extension of a proposer's duties. The Court of Appeal held that on the facts of the present case Delos had not been required to ask EB whether he knew of any circumstances which might affect the risk, given that he had no operational role or function regarding the trading of the vessel and her insurance. Such a question would have been pointless. Accordingly, there had not been a failure to make a reasonable search.

Comment and three unresolved issues

Delos is very much a case confined to its facts. The use of a sole nominee director whose function is purely to obey instructions may be common enough amongst the maritime community which operates on the basis of a network of one-ship companies under common control, but it is unusual in other contexts. In most situations it will be at least difficult to establish that a director is not part of the company's senior management, so that a defence based on lack of actual knowledge will fall at the first hurdle. As far as constructive knowledge is concerned, in most cases a reasonable search will necessarily encompass seeking information from directors responsible for the conduct of

the company's affairs. The Delos decision is not, therefore, of general application. However, there are three aspects of the decision that are of wider significance.

The first is whether section 40(1) is objective or subjective. What is a reasonable search is plainly objective, but it is less clear whether the assured is treated as knowing the facts that an objective reasonable search "would" have revealed or whether the assured is treated as knowing the facts that an objective reasonable search "should" have revealed. If the latter was correct and the test was objective, then a policyholder who made a reasonable search could nevertheless be fixed with knowledge of facts that the search did not actually reveal but should have done so. The Court of Appeal was of the provisional view – in the absence of argument on the point – that a wholly objective test would be "unfair, and contrary to the purpose" of the legislation.

The second is the operation of section 48 of the 2024 Act, under which an insurer has a remedy only on proof that it would not have entered into the contract of insurance at all or would have done so only on different terms. Dias J favoured a test for inducement that encompassed hypothetical counterfactuals. The counterfactual was that if EB's charges had been disclosed then the insurers would have insisted upon his removal as director and Delos would have complied. Accordingly it could not be said that, even if Delos had possessed the relevant knowledge, the insurers would have refused coverage. The insurers challenged this reasoning. The Court of Appeal found it unnecessary to rule on the point, but expressed the view that there was nothing in the Act to call for investigation of any further counterfactual once the insurer had stated its terms. If the argument was correct, an assured could be better off by breaching the duty of fair presentation and then saying that it would have complied with any condition which the insurers would have imposed had there been full disclosure.

The third is the meaning of the requirement in section 31(1) of the 2024 Act to disclose "every material circumstance". Dias J had been of the view that materiality encompassed not just the fact withheld but surrounding facts. Thus, if the charges against ED were material, the facts that he denied the charges and had not been prosecuted would have been relevant as exculpatory evidence. The point was argued although not discussed in the judgment, but the transcript of the hearing shows that the Court of Appeal was strongly supportive of the relevance of exculpatory evidence as affecting and potentially eliminating an assertion of materiality by insurers.

If the argument was correct, an assured could be better off by breaching the duty of fair presentation and then saying that it would have complied with any condition which the insurers would have imposed...

Proportionate Liability and Beyond

The Future of the Building Industry in New Zealand

The Government has recently announced major reform to New Zealand's building industry. The proposed changes aim to improve the building consent system, making it more consistent, and reducing costs for homeowners, businesses, and local councils. These reforms will be the most significant changes to the building industry in decades.

The key initiatives are to:

- scrap the current joint and several liability regime, and replace it with proportionate liability;
- explore options such as requiring professional indemnity insurance and home warranties; and
- allow councils to voluntarily consolidate their Building Consent Authorities (BCAs) functions with each other.

Joint and several v proportionate liability

When a plaintiff sues multiple defendants, one of the key issues can be how liability is apportioned between those defendants.

The current joint and several liability regime means that all defendants (usually those who have worked on the building of a property in a variety of roles, together with the consenting authority) are jointly liable for the entire cost of repairs incurred by a plaintiff (usually the building owner). Where one defendant is insolvent, the others will need to cover that defendant's share.

The effects of the rule have been particularly pronounced, and a source of concern, due to the proliferation of 'leaky building' claims in the early 2000s. Defendants who are likely to be insured (architects, engineers, and project managers) and local councils are often the 'last men standing', despite varying levels of responsibility for the plaintiff's loss.

The Government's view is that the large payouts that councils have been required to make over the past few decades have led to councils being highly risk-averse when issuing consents and carrying out inspections. This has resulted in builders facing delays and consequential cost escalations. It has also likely resulted in ratepayers paying higher rates, as councils need the increased income to meet that cost burden.

In contrast, proportionate liability means that each defendant would only be responsible for the work they carried out or the decisions they signed off. The rule means that a plaintiff can only recover a portion of its loss from each defendant, and so would have to join every potential defendant to recover the total loss. If a defendant is unavailable or insolvent, the plaintiff will bear the loss, unless they can look to insurance. Of course, a plaintiff could not just join anyone and everyone who was near the building site, as the plaintiff could have to pay the court costs of any defendant who was found to not have any liability to the plaintiff.

The Law Commission considered this issue a decade ago, and in its report, Liability of Multiple Defendants, it recommended retaining joint and several liability, but possibly with a cap on liability for minor defendants and for consent authorities.

The Law Commission's review of Australia's experiences with proportionate liability raised some particular concerns. The evidence suggested the regime in Australia has led to an increase in the complexity and cost of litigation, and reduced the chance of settlements. This is because the proportionate system requires a full assessment of the relative liability of defendants at trial, making the chance of defendants agreeing to the apportionment of liability outside of court less likely. The Australian regime also incentivises plaintiffs to add as many defendants as possible to a proceeding, no matter how tangential a defendant's alleged contribution may have been.

However, the main disadvantage that the Law Commission saw with proportionate liability was that the plaintiff would be the one bearing the risk that defendants would be unable to pay their share. It is for this reason that the change to proportionate liability is unlikely to occur without the implementation of the second pillar of the reforms.

Mandatory professional indemnity insurance and home warranties

The change to proportionate liability can create significant risks to property owners in the event of a defendant's (or multiple defendants') insolvency. When the Law Commission released its report, Liability of Multiple Defendants, in 2014, it recommended that if a move toward proportionate liability was the preferred option, it should not take place unless a comprehensive residential building guarantee scheme was implemented.

The Government's announcement included an intention to consult with the building sector about a mandatory home warranty scheme and comprehensive professional indemnity insurance.

For residential building, this is likely to be along the lines of a Master Build Guarantee or New Zealand Certified Builders' Halo, or the Building Warranty Insurance offered by Stamford Insurance. It would be compulsory for every new residential build.

However, it is still unclear whether these warranties would be available to everyone. Currently around two thirds of builders are members of either Certified Builders or Master Builders. Of the one third that doesn't belong to one of the organisations, only half would meet the criteria to join. The others would not be able to offer one of those warranties for their own work – they would need to contract to another builder. There have also been questions raised about whether Master Builders and Certified Builders should be regulated, as insurers are, to ensure that they meet solvency requirements.

Similarly, Stamford Insurance has said that it is selective about who it provides cover for, and they won't necessarily be willing to take on an increased share of the market. It remains to be seen whether any other insurers will look to enter the market, or whether a government-backed guarantee scheme would be needed.

For commercial buildings, the proposal is that every party involved in a commercial building project would be expected to have comprehensive professional indemnity insurance. Many already do, but this would ensure universal coverage. This consultation will need to include ensuring that suitable insurance products are available. The willingness of the insurance industry to provide professional indemnity insurance or similar products to building contractors is a noticeably unaddressed issue.

Finally, main buildings in New Zealand are not strictly residential or commercial but are a hybrid of both – for example an apartment building with shops on the ground floor. This has been a significant issue with leaky building cases, until it was finally confirmed that the same duty of care is owed for all types of building. If buildings are to be treated differently depending on their use, there will need to be careful consideration of how to deal with hybrid buildings.

Consolidation of Building Consent Authorities

The final part of the Government's announcement was that councils will be allowed to voluntarily consolidate their Building Consent Authority (BCA) functions with each other.

This change would assist builders, designers, and homeowners by standardising different interpretations of the Building Code. The Government has received reports where builders' paperwork that would be accepted by one authority was being rejected by a neighbouring authority simply because each BCA applies the rules differently.

The Government indicated that many councils have asked for this change. At present councils do pass on some of the work to other councils on a contract basis but the council that passed it on still remained liable. A formalised consolidation of BCAs could avoid this. This change will also allow councils to share resources like building inspectors and IT systems and pass the savings on to ratepayers.

There is no indication yet of the sort of legal structure that these consolidated BCAs would adopt. Consideration will need to be given to what will happen if they are found to be negligent in their work, but don't have the funds to pay. At the beginning of the leaky building crisis building certification was done by private companies rather than councils, and these businesses swiftly collapsed. Particularly with a move to proportionate liability, we will want to ensure that doesn't happen again.

The next steps

The legislation to implement these changes is expected to be introduced early next year, and the Government has indicated that it expects that the changes will be in force by mid-2026. We will continue to provide updates when further announcements are made.

Clarifying contribution claims in construction litigation

The supreme court's ruling

In a landmark September 2024 decision, the Supreme Court resolved a long-standing debate in construction litigation: whether the ten-year limitation "longstop" under the Building Act 2004 overrides the right to bring contribution claims under the Law Reform Act 1936.

The issue was central to the case of *Beca Carter Hollings and Ferner Limited v Wellington City Council [2024] NZSC 117* (**Beca**), where the Court clarified the relationship between the Building Act's longstop and the right to bring contribution claims. The ruling marks a pivotal development for New Zealand's construction and insurance sectors, overturning the previously prevailing interpretation of the law. It has important implications for all parties involved in building defect litigation, particularly where defects are discovered long after construction is completed.

Legal Context

Construction defects often emerge years after completion, raising complex questions about liability and timing. Section 393(2) of the Building Act imposes a ten-year longstop on "civil proceedings relating to building work," intended to provide finality for those involved in construction. Historically, this was interpreted to include contribution claims brought by defendants seeking to share liability.

Contribution claims are governed by section 17 of the Law Reform Act 1936, which allows a party found liable in tort to seek a proportionate contribution from other concurrent tortfeasors. Section 34 of the Limitation Act 2010 also applies, setting a two-year limitation period for contribution claims, starting from the date the liability of the party seeking contribution is determined.

The BNZ Case

The issue came to the fore in *BNZ v Wellington City Council [2021] NZHC 1058* (**BNZ**). BNZ had leased a purpose-built building in Wellington that became uninhabitable following the 2016 Kaikōura earthquake. BNZ sued Wellington City Council (**WCC**), alleging negligence in the building consent process, inspections, and the issuance of a code compliance certificate. WCC, in turn, sought contribution from Beca Carter Hollings & Ferner Limited (**Beca**), the engineering firm responsible for the building's structural design and construction monitoring.

Beca applied to strike out the third-party claim, arguing it was time-barred under section 393(2) of the Building Act. WCC countered that its claim was governed by section 17(1)(c) of the Law Reform Act and that the right to contribution was not subject to the Building Act's longstop.

High Court's Interpretation

Justice Clark rejected Beca's application, holding that the Building Act's longstop does not apply to contribution claims. Instead, such claims are governed by section 34 of the Limitation Act, which provides a two-year limitation period starting from when the liability of the party seeking contribution is quantified.

The Court emphasised that the longstop applies to original claims brought by plaintiffs, not to ancillary claims like contribution. It noted that the Limitation Act distinguishes between original and ancillary claims, with the latter subject to a different regime. Contribution claims are also excluded from the Act's general fifteen-year longstop.

This marked a departure from earlier rulings that treated contribution claims as subject to the same limitation periods as primary claims. Justice Clark's reasoning was grounded in legislative history and the principle that specific provisions should prevail over general ones unless Parliament clearly indicates otherwise.

Appeal and Supreme Court Decision

Beca appealed, but the Court of Appeal upheld the High Court's decision. Beca then sought leave to appeal to the Supreme Court, which affirmed the lower courts' approach, albeit by a narrow 3:2 majority.

The Supreme Court acknowledged that the language of section 393(2) was broad enough to include contribution claims. However, the majority concluded that if Parliament had intended to override the specific regime for contribution claims, it would have done so explicitly.

The Court held that the right to seek contribution arises only once a party is found liable to a plaintiff. Therefore, the limitation period begins at that point – not when the building work was completed. As a result, contribution claims can be brought up to two years after liability is established, even if more than ten years have passed since the construction work occurred.

Implications for the Construction and Insurance Sectors

This decision has far-reaching implications for those involved in construction projects, particularly insurers and professionals such as engineers, architects, and contractors. Defendants in building defect cases may now face contribution claims after the ten-year period typically associated with construction liability has expired.

While the Building Act's longstop still protects against original claims brought by plaintiffs after ten years, it no longer shields defendants from contribution claims brought by co-defendants. This creates a longer tail of potential liability, especially in complex disputes involving multiple parties.

The ruling alleviates the time pressure on defendants who previously had to rush to join third parties when sued close to the expiry of the longstop. This gives parties more time to assess liability and respond appropriately.

In light of this ruling, Professionals involved in building design may need to reassess their professional indemnity insurance arrangements. Insurers, in turn, will need to evaluate their exposure and the adequacy of run-off cover for professionals who may face claims well after their involvement in a project has ended.

Conclusion

The Supreme Court's decision in Beca, along with the earlier High Court ruling in BNZ, has reshaped the legal landscape for contribution claims in New Zealand's construction sector. By confirming that the Building Act's longstop does not apply to contribution claims, the courts have clarified a previously uncertain area of law and aligned the treatment of such claims with the specific provisions of the Limitation Act.

While the decision will extend the duration of potential liability for some parties, it reinforces the principle that contribution claims are a distinct legal mechanism with their own rules and timelines. As the construction industry continues to grapple with long-tail risks, these rulings provide much-needed clarity on how and when contribution claims can be pursued.

This decision has far-reaching implications for those involved in construction projects

The employment relations amendment bill

Its implications for the insurance industry

The proposed changes to the Employment Relations Act 2000 (the Act) represent the most significant shift in New Zealand's employment landscape in over a decade. For insurers, these reforms will directly influence risk assessment, claims management, and policy wording. This article outlines the main changes and analyses their impact on the insurance industry.

Remedies and Awards

One of the most notable aspects of the Employment Relations Amendment Bill (the Bill) is the reduction or outright removal of available remedies for certain claims. Under the proposed changes, there are no remedies available whatsoever where there is contributing behaviour on the part of the employee and that behaviour amounts to serious misconduct. Reinstatement and compensation are unavailable if there is contributing behaviour on the part of the employee, and all other available remedies such as lost wages can be reduced by up to 100% for contributing behaviour.

This marks a significant shift where the Authority and Court's discretion is curtailed, and the value of claims is likely to decrease as a result. For insurers, this means a reduction in the quantum of awards payable under EPL policies. It may also lead to more claims being resolved on a commercial basis at earlier stages, as the incentive for employees to progress to the Authority wanes.

The lack of a statutory definition for "serious misconduct" may become problematic, because a finding of serious misconduct now results in no remedies being available. This could prompt a stricter, more precise definition being adopted, likely focusing on conduct such as theft, fraud, and assault, though this remains to be seen. Policyholders may seek clarity from insurers or brokers regarding coverage for claims involving allegations of serious misconduct, so insurers should be prepared to adapt and respond where necessary.

Salary Threshold

Employees earning over $180,000 per year base salary will be unable to bring personal grievances for unjustified dismissal, though other claims remain available. This could redirect high-earning claimants towards unjustified disadvantage, breach of contract, or discrimination claims, potentially increasing the complexity and cost of such cases for insurers.

Currently, the Authority and Court have tended to award a single, global sum encompassing both dismissal and disadvantage claims where both are pleaded. With the introduction of the salary threshold, disadvantage claims could evolve into a more complex, standalone category, with remedies tailored specifically to the nature and impact of the disadvantage, rather than simply rolling them into a general award. Over time, this may lead to higher awards for unjustified disadvantage, rather than an add-on to a dismissal claim.

For the insurance industry, this could mean a rise in the number and value of disadvantage-only claims, particularly from high earners who are otherwise barred from bringing a claim for unjustified dismissal. Insurers may need to adjust policy wording, risk appetite, and claims handling processes to account for this development. There may also be increased litigation to test and define what constitutes disadvantage, potentially resulting in a body of case law that treats disadvantage grievances as distinct, high-value claims in their own right.

We may also see a development in New Zealand's discrimination laws to fill the gap in available remedies for high-earning employees.

There will be a 12-month transitional period before this salary threshold comes into effect. During this window, there may be an increase in grievances filed by high-earning employees seeking to act before the salary threshold is implemented. Insurers should pay close attention to claim patterns throughout this period.

Test of justification

Section 103A of the Act sets out the test of justification for determining whether a dismissal or other action was what a fair and reasonable employer could have done in all the circumstances. There are two main proposed changes to the test of justification.

The first is introducing a new factor that must be considered when applying the test, which is whether the employee obstructed the employer's processes (for example, an investigation). This addition aims to ensure that an employer is not unfairly penalised if procedural shortcomings were caused by the employee's own obstructive behaviour.

The second change amends the wording of s 103A(5), clarifying that a dismissal or action cannot be deemed unjustifiable solely due to procedural defects, if those defects did not result in the employee being treated unfairly. This removes the phrase "minor procedural defects", focusing solely on whether the breach resulted in unfairness. This change allows for more robust defences where the outcome would have been the same regardless of defects in the process.

This could mean less exposure to substantial awards even where there are procedural failings. An example of this is a redundancy situation where the insured did not consult on potential redeployment opportunities, but there were no redeployment opportunities available. Therefore, even though there was a procedural failing in the lack of consultation, the outcome would have been materially the same regardless.

Protected Negotiations

The existing position is that exit discussions are only protected if there is a dispute or serious problem on foot between the parties. The employee has to agree to the discussions being held on a without prejudice basis, and communications must be for the genuine purpose of resolving the dispute. In the status quo, engaging in exit discussions is a high risk, high reward strategy, as employers risk a personal grievance for unjustified disadvantage and/or constructive dismissal, or a breach of good faith.

The proposed change under the Employment Relations (Termination of Employment by Agreement) Amendment Bill is to make it so that an employer can make an exit offer regardless of whether there is an existing dispute or serious problem. Any offer and the negotiations would be protected such that they will not amount to a personal grievance, and they are inadmissible as evidence in the Authority or Court.

This is a significant change for employers because it provides an additional tool for resolving an employee issue and potentially avoiding a costly investigation and/or disciplinary process, as well as the costs of addressing any personal grievances.

Contractor Gateway Test

The introduction of a "contractor gateway test" is expected to reduce claims from individuals who are not employees. From an insurance perspective, however, insurers must continue to treat claims as they are raised, regardless of the merits. Even if a personal grievance is raised by a contractor, the claim process must be followed as if the claim for 'employee status' were valid, meaning that this change has little impact.

What Does the Future Hold?

These legislative changes raise several strategic questions for insurers. Will the volume of claims decrease as employees face higher hurdles and reduced remedies? Or could there be a shift towards more complex litigation as parties test the new boundaries?

The changes may also create more room for negotiation and alternative dispute resolution, as the ability to reduce remedies for contributory behaviour becomes a powerful tool during settlement discussions. The ability to have protected negotiations could also reduce the risk of claims being brought in the first place.

Insurers may need to adjust policy wording, risk appetite, and claims handling processes to account for this development.

Privacy update

Overview of the notification requirements created by new information privacy principle 3a

The Privacy Amendment Bill (Bill) is expected to pass its third reading this year, thereby amending the Privacy Act 2020 (Privacy Act) to include new Information Privacy Principle 3A (IPP3A) — placing new obligations on agencies to notify people when their personal information is collected indirectly.

This article comments on:

- background and objectives of IPP3A;
- new notification obligations introduced by IPP3A;
- exceptions to the new notification requirements;
- some key implications of IPP3A for the insurance sector; and
- how insurers can prepare for IPP3A.

Background and objectives

Under current Information Principle 3 (IPP3), agencies are required to take reasonable steps to notify an individual of various matters when that agency is collecting personal information directly from the individual concerned (unless an exception applies). These matters are:

- the fact that the information has been collected;
- the purpose of the collection of that information;
- the intended recipients of the information;
- the name and address of the agency that is collecting the information and the name of the agency that holds the information;
- whether the collection is authorised or required by law and, if so, which law; and
- the individual's rights to access and correct their information, (the Notifiable Matters).

In what some have described as a "gap" in New Zealand's privacy framework, agencies are not currently required to make similar notifications where they have collected information about an individual indirectly (i.e. via any source other than the individual themselves). The Bill's explanatory note acknowledges this "gap", and describes the key purpose of the bill as to "improve transparency for individuals about the collection of their person information and to better enable individuals to exercise their privacy rights".

Obligations introduced by IPP3A

Under new IPP3A, an agency that collects an individual's personal information indirectly is required to take steps that are reasonable in the circumstances to notify the individual concerned of the Notifiable Matters (unless an exception applies). IPP3A will apply to all indirect collections of personal information which occur on or after 1 May 2026.

Agencies may notify individuals of the Notifiable Matters either prior to the indirect collection of the information, or subsequent to that collection. Subsequent notification is required to occur as soon as reasonably practicable in the circumstances, thereby introducing subjective considerations into the

assessment of how soon notification is required." In the Privacy Commissioner's draft guidance on IPP3A (Draft Guidance), the Commissioner has given examples of "as soon as reasonably practicable" being both within days and within months. The Commissioner's examples take into account the ease of notification and the specific circumstances of the collecting agency.

Exceptions to the new obligations introduced by IPP3A

Several exceptions apply to the notification requirements introduced by IPP3A. The list of exceptions matches those applying to notification under IPP3, with a few additions. These additional exceptions are:

- Prior notification of the Notifiable Matters has already been given: An agency is not required to notify an individual following indirect collection of personal information where that individual was already notified in advance of the Notifiable Matters prior to the indirect collection occurring. This advanced notification can be provided either by the disclosing party or the collecting party.
- Non-compliance with IPP3A will not prejudice the individual: An agency is not required to notify an individual where it believes on reasonable grounds that the individual will not be prejudiced by, or suffer any detriment as a result of, the agency not providing notification of the Notifiable Matters. The Draft Guidance states that what may be considered detrimental will depend on the individual concerned, but that this exception should only be used for low risk or common cases. The Commissioner proposes that agencies follow a "no surprises" test, under which if an agency considers it likely that an individual would be surprised by the indirect collection, then this exception should not be relied upon.
- It is not reasonably practical in the circumstances to inform the individual: An agency is not required to notify an individual where, in the specific circumstances, notification is not practical. The Draft Guidance confirms that merely the fact that notification is inconvenient, expensive, and/or administratively burdensome does not automatically mean that notification is not necessary. Similarly, the fact that an agency may existing systems or processes which are incompatible with the requirements of IPP3A is not a valid reason to rely on this exception. When assessing whether this exception should be relied upon, the agency should take into account the quantity and/or sensitivity of the information collected as, the higher the volume or sensitivity of that information, the greater the expectation is that the individual be informed of the indirect collection.

Key implications of IPP3A for the insurance sector

As the insurance sector commonly relies on the indirect collection of personal information, IPP3A has significant implications for the sector. For example, in the event of a motor vehicle accident, an insurer may collect the following information at various stages of the processing and resolution of the claim:

- the details of the other party involved in the accident (from the insurer's customer);
- information about the motor vehicles involved in the accident from the NZTA Motor Vehicle Register;
- information about the other party from that other party's insurer;
- information about the accident from the New Zealand Police; and
- information about the customer and the damage done to the customer's vehicle from the repairer.

This raises a variety of IPP3A compliance issues and uncertainties, including:

- If the contact information of the other party provided to the insurer by the insurer's customer is incorrect, does the insurer need to take steps to ascertain the other party's correct contact information, or is notification not reasonably practical in this case? Alternatively, given the indirect collection is unlikely be surprising to the other party in this situation, can the "no surprises" test be used as a basis to not notify that individual?
- As the information may be collected at various stages of the claim process, does the insurer need to notify the individual of the collection at each stage, or can this occur all at once after all relevant information has been collected?
- If the insurer obtains dashcam footage of the accident which includes identifiable images of third party pedestrians, does the insurer need to notify those pedestrians of the collection?
- As the NZTA Motor Vehicle Register is not freely available to the public, can information collected from it be considered public information?

In a more sensitive example, an insurer may be investigating a case of suspected fraud and may need to collect information from various sources in order to complete that investigation. In this case, notification to the individual of the fact of the indirect collection may result in the investigation being jeopardised. Would an insurer be required to disclose the fact of indirect collection to the individual in this case?

Insight provided in the Draft Guidance

The Draft Guidance contains various example scenarios, some of which assist in resolving the issues outlined above. Some key takeaways from these examples include:

1. Obligations where information is collected from business partners: Where an agency collects information about an individual from a business partner (such a repairer, in the context of a motor vehicle accident), the starting position is the insurer must disclose that collection to the individual.
2. Obligations where images or videos are received which contain identifiable individuals: Where an agency obtains images or videos which contain identifiable individuals (such as where an insurer obtains such images or videos as part of a claim), an assessment will need to be completed as to whether it is reasonably practical to notify each of the individuals in those images and videos. In one example given by the Commissioner, it was concluded that where the names and contact details of the individuals were not provided alongside the images or videos, it may not be reasonably practical to obtain this information in order to then notify those individuals.
3. Obligations where a fraud investigation is underway: Where an agency is conducting an investigation into fraud, there may be situations in which the agency will need to indirectly collect information from a third party (such as the individual's bank). Where notifying the individual in this circumstance risks undermining the investigation, notification may be withheld on this basis.

Remaining concerns following the publication of the Draft Guidance

Several concerns and uncertainties for the insurance sector persist despite the publication of the Draft Guidance. These include:

1. Notification fatigue: Given the frequent use of indirect collection by insurers and the fact that it may occur at various stages of the claims process, uncertainty surrounding the timing and frequency of notification risks leading to "notification fatigue", therefore potentially undermining the intention of IPP3A.
2. High volume of business relationships that may need to be disclosed: In its submission on the Bill, the Insurance Council of New Zealand noted the challenges associated with disclosing the details of each agency that personal information is indirectly collected from, considering the wide range of agencies that insurers work with. It therefore suggested this obligation be watered down to simply state the category/class of entity from whom information may be collected (such as from a repairer, to use the motor vehicle example). This would allow notification to simply be provided in advance via the insurer's privacy policy. This suggestion reflects that adopted by the Australian Information Commissioner in its comparable guidance. However, it has not been adopted by Parliament in the Bill nor by the Commissioner in the Draft Guidance.
3. Lack of detail as to what constitutes "reasonable steps": The Draft Guidance provides little insight as to what constitutes "reasonable steps" to notify an individual. Given the subjective nature of this assessment, in the lack of clear guidance and parameters, insurer's risk either taking insufficient steps or taking excessive steps to the extent that compliance costs are disproportionately and unreasonably increased.
4. Lack of detail as to what constitutes "as soon as reasonably possible": While the Draft Guidance provides two examples of what constitutes notification "as soon as reasonably possible", these examples are somewhat specific to their circumstances and are both of little direct relevance to the insurance sector.
5. High compliance costs: Since the introduction of the Bill, the insurance sector has held concerns as to the high compliance costs that may result from the sector's frequent and often unavoidable use of indirect collection. While it was hoped that the Draft Guidance would provide sufficient clarity to the sector regarding when it may rely on exceptions, the examples given are generally quite specific and of limited direct usefulness to the sector.
6. Limited amount of time to resolve uncertainties: Given the Bill's delay in becoming law following multiple interrupted third readings, the runway ahead of the planned 1 May 2026 enactment of IPP3A is rapidly shortening, reducing the amount of time available for the Privacy Commissioner to update its guidance ahead of IPP3A taking effect.

How insurers can prepare for IPP3A

Notwithstanding the uncertainties that linger, it is important that insurers take practical steps sooner rather than later to help them comply with IPP3A when it takes effect on 1 May 2026 (assuming the Bill passes into law). The below are some steps that can be taken in preparation:

1. Review your collection practices: Gain an understanding of the means via which you currently collect personal information, and identify which of these will be captured by IPP3A.
2. Evaluate your indirect collection practices against the IPP3A exceptions: Consider which of your indirect collection practices do or do not have an available exception. Where exceptions apply, document which exceptions you are applying to which indirect collection practices, and set out your reasoning for doing so.
3. Develop notification procedures, workflows, and timeframes: For each of your indirect collection practices which do not have an available exception, consider whether it is possible for notification of the Notifiable Matters to be occur in advance of indirect collection. For those that cannot be notified in advance, consider how soon after each indirect collection practice constitutes "as soon as reasonably practical". Ensure policies and procedures for notification are well documented and accessible to relevant personnel within your organisation.
4. Update your privacy policy: Update your privacy policy to provide your customers/clients with information about how you comply with IPP3A. If any of your indirect collection practices allow for notification of the Notifiable Matters in advance, in certain circumstances it may be possible to make this notification within your privacy policy.
5. Train your staff on your indirect collection procedures: Ensure staff are aware of the obligations your organisation holds under IPP3A and what needs to occur in order to comply with those obligations.

Conclusion

If you would like further information on the implications of IPP3A on your organisation, get in touch with our Privacy and Data Security Team.

It is important that insurers take practical steps sooner rather than later to help them comply with IPP3A when it takes effect on 1 May 2026.

RMA Amendments to fines

Frequently asked questions and what insurers need to know now

The most recent step in the transition to a new Resource Management system was completed in August 2025, when the Resource Management (Consenting and Other System Changes) Amendment Act 2025 was passed. Along with changes making it easier to consent new infrastructure, enable sufficient housing capacity, and support primary sector growth, the Government has strengthened the RMA compliance and enforcement regime.

Changes to fines, and to the insurability of those fines, came into effect immediately. There are some important practical implications of those changes for insurers and businesses alike.

Is there a "grace period" for insurance and how does timing affect coverage eligibility?

The Amendment Act made infringement fees or fines uninsurable. Any part of an existing statutory liability insurance policy which covers fines under the RMA will immediately be of no effect.

There is some confusion about whether a two-year grace period applies to the new regime. The answer is definitively no.

The timing of both the offence occurring and the sentencing is critical:

- The increased maximum fines apply from 21 August 2025. For any offending committed prior to that date, the old maximum fines apply.
- The legal prohibition against insuring for fines applies from 21 August 2025. Any policy still in place from that date will be of no effect, to the extent that it purports to cover fines. Therefore, fines imposed after 21 August are not insurable, regardless of when the offence occurred.
- The penalties associated with providing or accepting insurance do not apply for two years. Some are confusing this with a grace period – but it is only this provision that is delayed in taking effect. We anticipate this is to provide insurers time to make any necessary changes to policies as they roll over.

What costs can be covered by statutory liability policies?

Despite the prohibition on insuring fines, policies can still lawfully cover legal defence costs, expert witness fees, and court-ordered remediation expenses. This is in line with the Health and Safety at Work Act 2015.

How have financial penalties changed?

Maximum fines have increased dramatically: for individuals, from $300,000 to $1 million; for corporates, from $600,000 to $10 million. This puts environmental offending at a significantly higher maximum fine than, for example, health and safety offending.

What is the likely impact on legal proceedings?

The Amendment Act reduced the maximum imprisonment from two years to 18 months. This means that all prosecutions will be judge-alone trials, with the option to elect a jury trial eliminated by the change.

These changes fundamentally alter the risk calculation for defendants. The prospect of multi-million-dollar fines creates powerful incentives to contest charges that might previously have been resolved through guilty pleas and negotiated facts.

Are multi-million-dollar fines likely?

We can glean some likely guidance on the increase in fines from the Stumpmaster case (Stumpmaster

v WorkSafe New Zealand [2018] 3 NZLR 881), the High Court decision that provided clarity on how increased health and safety maximum fines were to be approached.

For environmental offences, we don't expect to see flat multipliers applied, based on the difference between previous maximums and the new ones. Rather, we expect to see proportionate scaling. The Chick bands (from Waikato Regional Council v GA & BG Chick Ltd (2007) 14 ELRNZ 291, and reviewed in Otago Regional Council v Greg Cowley Ltd [2019] ELHNZ 156) are currently:

- least serious – a one-off incident, with little environmental effect, a starting point of up to $40,000,
- moderately serious – unintentional but careless, with a starting point of between $40,000 and $80,000, or
- more than moderately serious – a deliberate act, or one occasioned by a real want of care. These incidents are often ongoing, or a singular, very significant event. These incidents currently have a starting point for a fine of $80,000 or more.

These bands are likely be reworked to fit within the new fines framework.

Like with the health and safety legislation, it will take time for cases under the new regime to work through the Courts, and we expect to see a spread of penalties until more definitive, higher Court guidance is provided.

With a new maximum fine of $10 million, a multi-million dollar starting point for a fine is a distinct possibility. This is where the importance of mitigating factors will need to be emphasised, to reduce the starting points. Our experience from the health and safety sector also suggests that sentencing will increasingly involve evidence about the financial position of a defendant, who may not be able to pay fines at these new levels. This type of evidence (largely from accountants) has become commonplace for health and safety cases.

What practical steps should be taken now?

Update policy documents and claims protocol.

Every insurer operating in this space needs to conduct an immediate review of their policy wording. Policies that explicitly cover RMA fines contain provisions that are now of no effect and should be removed. Those with broad statutory liability coverage may need specific RMA fine exclusions to avoid ambiguity. Particularly problematic are policies that link defence costs to fine coverage, as these provisions require

restructuring since fines are no longer insurable but defence costs remain covered.

Communicate with insureds

The timing of these changes creates practical challenges. Communication with insureds is critical to manage expectations about coverage changes, and insurers must decide whether to update policies immediately or wait for renewal. Premium adjustments should reflect both the removal of fine coverage and the likely increase in defence cost exposure. Insureds should be warned of the increased risk alongside the lack of insurance cover, to emphasise the importance of compliance.

Revise reserving practices for higher legal expenses and potentially longer litigation.

The combination of higher penalties and complex financial disclosure requirements will substantially increase defence costs. With the maximum corporate penalty reaching $10 million, defendants have compelling reasons to contest charges aggressively.

If matters go a similar way to health and safety legislation, there will be a new focus on the ability of a defendant to pay a fine. Courts will likely require extensive financial information to assess ability to pay, including five years of financial accounts and two-year forecasts, typically requiring professional accounting support.

Councils are expected to follow WorkSafe's lead by engaging forensic accountants to scrutinise financial evidence, all of which leads to increased expert witness costs.

Author: Jamie Robinson

With the maximum corporate penalty reaching $10 million, defendants have compelling reasons to contest charges aggressively.

Privacy in the Digital Age

Navigating Health Information Obligations in New Zealand

In today's rapidly evolving health sector, the intersection of technology, ethics, and law has created a complex landscape for privacy. As health services become increasingly digitised, questions arise about who health providers owe duties to, what those duties entail, and how they can be effectively discharged. At the heart of these concerns lies the fact that health information is deeply personal, and its protection is essential to maintaining trust between providers and patients.

Privacy Fundamentals: Transparency and Consent

The privacy law in New Zealand is built on two foundational principles: transparency and consent. These principles apply across all sectors but take on heightened importance in health and disability services. Under the Privacy Act 2020, individuals must be informed of:

- Why their information is being collected;
- How it will be used;
- Who is collecting it;
- Who may access it.

These obligations ensure that individuals retain autonomy over their personal data and stay informed on its disclosure. In the health context, this means that patients must understand not only the purpose of data collection but also the scope of its use—especially when shared among multidisciplinary care teams.

The Health Information Privacy Code 2020 (HIPC)

Recognising the sensitive nature of health data, the Health Information Privacy Code 2020 (HIPC) supplements the general privacy principles with 13 specific rules tailored to health providers. These rules align with the Privacy Act but impose additional obligations that reflect the unique vulnerabilities of health information.

Key requirements under the HIPC include:

- Mandatory privacy policies for all providers, regardless of size.
- Disclosure of team-based care, informing patients that their information may be shared with a wider group of professionals involved in their treatment.
- Verification of key data, requiring providers to ask patients to update or confirm critical information.
- Retention of health records for a minimum of 10 years.

These rules are not merely formalities—they are essential safeguards designed to prevent misuse.

Notifiable Privacy Breaches: What Happens When Things Go Wrong

Despite best efforts, privacy breaches can and do occur. A breach is defined as any unauthorised access, disclosure, alteration, loss, or destruction of personal health information. It also includes situations where individuals are unable to access their own data due to technical failures or systemic issues.

Under the HIPC, providers are required to notify both the Office of the Privacy Commissioner and affected individuals if the breach is likely to cause serious harm. The threshold for serious harm is intentionally broad, encompassing:

- Physical, psychological, or emotional harm;
- Financial fraud; or
- Family violence.

A notable example is the case of *Tai Rakena v Chief Executive, Department of Corrections.*[1]

Mr Rakena, an inmate at Rimutaka Prison, requested access to his own medical records. Although the Health Centre complied, his records were mistakenly delivered to another prisoner due to a cell transfer. While the breach was unintentional and the records were returned in a timely manner, the incident highlighted the importance of having robust delivery protocols.

Telehealth and the Digital Frontier: New Risks in a Connected World

The COVID-19 pandemic accelerated the adoption of telehealth across New Zealand, breaking down barriers to care and enabling flexible service delivery. However, this shift also introduced new privacy challenges. Digital platforms, while convenient, can be vulnerable to misuse—especially when access controls are poorly enforced.

In *Nursing Council of New Zealand v T*,[2] a nurse employed as a remote triage officer used the Medical Application Portal (MAP) to access the medical records of friends, colleagues, and former patients without clinical justification.

Her actions breached both the HIPC and her professional obligations under the Health Practitioners Competence Assurance Act. The Tribunal found that her conduct amounted to malpractice and brought the nursing profession into disrepute.

This case serves as a lesson that even well-intentioned professionals can cross ethical boundaries when systems lack adequate oversight. It also underscores the need for continuous training, ethical awareness, and technological safeguards.

Looking Ahead: Building a Culture of Privacy

As New Zealand's health sector continues to embrace digital innovation, the challenge will be to balance the practical benefits of accessibility with the accountability that is necessary to protect the privacy of individuals. Privacy is not just a legal requirement—it is fundamental to building patient trust in individual providers but also the healthcare industry.

To meet this challenge, health providers should:

- Invest in privacy training for all staff, including non-clinical personnel;
- Conduct regular audits of data access and usage; and
- Foster a culture of ethical responsibility, where privacy is seen as integral to care.

Ultimately, protecting health information is about more than compliance—it's about compassion. When patients share their stories, symptoms, and struggles, they entrust providers with their most intimate truths. Safeguarding that trust is not just good practice—it's the essence of good care.

Duncan Cotterill specialises in regulatory compliance and legal training for clinicians and offers tailored support to help your organisation stay ahead of legal obligations and industry standards. If you have any questions or would like to explore how Duncan Cotterill can assist your team, we encourage you to reach out and start the conversation.

[1] Tai Rakena v Chief Executive, Department of Corrections, [2017] NZHRRT 24

[2] Nursing Council of New Zealand v T, HPDT 849/Nur16/343P, 23 September 2016

Psychosocial Harm

Psychosocial risks in the workplace – such as bullying, harassment, and poor organisational justice – are increasingly recognised as significant threats to worker health and safety. Recent Australian prosecutions under the Work Health and Safety Act (WHS Act) provide valuable insights for New Zealand insurers and employers, especially as regulatory focus on psychosocial harm intensifies under the Health and Safety at Work Act 2015 (HSWA).

SafeWork NSW v Western Sydney Local Health District[1]

In a landmark case, SafeWork NSW prosecuted the Western Sydney Local Health District (WSLHD) for allegedly failing to manage psychosocial risks during an internal investigation into staff conduct. The case was triggered following the deaths of two nurses who were in a domestic relationship. On 16 August 2020, an incident occurred at the hospital's secure mental health facility, where a patient was placed in seclusion after absconding. Concerns were raised about the nurses' conduct during the seclusion process, prompting an internal investigation that later became the focus of the prosecution.[2]

The prosecution argued that the internal investigation was poorly handled, exposing the nurses to psychosocial hazards – most notably, a lack of organisational justice. It was alleged that the process itself created risks due to procedural failures, breaches of internal policy, and an inadequate response to workplace complaints, concerns, and grievances.[3]

The key points from the case were:

- The court clarified that a breach of duty under section 19 of the WHS Act need not involve actual harm or injury; exposure to risk itself suffices, and "risk" is interpreted as the mere possibility of danger, not necessarily actual danger.[4]
- The court admitted statements from the nurses about their subjective feelings, recognising their relevance in establishing risk of psychological harm.[5]
- The court found that WSLHS's failure to apply its own policies could have controlled the risk of psychological harm.[6]
- No determination was made on what steps employers must take to prevent stress from becoming a risk of psychological injury, highlighting the evidentiary challenges in prosecuting psychological harm.

The prosecution was ultimately withdrawn after three weeks and 20 witnesses. The court noted that stress arising from complaint and grievance processes is not, in itself, a breach of the WHS Act.[7]

George v State of New South Wales[8]

In another recent significant case, a police officer, Ralph George, successfully claimed sued for and was awarded damages for psychiatric injury caused by workplace bullying and harassment by a supervisor.[9]

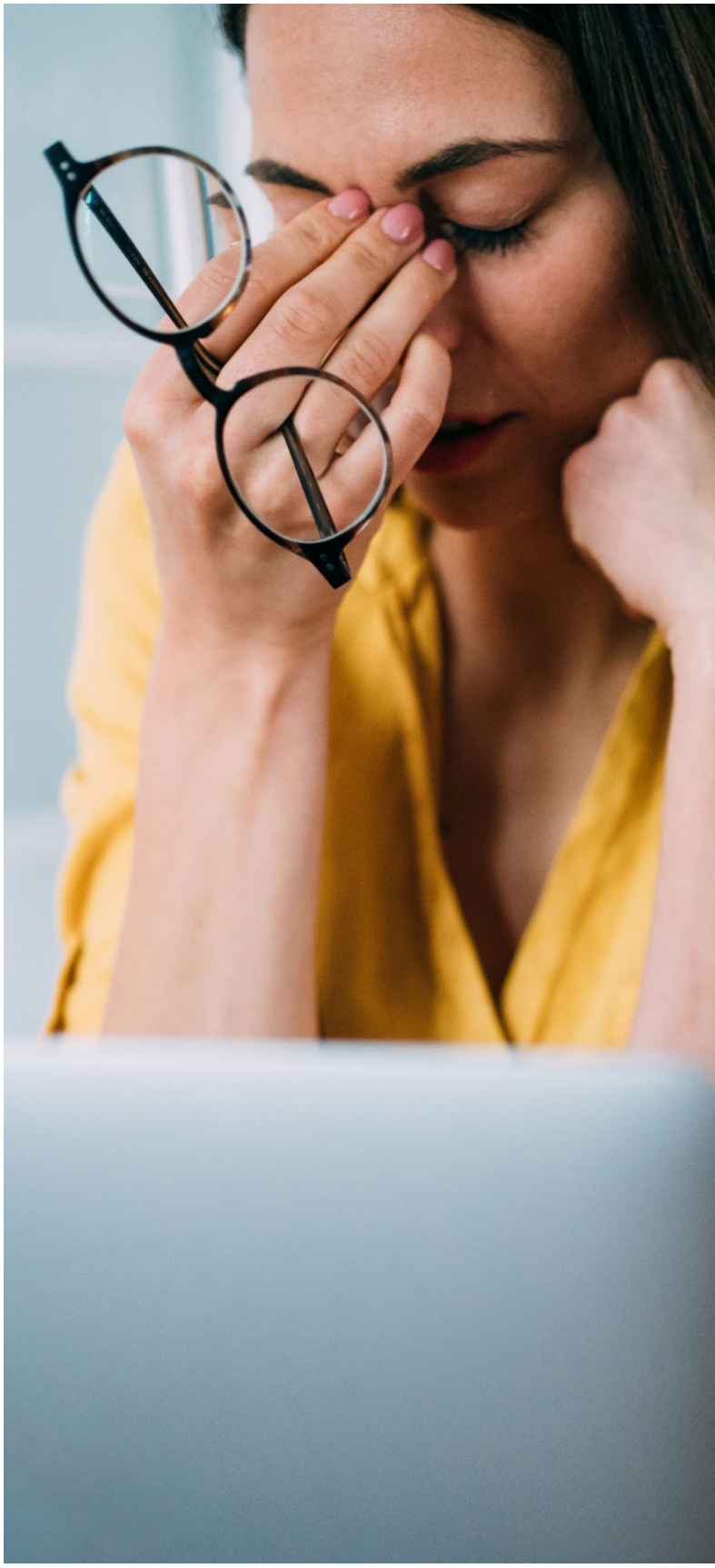
The officer, who had a long and distinguished record of service, began to experience a noticeable shift in workplace treatment from his supervisor following a 2015 speeding infringement involving a police vehicle, despite ongoing uncertainty regarding who was actually driving at the time.[10] Subsequently, the officer was excluded from verbal communication, denied reasonable flexibility to attend medical appointments, and publicly singled out during team meetings.[11]

The court found that:

- The employer was vicariously liable for the supervisor's conduct, which exacerbated the officer's pre-existing psychiatric conditions.[12]
- The risk of psychiatric injury was foreseeable, and the employer had a duty of care to prevent such harm. Even in the absence of a formal complaint or diagnosis.[13]
- Damages of $953,244 were awarded, reflecting the serious impact of psychosocial harm on the worker's mental health and employment capacity.[14]

These cases underscore several key points for New Zealand insurers and employers.

- Growing regulatory focus: both Australia and New Zealand now explicitly recognise psychosocial risks as part of workplace health and safety obligations. The HSWA defines health as including both physical and mental health, and businesses must manage psychosocial risks as part of their legal duties.[15]
- Evidentiary challenges: the withdrawal of the WSLHD prosecution demonstrates the difficulties of proving breaches related to psychosocial harm, especially where stress arises from inherently stressful processes like investigations or grievances.
- Importance of policy compliance: Courts are willing to scrutinise whether employers have and follow robust policies for managing psychosocial risks. Failure to comply with internal procedures can be pivotal.
- Employer liability: The George case shows that employers can be held liable for psychiatric injuries caused by workplace bullying or harassment, especially where the risk is foreseeable and not adequately managed.
- Practical guidance: The April 2025 edition of New Zealand's WorkSafe Psychosocial Guidelines underscores the importance of proactively identifying, assessing, and controlling psychosocial hazards in the workplace. The guidelines emphasise the need for meaningful consultation with workers and regular review of control measures. Officers are required to exercise due diligence to ensure compliance with these standards. Notably, workplace culture and conduct have a direct impact on legal exposure. Proactive risk management, early intervention, and robust complaint-handling procedures are essential. Employers who fail to address harmful behaviours in the workplace may face significant liability.[16]



Psychosocial risks at work can affect both physical and mental health. The guidelines define these risks as the likelihood that a psychosocial hazard will cause harm. Leaders play a crucial role in creating a psychologically safe workplace by proactively identifying, managing, and reviewing these risks. This involves raising awareness, consulting with workers, and responding constructively to concerns. Effective consultation not only fulfils legal duties under the HSWA but also helps identify specific challenges. Once risks are identified, appropriate control measures should be implemented and regularly reviewed to minimise harm as far as reasonably practicable.[17]

For New Zealand insurers, these Australian cases highlight the increasing medicolegal risks associated with psychosocial harm in the workplace. While prosecutions remain challenging, the regulatory direction is clear: robust policies, active risk management, and compliance with the HSWA are essential to mitigate the risk of liability and protect worker wellbeing.

[1] SafeWork NSW v Western Sydney Local Health District [2025] NSWDC 48.
[2] At [2].

[3] SafeWork NSW v Western Sydney Local Health District [2023] NSWDC 279.

[4] SafeWork NSW v Western Sydney Local Health District, above n 1, at [5] [11]-[12].
[6] At [4-6] and [31].
[7] At [24].
[8] At [24]-[27].

[9] George v State of New South Wales [2025] NSWDC 292.
[10] At [1].
[11] At [18]-[24].
[12] At [143].
[13] At [228(4)] and [78].
[14] At [121] and [154].
[15] At [286].

[16] Health and Safety at Work Act 2015, s 16.

[17] WorkSafe "Managing Psychosocial Risks at Work – Guidelines for All Businesses" April 2025.

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