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NO. 68478-7

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON  
DIVISION I

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QUELLOS GROUP LLC, *Appellant/Cross-Respondent*,

v.

FEDERAL INSURANCE COMPANY and INDIAN HARBOR  
INSURANCE COMPANY, *Respondents/Cross-Appellant*.

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**BRIEF OF APPELLANT AND CROSS-RESPONDENT QUELLOS  
GROUP, LLC, IN RESPONSE TO BRIEF OF RESPONDENT AND  
CROSS-APPELLANT FEDERAL INSURANCE COMPANY**

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## INTRODUCTION

Quellos Group LLC (“Quellos”) submits this brief in opposition to the cross-appeal brief (or “F.B.”) filed by Federal Insurance Company (“Federal”) and Indian Harbor Insurance Company (“Indian Harbor”) (collectively the “Excess Carriers”). In their cross-appeal, the Excess Carriers contend that the motion Federal filed based on certain policy exclusions provides an alternative basis for affirming the trial court’s decision granting summary judgment based on the attachment point provisions, which are at issue in the appeal brought by Quellos.<sup>1</sup>

The Excess Carriers contend that the trial court should have granted a summary judgment that these policy exclusions eliminate all coverage for the POINT losses. They argue that these exclusions serve to preclude coverage not only for two former Quellos directors, Jeff Greenstein and Charles Wilk, who ultimately entered guilty pleas after resigning from Quellos, but also for Quellos, insured affiliates, and the insured individuals representing these companies not charged with any sort of crime. For the reasons discussed below, the trial court correctly rejected that argument and denied summary judgment based on numerous

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<sup>1</sup> Brief of Appellant/Cross-Respondent; Brief of Appellant/Cross-Respondent in Reply to Brief of Respondent/Cross-Appellant Indian Harbor Insurance Company.

factual issues relating to the proper allocation of losses to the claims asserted against these other insureds.

This Court should uphold the trial court's decision on the policy exclusions, but should grant Quellos the relief requested in its appeal and reverse the decision on the attachment point provisions.

**RESPONSE TO ISSUES AS TO ASSIGNMENTS OF ERROR**

1. Whether the trial court properly denied summary judgment as to the insured individuals not accused of any crime based on (a) one policy exclusion precluding coverage for claims "arising out of" the proscribed conduct and (b) another applying to acts committed with knowledge of their wrongfulness when (i) the evidence showed that, in addition to the costs relating specifically to the defense of the insured individuals who entered guilty pleas, costs totaling \$45.15 million were incurred to respond to government investigations and to defend and settle civil claims involving other insured individuals, and (ii) there were material factual disputes about whether any of the \$45.15 million in costs was allocable to the insured individuals who plead guilty? (Assignments of Error 1 and 2)

2. Whether the trial court properly denied summary judgment as to the claims asserted against Quellos based on the two conduct-based exclusions described above when (i) the Excess Carriers failed to demonstrate that any of the \$45.15 million in costs at issue were allocable

to any claims asserted against Quellos itself, and (ii) there were genuine issues of material fact about whether these claims asserted “arose out of” proscribed conduct or involved knowing wrongful acts and what costs, if any, were allocable to claims involving the excluded conduct. (Error 1 and Statement of Issue 1 and 3)

3. Whether the trial court correctly denied summary judgment based on the answer of Quellos’ then General Counsel to Question VI in the 2000 application for primary coverage when (i) the question calls for an assessment of what she subjectively believed, (ii) she testified that she answered the question honestly after conducting a reasonable inquiry, and (iii) the Excess Carriers presented no evidence to prove that they relied on her answer in issuing their 2004-05 excess policies? (Error 3 and Statement of Issue 1 and 3)

4. Whether the trial court correctly denied summary judgment based on the exclusion for wrongful acts occurring prior to specified “Continuity Dates” when the exclusion cannot apply because the transaction resulting in the underlying claims had not even been designed at the time of the applicable Continuity Dates? (Error 4 and Statement of Issue 2)

### **STATEMENT OF THE CASE**

#### **I. OVERVIEW OF THE POINT TRANSACTIONS AND UNDERLYING PROCEEDINGS**

The instant coverage dispute concerns millions of dollars in losses

incurred in connection with government investigations and claims asserted by individual investors for whom certain Quellos affiliates executed a tax shelter transaction. *See generally* CP 146-72. The transaction, referred to as the portfolio optimized investment transaction (“POINT”), was designed to allow clients to defer tax liabilities by offsetting their capital gains with losses that could be realized from a portfolio of assets that had declined in value, while providing an opportunity for profit if those assets appreciated. CP 1179 at ¶5.

It is undisputed that most of the work on the POINT transactions was performed by Quellos Custom Strategies, LLC f/k/a Quadra Custom Strategies (“Quellos Custom”), with additional services provided by Quadra Financial Group, L.P. (“Quadra Financial”) and Quellos Financial Advisors, LLC (“Quellos Financial”). CP 1179 at ¶4. It also is undisputed that design of the POINT transaction occurred during the summer of 1999. CP 1178 at ¶3.

Subsequently, in 2000 and 2001, Quellos Custom, Quadra Financial and Quellos Financial assisted five clients in performing a total of six POINT transactions, with the first of such transactions occurring on April 28, 2000. CP 1179 at ¶6. On February 8, 2005, the Internal Revenue Service (“IRS”) initiated its investigation into the POINT transactions by sending a summons to Quellos (the “IRS Investigation”).

CP 1108 at ¶12. The IRS subsequently disallowed tax benefits claimed on each of the POINT transactions. CP 1108 at ¶13.

In 2005, the Senate Permanent Subcommittee on Investigations (“Senate Subcommittee”) initiated an investigation regarding various tax shelter strategies, including POINT (the “Senate Investigation”). CP 1108 at ¶14. In August 2006, Jeff Greenstein, the former CEO of Quellos, gave testimony before the Senate Subcommittee about the POINT transaction (CP 1108-09 at ¶15), and defended the legitimacy of the transaction. CP 666-67, 671-72, 679-80.

In July 2007 and June 2008, Quellos received grand jury subpoenas seeking documents and other information relating to the POINT transaction in connection with an investigation initiated by the United States Attorney’s office for the Western District of Washington (the “U.S. Attorney Investigation”). CP 1109 at ¶16. Quellos incurred defense costs responding to this formal investigation on behalf of the company and eleven directors, officers and employees, including Jeff Greenstein and Charles Wilk, a former director of at least one Quellos subsidiary, including Quellos Custom. CP 1109 at ¶17.<sup>2</sup>

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<sup>2</sup> The amounts incurred specifically in defending Messrs. Greenstein and Wilk in this proceeding are separately listed in Quellos’ interrogatory responses, submitted as evidence in support of Federal’s summary judgment motion. *See* CP 1279-84.

On June 4, 2009, after having advised Quellos seven months earlier that the company itself would not be charged with wrongdoing because the activities under investigation were confined to a discrete and minor area of Quellos' overall business, the U.S. Attorney's office announced the indictments of Messrs. Greenstein and Wilk for alleged wrongdoing in connection with the POINT transactions. CP 1109 at ¶18.

As of March 26, 2009, Mr. Greenstein had resigned, and Mr. Wilk ended his employment in October 2007. CP 1179 at ¶7. On September 10, 2010, both Mr. Greenstein and Mr. Wilk, entered guilty pleas. *See* CP 942-64.

Long before the criminal indictments of Messrs. Greenstein and Wilk, two POINT clients asserted claims arising out of the POINT transactions for negligence, negligent misrepresentation, breach of fiduciary duty, and intentional misrepresentation (collectively, the "individual investor claims"). CP 1109 at ¶19. The first of the individual investor claims was made in June 2005, four years before the indictments, and the second of these claims was made in March 2006, over three years before the indictments. CP 1109 at ¶20. A settlement was reached with one individual investor in March 2006, approximately three years before the indictments, and with the other individual investor in November 2007, approximately two years before the indictments. CP 1110 at ¶22. These

settlements were negotiated and executed based on the individual investors' allegations of negligence, negligent misrepresentation, breach of fiduciary duty, and intentional misrepresentation. CP 1110 at ¶23.

The settlements, which totaled \$34.75 million, released all claims that could have been asserted against any Quellos entity or person representing Quellos, including all of its directors, officers, employees, and insurers. CP 1110 at ¶24, CP 911. The settlements and related costs of representation exceeded the limits of the Investment Management Insurance Policy sold to Quellos by American International Specialty Lines Insurance Company ("AISLIC"), for the policy period between September 21, 2004 to September 21, 2005 (2004-05 AISLIC Policy"), and the excess policies for the same policy period. CP 1110 at ¶25.

Quellos gave timely notice of various claims related to the POINT transaction, including the individual investor claims, beginning in the 2004-05 policy period, and also apprised its insurers of the settlement discussions regarding the two individual investor claims. CP 1110 at ¶26. For the larger of these claims, the insurers declined to participate in the discussions and denied coverage. CP 1110 at ¶26.

In addition to seeking coverage for the defense and settlement of the individual investor claims discussed above, Quellos seeks coverage from the Excess Carriers for a variety of additional costs. These costs

include investigative expenses and defense costs incurred in connection with government investigations of the POINT transactions, including the IRS Investigation, the Senate Investigation, and the U.S. Attorney Investigation, but exclude those related specifically to the defenses of Messrs. Greenstein and Wilk. *See* CP 1279-84.

The total POINT losses incurred by Quellos for which it is seeking coverage is approximately \$45.15 million, of which Quellos recovered \$4.98 million from AISLIC. CP 1285. In addition to paying \$34.75 million to settle the two individual investor claims, Quellos incurred \$740,000 to defend those claims. CP 911, 1281, 1283-84. Quellos also incurred \$1.6 million in costs associated with the IRS and Senate Investigations, \$6.68 million in costs associated with the U.S. Attorney Investigation, and \$1.36 million in connection with proceedings before California government agencies. CP 1282-83. These amounts do not include \$17.44 million incurred specifically for the defense of Greenstein and Wilk during the U.S. Attorney Investigation. CP 1282.

## **II. QUELLOS' APPLICATIONS FOR PRIMARY INSURANCE**

Quellos seeks coverage for the POINT losses under 2004-05 policies that are renewals of the policies Quellos purchased for the period of 2000 to 2004. In connection with obtaining primary insurance coverage from AISLIC for this first policy period, Marie Bender, then Quellos'

General Counsel, completed an Investment Management Insurance Application, dated September 30, 2000. *See* CP 1107 at ¶4, CP 1113-25. Ms. Bender answered “no” to the following question in this application: “Does the applicant or any of its partners, directors, officers, employees or trustees have any knowledge of any fact or circumstance which might give rise to a claim under the proposed policy?” CP 1107 at ¶5.

In opposition to the Excess Carriers’ summary judgment motion, Quellos submitted Ms. Bender’s sworn testimony that she answered this question honestly, with no intent to deceive and only after making a reasonable, good faith inquiry within Quellos and concluding that no fact or circumstance was then known that reasonably might give rise to a claim covered by the proposed policy. CP 1107 at ¶5. Ms. Bender further swore that a tax attorney issued an opinion letter approving various POINT transactions, and that, as of September 30, 2000, Quellos Custom had completed POINT transactions for three clients who had not, to her knowledge, expressed any dissatisfaction with the services rendered or expressed any intent to pursue any type of claim against Quellos. CP 1107 at ¶¶6-7. The evidence submitted by Quellos also showed that, as of September 30, 2000, the IRS had not yet taken any action to question the validity of any POINT transaction or deny the tax benefits generated by any of the POINT transactions. CP 1107 at ¶8.

This evidence further showed that Quellos described to AISLIC its tax strategy services in connection with its original 2000 Application for primary insurance, and again for the 2004 renewal application. CP 1108 at ¶9. Among the documents Quellos provided to AISLIC as part of the 2004 Renewal Application was a brochure describing the services provided by Quellos affiliates for maximizing after-tax returns for its clients through legal structures and complex investment strategies. *See* CP 1108 at ¶¶10-11, CP 1127-77. In addition, as part of the 2004 Renewal Application, Quellos provided AISLIC with Quellos Custom’s “Form ADV,” which discussed the inherent risk that the IRS could challenge an investment strategy, such as the POINT strategy, could deny the claimed tax benefits, and potentially subject a client to the payment of back taxes, interest charges, and penalties. *See* CP 1108 at ¶¶10-11, CP 1127-77.

### **III. QUELLOS’ 2004-05 INVESTMENT MANAGEMENT INSURANCE POLICIES**

The policies at issue in this action include AISLIC’s 2004-05 Investment Management Insurance Policy, which provides primary, claims-made coverage of \$10 million (CP 47 at Items 2 & 3), the 2004-05 policy issued by Federal, which provides \$10 million in first-layer excess coverage above the 2004-05 AISLIC Policy (“2004-2005 Federal Excess Policy”). (CP 97 at Items 1 & 5), and the policy issued by Indian Harbor,

which provides \$20 million in second-layer excess coverage above that AISLIC Policy (the “Indian Harbor Policy”). *See* CP 110-12.

The 2004-05 Federal and Indian Harbor Policies (collectively the “Excess Policies”) incorporate the terms of the 2004-05 AISLIC Policy by providing coverage “in conformance with” the terms of the primary policy. CP 99 at § 1; CP 110 at § I. The 2004-05 AISLIC Policy, and the 2004-05 Excess Policies that “follow form” to this Policy, provide insurance coverage to Quellos and a host of corporate affiliates and insured individuals, including officers, directors and employees, for “damages resulting from any claim or claims first made . . . during the Policy Period . . . for any Wrongful Act of the Insured” in rendering Investment Advisory Services or Extended Professional Services. CP 50 at § 1.I. (Insuring Agreements), CP 53 at 2.(e) (defining “Insured”), CP 78, 94.

The 2004-05 AISLIC Policy defines the term “Wrongful Act” expansively as “any breach of duty, neglect, error, misstatement, misleading statement, omission or other act wrongfully done or attempted by” Quellos. CP 53 at § 2.(i). Consistent with the risks of Quellos’ tax investment and tax management business, the 2004-05 AISLIC Policy defines “Extended Professional Services” to mean “providing, executing or implementing tax planning, tax strategy, advice and consulting, tax

preparation, estate planning, investment planning, asset allocation, legal services, accounting services, and similar services for others.” CP 94.

The 2004-05 AISLIC Policy provides coverage for all sums the Insured must pay as “Formal Investigation Costs,” which includes “Defense Costs incurred by an Insured in response to a Formal Investigation.” CP 84-85.

In addition to invoking Ms. Bender’s answer to the question on the 2000 AISLIC Policy application, the Excess Carriers sought summary judgment based on three exclusions in the 2004-05 AISLIC Policy. The first is a conduct-based exclusion stating that the AISLIC Policy “does not apply . . . to any claim arising out of, based upon or attributable to the committing in fact of any criminal or deliberate fraudulent act by any Insured, or any knowing or willful violation of any statute by any Insured.” CP 69 at § 4.I.1 (as amended by Endorsement No. 5(1), CP 69). The second exclusion, also conduct-based, states that this policy does not apply “to any actual or alleged Wrongful Act committed with knowledge that it was a Wrongful Act.” CP 54 at § 4.I.3. The third exclusion states that this policy does not apply to any “actual or alleged Wrongful Act occurring prior to the Continuity Date specified in Item 6 of the Declarations, if on or before such Continuity Date any Insured knew of such Wrongful Act or could have reasonably foreseen that such Wrongful Act could lead to a claim.” CP 54 at §§ 4.I.3, 4.II.4. Endorsement No. 8

(CP 78) specifies Continuity Dates for additional insured affiliates of Quellos, including the following:

Quadra Financial Group, LP:	November 7, 1994
Quellos Financial Advisors, LP:	July 1, 1997
Quellos Custom Strategies, LLC:	March 24, 1999

#### **IV. THE SUMMARY JUDGMENT PROCEEDINGS**

##### **A. The Parties' Summary Judgment Motions**

In October 2011, Federal filed a summary judgment motion, joined by Indian Harbor, arguing that the guilty pleas of Messrs. Greenstein and Wilk served to deprive all of the insureds, even those accused of no wrongdoing, of any coverage for the POINT losses. CP 1019-59. The parties also filed cross-motions for summary judgment regarding the Excess Carriers' affirmative defense that Quellos forfeited all excess coverage merely by settling with AISLIC for less than the full primary policy limits. CP 7-21, 113-42.

##### **B. The Trial Court's Summary Judgment Ruling**

At the conclusion of the hearing held on December 16, 2011, in a ruling from the bench, the trial court granted in part and denied in part Federal's summary judgment motion. The court ruled that the two conduct-based exclusions in the AISLIC Policy, which the Excess Carriers denominated the Fraud and Knowing Wrongful Acts Exclusions, barred coverage for POINT losses incurred by Messrs Greenstein and Wilk (RP

97:7-12, 98:4-14)<sup>3</sup>, but rejected the argument that these conduct-based exclusions could serve, as a matter of law, to bar coverage altogether for other insureds, including Quellos and its affiliates, and the remaining directors, officers, and employees not accused of any intentional misconduct. RP 93:14-99:8. With respect to these other insureds, the court ruled that “there is a genuine issue of material fact as to which costs are covered, [and] which costs are not.” RP 97:18-19; *see* RP 96:4-98. The trial court also rejected the Excess Carriers’ arguments that the Continuity Date Exclusion and Ms. Bender’s response to Question VI of the 2000 AISLIC Application barred coverage to these insureds. RP 97:25-98:7.

The trial court granted summary judgment to the Excess Carriers on the exhaustion issue. RP 100:5-21. Quellos submits that the trial court erred in granting summary judgment to the Excess Carriers on this issue for the reasons stated in its opening brief on appeal and in reply to the response brief filed by Indian Harbor.

#### **STANDARD OF REVIEW**

This Court reviews summary judgment orders *de novo*, considering all facts and reasonable inferences in the light most favorable to the nonmoving party. *Seiber v. Poulsbo Marine Ctr., Inc.*, 136 Wn. App. 731,

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<sup>3</sup> The transcript of proceedings before the trial court is included as Exhibit A in the Appendix to Quellos’ Opening Brief.

736-37, 150 P.3d 633 (2007). Summary judgment is proper where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Id.*; *see also* CR 56(c).

### **SUMMARY OF ARGUMENT**

The Excess Carriers contend that the policy exclusions at issue entitled them to summary judgment for four reasons. Not one has merit and the trial court's ruling should be affirmed.

First, the Excess Carriers argue that two conduct-based exclusions entitled them to summary judgment. But they concede that a non-imputation provision precludes these exclusions from applying to the POINT claims asserted against the insured individuals, other than Messrs. Greenstein and Wilk, who were never charged with any sort of crime. The trial court correctly denied summary judgment as to the POINT claims asserted against these other insured individuals because the Excess Carriers failed to demonstrate any basis for allocating \$45.15 million in POINT losses not specifically related to the defense of Messrs. Greenstein and Wilk between the claims asserted against the insured individuals and claims asserted against others for any excluded conduct.

The Excess Carriers' second argument is that, because *Quellos* is not covered by the non-imputation provision, the trial court should have ruled as a matter of law that the two conduct-based exclusions bar

coverage for the POINT claims asserted against Quellos itself. To prevail on that contention, the Excess Carriers had to make two showings. First, they would have had to demonstrate that any of the \$45.15 million in POINT losses not attributable to the defense of Messrs. Greenstein and Wilk should be allocated to any claims against Quellos itself, rather than to the claims asserted against the other insured individuals. The Excess Carriers failed to make that showing for the reasons stated above.

Second, the Excess Carriers would have had to show that any amounts that could properly be attributed to the claims against Quellos were allocable to claims for excluded conduct. They also failed to make this showing. For example, Quellos' evidence established that the POINT losses included the \$34.75 million paid to settle the civil matters asserted by the individual investors, which asserted three negligence-based claims as well as one claim based on intentional misconduct. Given that these settlements were reached years before Messrs. Greenstein and Wilk were even charged with any crime, and that the negligence-based claims provided a separate basis for liability not requiring any proof of excluded conduct, there was no basis at all on which the trial court properly could have granted summary judgment as to the claims asserted against Quellos.

The Excess Carriers' third argument is based on an answer that Marie Bender, then Quellos' General Counsel, gave on the original

application for primary insurance coverage submitted in September 2000, long before Quellos applied for the 2004-05 renewal Excess Policies at issue. The Excess Carriers were not entitled to summary judgment based on this answer because the question calls for a subjective analysis concerning what Ms. Bender personally believed, and Ms. Bender testified that she answered this question honestly, after conducting a reasonable inquiry within Quellos. Furthermore, the Excess Carriers failed to show that her answer was material to the underwriting of the Excess Policies.

Fourth and finally, the Excess Carriers argue that a “Continuity Date Exclusion” bars coverage because Quellos supposedly could have reasonably foreseen claims relating to the POINT transactions before August 25, 2000, which Federal claims is the operative Continuity Date. This argument ignores an endorsement to the primary policy establishing that the latest Continuity Date for the Quellos affiliates involved in the POINT transactions was March 1999. No person could have reasonably foreseen any POINT claims in March 1999 because the POINT transaction was not even designed until the summer of 1999.

#### **ARGUMENT**

#### **I. THE TRIAL COURT CORRECTLY REJECTED THE ARGUMENT THAT THE CONDUCT-BASED EXCLUSIONS ENTITLED THE EXCESS CARRIERS TO SUMMARY JUDGMENT.**

A hornbook rule of insurance law is that insurers bear the heavy

burden of proving that policy exclusions apply to bar coverage altogether for claims and related costs of defense and settlement. *See, e.g., Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 142 Wn. 2d 654, 674, 15 P.3d 115 (2000). The trial court correctly determined that the Excess Carriers failed to satisfy this burden on summary judgment because material issues of fact preclude a finding that the conduct-based exclusions bar coverage for the claims asserted against the insured individuals other than Greenstein and Wilk and Quellos itself.

As discussed above, Quellos incurred \$43.8 million in losses unrelated to the defense of Messrs. Greenstein and Wilk. To carry its burden on summary judgment, the Excess Carriers would have had to have shown as a matter of law how that money was allocated with respect to the various claims against Quellos, Greenstein, Wilk, and each of the other individual insureds. However, there was a totally insufficient factual record, let alone an undisputed factual record, upon which the trial court could make such a finding. For example, while the Excess Carriers pointed to the fact that \$1.27 million in costs were incurred in connection with the defense of a number of these other insured individuals in the U.S. Attorney Investigation, they failed to demonstrate that none of the other costs at issue could be attributed to these insured individuals under the applicable allocation principles. The trial court, therefore, was required to

find that there were “genuine issues of material fact” as to whether the conduct-based exclusion barred coverage for the claims against insured individuals other than Messrs. Greenstein and Wilk. RP 96:24-97:1.

Moreover, to meet their burden with respect to the claims asserted against Quellos under the applicable principles, the Excess Carriers would have had to show that there was no genuine dispute with respect to two separate allocation questions. First, they would have had to prove that an allocation between the claims asserted against the non-indicted insured individuals and those asserted against Quellos itself was required with respect to the \$45.15 million in losses at issue. Second, they would have had to have proven that any of whatever amount that properly could be allocated to the claims against Quellos itself could be attributed to claims for excluded conduct, rather than to negligence-based claims that also were asserted against Quellos and the insured individuals. Because the Excess Carriers failed to make either of these showings, the trial court was required to determine, and correctly determined, that there were “genuine issues of material fact” as to whether the conduct-based exclusions barred coverage for the POINT claims asserted against Quellos itself.

**A. The Trial Court Correctly Found Material Factual Disputes About The Amount of POINT Losses Allocable To The Claims Asserted Against Insured Individuals Other Than Greenstein And Wilk.**

Owing to the non-imputation provision contained in the AISLIC

Policy, the Excess Carriers concede that the two conduct-based exclusions (contained in §§ 4(I)(1) and (3) of the AISLIC Policy) do not bar coverage for the Quellos directors, officers, and employees who were never even accused of intentional wrongdoing. F.B. 35, 45. This non-imputation provision unequivocally prescribes that no wrongful acts by Messrs. Greenstein and Wilk “shall . . . be imputed to any other” Quellos director, officer, or employee for purposes of the conduct-based exclusions at issue.<sup>4</sup> Settled principles of policy interpretation, in turn, mandate that such clauses preserve coverage for all insureds except those adjudged guilty of deliberate misconduct.<sup>5</sup>

**1. Washington Law Establishes Allocation In Cases Involving A Mix Of Covered And Non-Covered Claims Is Appropriate Only In Limited Circumstances.**

While the Excess Carriers contend that, as a matter of law, only

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<sup>4</sup> This provision states in full:

NOTE: *The Wrongful Act of any partner, officer, director, trustee, managing member or employee who is an Insured under this policy shall not be imputed to any other partner, officer, director, trustee, managing member, or employee who is an Insured under the policy for the purpose of exclusions I. 1) through 5) above.*

CP 54 at p. 5 (emphasis added).

<sup>5</sup> See, e.g., *Pereira v. Nat'l Union Fire Ins. Co.*, 2006 WL 1982789, at \*6 (SDNY July 12, 2006) (non-imputation clause rendered exclusion personal to each insured and precluded application to defeat coverage for non-culpable insureds); *Alstrin v. St. Paul Mercury Ins. Co.*, 179 F. Supp. 2d 376, 398 (D. Del. 2002) (insurer must prove applicability of conduct exclusion separately for each insured because of non-imputation clause); *SEC v. Credit Bancorp, Ltd.*, 147 F. Supp. 2d 238, 265 (SDNY 2001) (non-imputation clause “expressly states that the [criminal acts] exclusion does not apply to persons other than the dishonest actor.”).

\$1.27 million of the POINT losses are allocable to covered claims, they wisely avoid any mention of the governing principles of Washington insurance law for allocating losses between covered and non-covered claims, which completely foreclose their argument. Courts in Washington apply the same principles widely followed by courts throughout the county in determining how, if at all, a policyholder's losses are to be allocated when a mix of covered and non-covered claims are involved.<sup>6</sup> Different, though complimentary, principles apply to disputes involving the allocation of defense costs and settlement or other indemnity costs.

For defense costs, Washington courts employ a variant of what is commonly known as a "reasonable relationship" test, which mandates that, as long as the defense costs in question are reasonably related to or serve to benefit the defense of a potentially covered claim, the defense costs are covered regardless of whether they also may relate to or benefit the defense of a non-covered claim.<sup>7</sup> As one Washington court explained

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<sup>6</sup> The AISLIC Policy, and the Excess Policies by extension, provide with respect to defense costs and settlement payments that "the Insured and the Company agree to use their best efforts to determine a fair and proper allocation of the amounts as between the Insured and the Company." CP 52 at § II, p. 3. As the Ninth Circuit has explained, this provision "requires an allocation analysis, but not necessarily an allocation." *Safeway Stores, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 64 F.3d 1282, 1287 (9th Cir. 1995).

<sup>7</sup> See, e.g. *Safeway Stores*, 64 F.3d at 1289 ("Defense costs are ... covered by a D&O policy if they are reasonably related to the defense of insured directors and officers, even though they may also have been useful in defense of the uninsured corporation."); *Piper Jaffray Cos. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 38 F. Supp. 2d 771, 780 (D.

in applying this test to find full coverage for all defense costs incurred, “[i]t is only logical that where a dollar of loss is incurred as a result of both a covered claim and a non-covered claim, the dollar is covered—regardless of the dollar’s tangential benefit of settling, *or defending against*, the non-covered claim.” *In re Feature Realty Litigation*, 634 F. Supp. 2d 1163, 1174 (E.D. Wash. 2007) (emphasis added). *Accord Nordstrom, Inc. v. Chubb & Son, Inc.*, 54 F.3d 1424, 1436 n.5 (9th Cir. 1995) (no allocation of defense costs because liability was concurrent).

In evaluating disputes regarding the proper allocation of settlement costs, Washington courts employ a variant of what is commonly known as the “larger settlement” rule. This rule, employed by the majority of jurisdictions in this country, requires that an insurer pay 100 percent of a settlement involving insured and excluded claims unless the carrier can demonstrate that the uninsured claims increased the settlement costs.<sup>8</sup>

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Minn. 1999) (same); *Cont’l Cas. Co. v. Bd. of Educ. of Charles Cnty.*, 302 Md. 516, 532, 489 A.2d 536, 544 (Md. 1985) (same).

<sup>8</sup> *See, e.g., Safeway Stores*, 64 F.3d at 1287 (adopting larger settlement rule and affirming trial court’s conclusion that uninsured did not increase amount of settlement); *Owens Corning v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 257 F.3d 484, 493 (6th Cir. 2001) (same); *Caterpillar, Inc. v. Great Am. Ins. Co.*, 62 F.3d 955, 962 (7th Cir. 1995) (same). Courts explain that this rule is consistent with the reasonable expectations and intentions of the policyholder and insurer, because of the typically broad assurance in a D&O policy that the insurance company will indemnify for “all loss” that the policyholder “shall be legally obligated to pay” “implies a complete indemnity for claims regardless of who else might be at fault for similar actions.” *Caterpillar*, 62 F.3d at 962.

The Washington Supreme Court employed this test in *Public Utility Dist. No. 1 of Klickitat Co. v. International Ins. Co.*, 124 Wn. 2d 789, 810, 881 P.2d 1020 (1994) (“*Klickitat County*”). At issue was the extent of coverage to insured utilities, and their directors, officers, and employees, for the settlement of a lawsuit brought by bondholders alleging securities law violations in the sale of bonds that went into default. *Id.* at 794. The insurer argued that a jury must allocate between a covered negligence claim and an excluded claim alleging intentional misconduct. *Id.* at 810. The Washington Supreme Court held that the insurer was not entitled to allocation and must indemnify for the entire settlement because the harm, financial loss from the default, was the same for both claims. *Id.*

The Ninth Circuit also applied this test in concluding that Washington law obligated an insurer to cover 100 percent of a settlement despite a mix of covered and non-covered claims, as well as the presence of insured and uninsured defendants. *See Nordstrom*, 54 F.3d at 1433. Because the policy insured against wrongful acts of the directors, officers, and employees but not wrongful acts of Nordstrom itself, the insurer argued for allocation based on the relative culpability of the insured and uninsured parties. *Id.* at 1432. The court rejected this argument based on policy language like that at issue here, which broadly insured against “all loss ... which the Insured Person has become legally obligated to pay ...

for a Wrongful Act committed ... by such Insured Person.” *Id.* at 1432-33. The court reasoned that this provision made the insurer “responsible for any amount of liability that is attributable in any way to the wrongful acts or omissions of the directors and officers, regardless of whether the corporation could be found concurrently liable on any given claim under an independent theory.” *Id.* at 1433. Thus, only “if the corporate liability increased the amount of loss, would the amount of liability exceed that amount for which Federal was ‘legally obligated’ to pay.” *Id.* Under these principles, the insurer was responsible for 100 percent of the settlement because Nordstrom’s liability was concurrent with that of the insured directors and officers. *Id.*

Following *Nordstrom* and the Washington Supreme Court decision in *Klickitat County*, the *Feature Realty* court also concluded that no allocation of settlement costs was required in a case involving a covered common law claim and an excluded statutory claim (which required proof of intentional misconduct). 634 F. Supp. 2d at 1173. The court ruled that no allocation was warranted because no element of damage was “solely attributable to the non-covered cause of action” and there was “no evidence that the liability under the statutory claim was any more extensive than the liability” under the common law claim. *Id. Accord Klickitat County*, 124 Wn.2d at 810 (holding no allocation was warranted

and that insurer must indemnify for entire settlement because claimed harm was same for covered and uncovered claims).

**2. The Excess Carriers Did Not Meet Their Burden of Showing That Any Allocation To Excluded Claims Was Required With Respect To The POINT Losses Not Related Specifically To The Defense Of Messrs. Greenstein And Wilk.**

The allocation principles discussed above confirm that the trial court correctly rejected the Excess Carriers' argument that, as a matter of law, only \$1.27 million in POINT losses were allocable to the claims asserted against the insured individuals other than Messrs. Greenstein and Wilk. While it is true that Quellos incurred this amount in connection with the defense of certain of these other insured individuals in the U.S. Attorney Investigation, the Excess Carriers failed to establish any record – let alone any uncontested record – evidence that none of the remaining costs unrelated specifically to the defense of Messrs. Greenstein and Wilk in the U.S. Attorney Investigation were attributable to the claims asserted against the other insured individuals. On the contrary, as discussed below, the evidence presented a material dispute about whether any allocation is required with respect to POINT losses not relating specifically to the defense of Greenstein and Wilk. *See* CP 1279-84.

The Excess Carriers cannot dispute that Quellos had the authority under Washington law to indemnify its directors and officers for their

defense costs and other losses (*see* RCW 23B.08.510(i)). The Excess Carriers failed to present any evidence, let alone any uncontested evidence, that the defense costs not relating specifically to the defense of Messrs. Greenstein and Wilk in the U.S. Attorney Investigation did not benefit the defense of the other insured individuals. Absent such evidence, Washington law calls for a ruling that all of these additional defense costs are allocable to the claims asserted against these other insured individuals. *E.g., Nordstrom*, 54 F.3d at 1436 n.5.; *Feature Realty*, 634 F. Supp. 2d at 1174.

The Excess Carriers also failed to meet their burden of proving that the claims asserted against Messrs. Greenstein and Wilk increased the cost of settling the two individual investor claims. Quellos introduced evidence that these individual investors asserted civil claims of negligence, negligent misrepresentation, breach of fiduciary duty, as well as intentional misrepresentation, and that the settlements payments released all claims that were or could have been asserted against any Quellos entity or Quellos representative, including its directors, officers and employees. CP 1110 at ¶¶23-24. Absent evidence that the claims against Messrs. Greenstein and Wilk increased the cost of settlement, Washington law mandates that no allocation to any excluded claims is required with respect to the \$34.75 million paid to settle the two individual

investor claims. *See Klickitat County*, 124 Wn.2d at 810; *Nordstrom*, 54 F.3d at 1432-33; *Feature Realty*, 634 F. Supp. 2d at 1173-74.

The evidence cited by the Excess Carriers provides no support for their contrary contentions. They point first to the fact that Quellos listed only Quellos entities, when responding to part of an interrogatory requesting identification of “the entity, individual and/or other person to whom the matter was asserted ....” F.B. 35-36. But the interrogatory asked Quellos to identify the “entity” or “the person” “*to whom the matter was asserted,*” rather than all entities and persons potentially having liability for the matter. *See* CP 1279. Quellos thus only identified the Quellos entities that received notice of the claims. Furthermore, the Excess Carriers fail to mention that the very same interrogatory response states that the Excess Policies “provid[e] coverage for the investigations and lawsuits *threatened or commenced against Quellos and certain of its current or former directors and officers ....*” CP 1284 (emphasis added).

The Excess Carriers reference (F.B. 36) the Declaration of Marie Bender, Quellos’ former General Counsel, which attests that the individual investors asserted “claims of negligence, negligent misrepresentation, breach of fiduciary duty, and intentional misrepresentation *against Quellos.*” CP 1109 at ¶19 (emphasis added). The clear intent is to describe the nature of the claims asserted, not list all defendants against

whom the claims were asserted. Furthermore, Ms. Bender testified unequivocally in the same declaration that (1) “Quellos negotiated and executed the [POINT] settlements based upon the individual investors’ allegations of negligence, negligent misrepresentation, breach of fiduciary duty, and intentional misrepresentation,” and (2) “[t]he settlements released all claims that could have been asserted against any Quellos entity or person representing Quellos, including all of its directors, officers, employees, and insurers.” CP 1110 at ¶¶23-24.

Finally, the Excess Carriers speciously assert (F.B. 36) that the insured individuals must have actually signed the settlement agreements resolving the individual investor claims for there to be coverage. They provide no support for this assertion, and there is none. The Excess Policies follow form to the AISLIC Primary Policy and grant coverage for amounts that Quellos is “permitted or required to pay as indemnification” for the liability of insured individuals. CP 50 at § 1, Insuring Agreement B, CP 99 at § 1, CP 110 at § I. Quellos’ evidence demonstrated that the settlement payments made by Quellos released it and its directors, officers, and employees from all liability to the individual investors. CP 1110 at ¶24. Under the plain terms of the Excess Carriers’ policies, this evidence showed that these settlement payments fell within the scope of coverage.

**B. The Excess Carriers Did Not Meet Their Burden of**

**Showing That Any Of the POINT Losses Not Related Specifically To The Defense Of Messrs. Greenstein And Wilk Could Be Allocated to Excluded Claims Asserted Against Quellos Itself.**

The Excess Carriers also erroneously argue that, since the non-imputation clause applies only to insured individuals, the trial court should have found as a matter of law that both of the two conduct-based (the Fraud and Knowing Wrongful Acts Exclusions) bar coverage for Quellos. F.B. 26-35, 44. There is no basis for the trial court to make such a ruling because the Excess Carriers failed to demonstrate that the full \$45.15 million in costs not related specifically to the defense of Messrs. Greenstein and Wilk could not properly be allocated to the claims asserted against the other insured individuals. *See, supra*, § 1.A.2. On the scant evidence presented, moreover, the trial court also correctly concluded that material issues of fact would preclude summary judgment regarding the potential application of the conduct-based exclusions to the extent any allocation of losses between the POINT claims asserted against these other insured individuals and Quellos itself were permissible.

**1. The Trial Court Correctly Held That Issues Of Fact Preclude A Finding That The Fraud Exclusion Bars Coverage For Claims Asserted Against Quellos Itself.**

The Excess Carriers argue that the trial court erred in declining to hold as a matter of law that the Fraud Exclusion barred coverage for any

losses allocable to Quellos because the Fraud Exclusion purports to apply to any claim “arising out” of the prescribed conduct by “any Insured.” F.B. 30. In the context of the settlements of the two individual investor claims and other losses not related solely to the defense of Messrs. Greenstein and Wilk, however, the trial court correctly recognized that there are genuine issues of material fact concerning “what exactly arising out of means.” RP at 96:24-97:6.

Quellos settled the two individual investor claims in November 2007 and March 2006, more than two years before the U.S. Attorney announced the indictments of Messrs. Greenstein and Wilk, and four years before these individuals entered guilty pleas. CP 1109 at ¶¶18-22. At the time of these settlements, Mr. Greenstein also was still vigorously defending the legitimacy of POINT, testifying in August 2006 before the U.S. Senate that he believed the POINT transaction was legitimate, legal, and merely the utilization of lawful and customary means for trading securities. CP 671-72, CP 679-80. And while the individual investors asserted one claim for intentional misrepresentation, they also asserted claims for negligence, negligent misrepresentation, and breach of fiduciary duty. CP 1109 at ¶19. In light of these facts, extant at the time of the settlements of the individual investor claims, the trial court correctly concluded that there were triable factual issues about whether any part of

the settlement payment that might be apportioned to Quellos arose out of fraudulent or criminal acts instead of negligent acts.

*Feature Realty* underscores the validity of the trial court's decision. In that case, the policyholder, the City of Spokane, settled an underlying action alleging improper delays in the permitting of a development and asserted (1) a statutory claim under RCW Ch. 64.40 for willful misconduct in the handling of permit applications, and (2) a common law claim for intentional interference with business expectancy. *Id.* at 1291. In a prior decision, the court had concluded that the policy covered the common law claim but not the statutory claim because of an exclusion for "any claim 'arising from the willful violation of any statute, ordinance, or regulation committed by or with the knowledge or consent of any insured.'" 468 F. Supp. 2d at 1303.

Focusing on the "arising from" language in the exclusion, the insurer moved for summary judgment again, arguing that, as a matter of law, the exclusion even barred coverage for the common law claim because it was "exclusively premised" on the City's alleged violation of RCW Ch. 64.40. *Id.* The court disagreed, explaining that the common law claim for interference "stood independently of the underlying alleged violation of RCW Ch. 64.40. In fact, [the] interference claim was . . . a distinct claim based upon similar facts." *Id.* at 1304.

For the same reasons, the trial court correctly recognized the material factual disputes about whether the claims against Quellos for negligence, negligent misrepresentation, and breach of fiduciary duty “arose out of” any excluded claims relating to the alleged misconduct of Messrs. Greenstein and Wilk. *Id.* Although these negligence-based claims and the claim for intentional misrepresentation generally shared the same factual basis, i.e. the IRS’ disallowance of POINT, the claims regarding the negligently constructed tax shelter “stood independently” and were “distinct” from the claims regarding a fraudulently constructed tax shelter. Indeed, the individual investors could have prevailed on the negligence-based claims even in the absence of any criminal or fraudulent misconduct by Greenstein and Wilk. *Hutchins v. 1001 Fourth Ave. Associates*, 116 Wn.2d 217, 221, 802 P.2d 1360 (1991) (elements for proving negligence); *Lawyers Title Ins. Co. v. Baik*, 147 Wn.2d 536, 545, 55 P.3d 619 (2002) (elements for proving negligent misrepresentation); *Senn v. Northwest Underwriters, Inc.*, 74 Wn. App. 408, 414, 875 P.2d 637 (1994) (elements for proving fiduciary duty breach).

Although the Excess Carriers argue for a broader application of the Fraud Exclusion, the Washington decisions they cite confirm that the trial court correctly denied summary judgment on this issue. The Excess Carriers concede that Washington courts have construed the phrase

“arising out of” to mean “originating from, having its origin in, growing out of, or flowing from.” See F.B. 31 (quoting *Munn v. Mutual of Enumclaw Ins. Co.*, 73 Wn. App. 321, 325, 896 P.2d 99 (1994)).

Consistent with this definition, the Washington decisions cited by the Excess Carriers merely confirm that exclusions using the phrase “arising out of” bar coverage only when a claim grows out of or originates in the excluded conduct and cannot be asserted independently of it.<sup>9</sup> Because the individual investors’ negligence-based claims could be proven without a showing of criminal or fraudulent conduct by Greenstein and Wilk, and were asserted and settled years before their indictments or subsequent guilty pleas, it cannot be said as a matter of law that the Fraud Exclusion bars coverage for the claims asserted against Quellos.

Indeed, settled principles of insurance law dictate that an insurer’s “obligation to pay and the determination of coverage must be based upon the facts inherent in the settlement....” *Feature Realty*, 468 F. Supp. 2d at 1295 (rejecting argument that a settlement involved only non-covered wrongful acts committed outside of the policy period based on evidence

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<sup>9</sup> See *Stouffer & Knight v. Cont’l. Cas. Co.*, 96 Wn. App. 741,750 n.11, 982 P.2d 105 (1999) (exclusion for dishonesty excluded not only claim for embezzlement by employee but also related claim for negligent supervision by employer because negligence claim could not exist without underlying embezzlement); *City of Everett v. Am. Empire Surplus Lines Ins. Co.*, 64 Wn. App. 83, 88-89 823 P.2d 1112 (1991) (exclusion for claims arising from death barred coverage for claim of negligent supervision and training of deceased firefighter because the “very existence” the of negligence claim “depends upon the fatal injury ....”).

shedding “light on the underpinnings of the settlement,” which showed that the settlement was based on allegations of covered wrongful acts). *See also Texas Farmers Ins. Co. v. Lexington Ins. Co.*, 2010 WL 2035275 at \*2 (9th Cir. May 21, 2010) (coverage must be based on facts inherent in settlement); *Travelers Indem. Co. of Illinois v. Royal Oak Enter. Inc.*, 344 F. Supp. 2d 1358, 1366 (M.D. Fla. 2004) (same). The evidence presented regarding the facts inherent in the settlement of the two individual investor matters, which long-predated the indictments of Messrs. Greenstein and Wilk, reconfirms that the trial court properly denied summary judgment.

**2. The Trial Court Correctly Recognized That Issues Of Fact Preclude A Finding That The Knowing Wrongful Act Exclusion Bars Coverage For Claims Asserted Against Quellos Itself.**

The trial court also correctly ruled that the Excess Carriers were not entitled to summary judgment based on the Knowing Wrongful Act Exclusion. This exclusion provides that the AISLIC Policy, and the Excess Policies by extension, do not apply “to any actual or alleged Wrongful Act committed with knowledge that it was a Wrongful Act.” CP 54 at § 4.I.3. This exclusion does not even contain the “arising out of” phrase upon which the Excess Carriers so heavily rely in arguing that the trial court should have granted summary judgment based on the Fraud Exclusion. As with the Fraud Exclusion, moreover, the Excess Carriers

failed to demonstrate as a matter of law that the Knowing Wrongful Act Exclusion had any applicability to POINT losses not related specifically to the defense of Messrs. Greenstein and Wilk because they did not show (1) any of these \$45.15 million in POINT losses could properly be allocated between the covered claims asserted against the other insured individuals and Quellos, or (2) that, assuming that any part of these POINT losses could be properly be allocated to the claims asserted against Quellos itself, such losses could be attributed to the excluded claims involving the conduct prohibited by the Knowing Wrongful Acts Exclusion.

As discussed in detail above in Section I.B.1 above, the evidence presented supports the conclusion that the negligence-based claims asserted by the individual investors, which were asserted and settled years before the indictments or subsequent guilty pleas of Messrs. Greenstein and Wilk, stood independent of the claims based on the alleged intentional misconduct of Messrs. Greenstein and Wilk. *See Feature Realty*, 468 F. Supp. 2d at 1295; CP 1110 at ¶¶23-24. As also discussed above in Section I.C.1, these negligence-based claims provided a separate basis for liability that did not require proof of any intentional misconduct by Messrs. Greenstein and Wilk. In these circumstances, the Excess Carriers failed to demonstrate as a matter of law that the Knowing Wrongful Acts Exclusion could bar coverage for any of the negligence-based POINT claims

defended against and settled, even if they had met their burden (and they did not) of proving that an allocation between the claims asserted against the insured individuals and Quellos itself was required.

The Excess Carriers' argument makes even less sense in light of the broad coverage the Excess Policies provide for intentional acts committed in connection with tax planning, tax strategy and other financial services. See CP 50 at § 1.I (Insuring Agreement), CP 53 § II(2)(i) (definition of "Wrongful Act), CP 94. Because covered Wrongful Acts include intentional acts, which are necessarily committed with knowledge, courts narrowly construe intentional act exclusions to bar coverage only for claims involving intentional acts committed with the specific intent to cause harm. See, e.g., *Am. Home Assur. Co. v. Pope*, 591 F.3d 992, 999-1001 (8th Cir. 2010); *Am. Home Assur. Co. v. Cohen*, 815 F. Supp. 365, 368-69 (W.D. Wash. 1993).

In arguing for summary judgment, the Excess Carriers erroneously seek instead to broadly construe this exclusion to apply to negligence-based claims settled in the individual investor matters. Neither the terms of the Knowing Wrongful Acts Exclusion nor the facts inherent in these settlements, which long-predated the indictments of Greenstein and Wilk,

and resolved claims not requiring any proof of intentional misconduct, support such a ruling as to the claims asserted against Quellos itself.<sup>10</sup>

**III. THE TRIAL COURT CORRECTLY HELD THAT MS. BENDER'S HONEST RESPONSE TO THE AISLIC APPLICATION QUESTION DOES NOT BAR COVERAGE.**

There is no merit to the Excess Carriers' contention that Ms. Bender's negative answer to Question VI, in the 2000 AISLIC application for primary insurance, entitled them to summary judgment. To prevail, the Excess Carriers would have had to prove that the undisputed facts demonstrated, by "clear, cogent, and convincing evidence," that (1) Ms. Bender knowingly made a false statement; (2) Ms. Bender did so with the intent to deceive; and (3) the purportedly correct answer would have influenced the Excess Carriers' decision whether to issue the policies. *Queen City Farms, Inc. v. Central Nat'l Ins. Co. of Omaha*, 126 Wn.2d 50, 96-100, 891 P.2d 718 (1995); *Kay v. Occidental Life Ins. Co.*, 28 Wn.2d 300, 301-303, 183 P.3d 181 (1947). As shown below, the Excess Carriers failed to satisfy each of these elements.<sup>11</sup>

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<sup>10</sup> Indeed, for purposes of this Exclusion, the Excess Carriers failed even to demonstrate as a matter of undisputed fact that Greenstein and Wilk acted with the requisite intent to injure the POINT clients because, as the Excess Carriers have conceded (CP 1024), the purpose of the POINT transactions was to benefit these clients by deferring their tax liabilities. Washington courts recognize that whether a policyholder acted with specific intent to cause injury is a subjective analysis involving questions of fact not susceptible to summary judgment. See *Queen City*, 126 Wn.2d at 67-68, 93; *State Farm Fire & Cas. Co. v. Ham & Rye, LLC*, 142 Wn. App. 6, 18, 174 P.3d 1175 (Wash. App. 2007).

<sup>11</sup> The Excess Carriers find fault (Fed. Br. at 22, 43) with the trial court's explanation that it was denying summary judgment based on the application answer and the Continuity

**1. Ms. Bender's Answer Must Be Assessed In Terms of What The Evidence Showed About Her Subjective Beliefs.**

In arguing that Ms. Bender's answer to 2000 AISLIC application question entitled them to a summary judgment that none of the POINT losses are covered by the Excess Policies, the Excess Carriers argue the that the non-imputation clause does not apply argue to Ms. Bender's answer. This argument ignores RCW 48.18.090, which dictates that the Excess Carriers would have to prove as a matter of law that Ms. Bender was subjectively aware when she answered the question of facts or circumstances that could be expected to give rise to a claim against the applicant, Quadra Financial Group, L.P. This statute unequivocally prescribes that "no oral or written misrepresentation or warranty made in the negotiation of an insurance contract, by the insured or in his or her behalf, shall be deemed material or defeat or avoid the contract or prevent it attaching, unless the misrepresentation or warranty *is made with the intent to deceive.*" RCW 48.18.090(1) (emphasis added).

The Excess Carriers seek to avoid RCW 48.18.090 entirely based

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Date Exclusion for "similar reasons" to those invoked for the conduct-based exclusions (RP 97:25-98:7) because the non-imputation clause does not apply to the answer or the exclusion. Even if unclear, the ruling should be affirmed because it was correct. *See, e.g., Retail Clerks Local 629 v. Christiansen*, 67 Wn.2d 29, 31, 406 P.2d 327 (1965) (correct judgment "will not be reversed because the court may have given a wrong or insufficient reason."); *Crane & Crane, Inc. v. C & D Elec., Inc.*, 37 Wn. App. 560, 570, 683 P.2d 1103 (1984) (trial court "will not be reversed" if decision can be sustained under "any theory within the pleadings and proof.").

on the following statement appearing immediately after Question VI in the AISLIC Application: “It is agreed that if such knowledge exists any claim arising from such fact or circumstances will not be covered by the policy.” The Excess Carriers argue that RCW 48.18.090 does not apply because this quoted sentence restates Question VI as an exclusion. This argument cannot be reconciled with the broad wording of RCW 48.18.090, which prohibits an insurer not only from “avoiding” or “defeating” a policy based on an alleged application misrepresentation or warranty, but also from deeming such a representation or warranty “material,” or “preventing” the contract from “attaching.” This broad statutory prohibition applies whenever an insurer attempts to deny coverage based on alleged fraud in the application, regardless of whether the defense is couched as policy rescission, claim denial, offset or contribution. *Nat’l Union Fire Ins. v. Seafirst Corp.*, 662 F. Supp. 36, 39 (W.D. Wash. 1986).

None of the three cases cited by the Excess Carriers consider a broad statutory mandate such as RCW 48-18.090. Instead, they merely confirm, in foreign jurisdictions, the narrow scope of the common-law remedy of rescission due to application fraud. *See Am. Special Risk Mgmt. Corp. v. Cahow*, 192 P.3d 614, 622-23 (Kan. 2008); *Am. Guar. & Liab. Ins. Co. v. Fojanini*, 90 F. Supp. 2d 615, 619 n. 7 (E.D. Pa. 2000); *Culver v. Continental Ins. Co.*, 11 Fed. Appx. 42, 44-45 (4th Cir. 1999).

Question VI in the AISLIC application also calls for an assessment of what Ms. Bender subjectively believed because it asks whether “the applicant or any of its partners, directors, officers, employees or trustees have any knowledge of any fact or circumstance which might give rise to a claim under the proposed policy?” CP 1122 at Question VI. Because Question VI contains no terms requiring Ms. Bender’s answer to be assessed as an objective standard, it was the Excess Carriers’ burden to show that Ms. Bender subjectively was aware of such facts or circumstances, to dispute her representation that she did not.

The Washington Court of Appeal’s decision in *O’Connell v. Transamerica Indem. Co.*, 61 Wn. App. 103, 107-111, 809 P.2d 231 (1991), is instructive. At issue there was whether a subjective or objective standard applied to an exclusion of coverage when the insured “had knowledge of any act, error, omission or personal injury which could reasonably be expected to result in a claim ....” *Id.* at 107. The critical question, the court explained, is whether the insurer chooses an objective standard by including phrases such as “reasonably be expected” or “could have reasonably foreseen.” *Id.* at 109-10. If not, the standard is subjective and based upon the insured’s personal knowledge and beliefs.

Applying these principles, the *O’Connell* court held that the exclusion adopted (1) a subjective standard for identifying the acts, errors,

omissions, or personal injuries actually known to the insured; and (2) an objective standard to assess whether there existed an expectation of claims because this part of the exclusion asked whether claims could “reasonably be expected.” *Id.*; *see also Queen City*, 126 Wn.2d at 67-68, 93 (subjective standard determined whether insured intended damage because insurer could have “easily drafted language” adopting objective standard if it so intended, and finding insured’s intent was jury issue).

The Excess Carriers rely on inapposite cases construing exclusions in legal malpractice policies for wrongful acts committed prior to the policy period that the insured attorney could have reasonably expected might result in a claim, which charge the insured attorney or law firm with the knowledge and opinions of a reasonable attorney presented with the same facts or circumstances. *See* F.B. 39-40, 42 n. 6 (citing *Carolina Cas. Ins. Co. v. Ott*, 2010 WL 1849230, at \*10 (W.D. Wash. May 7, 2010) (charging insured with awareness of “ethical and fiduciary principles that all lawyers would know” and “implications of conduct and events that any reasonable lawyer would have grasped”)). In addition to applying this very different legal standard, all of these cases involved unmistakable rumblings prior to the policy period of the malpractice claims soon to come. In stark contrast, there was no hint of concern about the POINT transactions as of September 30, 2000, when Ms. Bender completed the

2000 AISLIC application. *See Carolina Cas.*, 2010 WL 1849230, at \*10-11 (prior to policy inception, client's case dismissed for want of prosecution, insured did not inform client, client filed bar grievance and retained new counsel who demanded case file); *Tewell, Thorpe & Findlay, Inc., P.S. v. Cont'l. Cas. Co.*, 64 Wn. App. 571, 573, 825 P.2d 724 (1992) (prior to policy inception, insured failed to detect easement in title search, purchaser demanded title insurance coverage, title insurer denied coverage and stated intention to implicate insured if purchaser sued); *see also Schwartz Manes Ruby & Slovin, L.P.A. v. Monitor Liability Managers, LLC*, 2011 WL 3627287 (S.D. Ohio Aug. 17, 2011) (prior to policy inception, insured law firm failed to appear for trial, judgment entered against client, and client retained new counsel who alleged dismissal was insured's fault); *Capitol Specialty Ins. Corp. v. Sanford Wittels & Heisler LLP*, 2011 WL 2530690 (D.D.C. June 27, 2011) (prior to policy inception, court dismissed class action because insured missed filing deadline); *see also Westport Ins. Corp. v. Markham Grp. Inc., P.S.*, 403 Fed. Appx. 264 (9th Cir. 2010) (insured knew, prior to policy inception, "that, due to errors on their part, a client's case had been dismissed and could not be refiled"); *Cuthill & Eddy, LLC v. Cont'l Cas. Co.*, 784 F. Supp. 2d 1331, 1340-43 (M.D. Fla. 2011) (prior to the policy period, the insured admitted

the accounting error and retained a defense attorney to respond when the client's attorney alleged malpractice and demanded the client file).

The same conclusion obtains here because Question VI of the AISLIC application, which is bereft of any reference to an objective standard, calls for assessment of whether Ms. Bender subjectively believed that any Quellos representative had knowledge of any fact or circumstance which Ms. Bender believed might give rise to a claim under the policy. The trial court correctly denied summary judgment based on Ms. Bender's answer because the declaration she submitted in opposition to Federal's summary judgment motion establishes that she personally knew of no facts or circumstances that might give rise to a claim when she completed the application. There, Ms. Bender swore that she answered this question "honestly, with no intent to deceive and only after making a reasonable, good faith inquiry within Quellos and concluding that no fact or circumstance was then known that reasonably might give rise to a claim covered by the proposed policy." CP 1107 at ¶5.

The decision in *Pereira v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2006 WL 1982789, at \* 5 n. 10 (SDNY July 12, 2006), also is instructive. In that case, the court construed language almost identical to Question VI as "focus[ing] on the signatory's state of mind ... rather than on the objective state of affairs ...." The court denied summary judgment

because of factual questions concerning whether the insured's CEO, who signed the application, was actually aware of the circumstances and whether he personally believed they might give rise to a claim. *Id.*<sup>12</sup> For the same reasons here, Ms. Bender's sworn testimony created a material factual dispute necessitating denial of summary judgment.

Ms. Bender's testimony further shows that the Excess Carriers were not entitled to summary judgment even if the answer were to be considered under an objective standard. Ms. Bender testified she did not believe, as of September 30, 2000, that facts or circumstances existed that might give rise to claims because, to her knowledge, (1) the three clients for whom Quellos Customs then had completed a POINT transaction had not expressed any dissatisfaction with the services rendered or expressed any intent to pursue any type of claim; and (2) the IRS had not then taken any action to question the validity of any POINT transaction or to disallow any of the tax benefits claimed by POINT clients. CP 1107 at ¶¶7-8.

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<sup>12</sup> See also *Gouverne v. Care Risk Retention Group, Inc.*, 2008 WL 2065835, at \*5-6 (S.D. Tex. May 13, 2008) (denying summary judgment because similar application question required subjective inquiry and insured physician testified he answered question honestly, despite fact he had committed obvious and outrageous acts of malpractice prior to signing application); *Chicago Ins. Co. v. Halcond*, 49 F. Supp. 2d 312, 316 (SDNY 1999) (denying summary judgment because same question required "subjective assessment" based on insured's perception of client outcomes and probability of litigation); see also *Levy v. North Am. Co. for Life and Health Ins.*, 90 Wn.2d 846, 848-50, 586 P.2d 845 (1978) (jury must determine fraud in application because insurer created "substantial doubt as to the intention and understanding of the parties" by questions such as "To the best of [your] knowledge and belief, [are you] in good health and free from impairment, deformity or defect?"); *Kay*, 28 Wn.2d at 305 (jury must consider intent to deceive because question asked whether insured was "aware of any circumstances ... which might affect the risk of an insurance on your life?").

Federal seeks to shift the inquiry to whether Greenstein and Wilk could have truthfully answered “no” to Question VI. F.B. 40-41. As shown above, the determinative consideration is whether Ms. Bender answered this question honestly with no intent to deceive. And it cannot be determined as a matter of law that Greenstein and Wilk knew from the outset that POINT was illegal and thus should have always anticipated claims. Mr. Greenstein’s testimony before the Senate Subcommittee directly conflicts with the statements upon which the Excess Carriers rely and creates issues of fact that only a jury can resolve. Indeed, Mr. Greenstein testified unequivocally that he believed, both before and after the IRS’s disallowance of POINT losses, that the POINT transaction was legitimate, legal, and merely the utilization of lawful and customary means for trading securities. CP 666-67, CP 671-72, CP 679-80.

The Excess Carriers contend that the insured individuals other than Greenstein and Wilk “subjectively knew that the POINT tax shelter had been built upon an artificial stock portfolio manufactured by Quellos and that such critical fact had not been disclosed to the Quellos clients and legal counsel, but that counsel would not have opined favorably as to POINT’s legality had the true facts been revealed to them.” F.B. 41. The claim is disingenuous because nothing in the record suggests that anyone within Quellos, aside from Greenstein and Wilk, had any reason to suspect

the POINT tax shelter was illegal. *See, e.g.* CP 1109 at ¶¶17-18.<sup>13</sup>

**2. The Excess Carriers Failed To Establish That The Answer To Question VI Was Material To Their Decisions To Issue The Excess Policies.**

The Excess Carriers also have failed to carry their burden of showing that Ms. Bender's answer to Question VI was material to their decision to issue the 2004-05 Excess Policies, and cannot establish that a jury trial is unnecessary on this issue in all events. *Queen City* makes it clear that dismissal of an insurer's application fraud defense is proper where, as here, the insurer had "completely failed to prove materiality, *i.e.* whether disclosure ... would have influenced its decision about the insurance contracts." 126 Wn.2d at 100. If anything, the evidence shows that the information was immaterial because the Excess Carriers issued their 2004-05 Excess Policies after Quellos submitted detailed information to AISLIC regarding its tax strategy services, and the inherent risks associated therewith, in connection with its 2004 Application.

Among the documents Quellos provided to AISLIC was a brochure describing Quellos Custom's services as maximizing after-tax returns for its clients through legal structures and complex investment strategies. CP 1108 at ¶¶10-11, CP 1127-35. In addition, Quellos

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<sup>13</sup> The only evidence cited by the Excess Carriers is the surreptitiously recorded phone conversation between "Quellos and Euram principles," as the Excess Carriers misleadingly describe it. The only people who participated in this conversation from Quellos were Greenstein and Wilk. CP 785.

provided AISLIC with Quellos Custom's "Form ADV," which discussed the inherent risk that the IRS could challenge an investment strategy, such as the POINT strategy, deny the claimed tax benefits, and potentially subject a client to the payment of back taxes, interest charges, and penalties. CP 1108 at ¶¶10-11, CP 1127-35.

The Excess Carriers underscore this point in observing that "the potential for claims arising from the disallowance of claimed tax benefits was manifest." F.B. 42. Yes, of course. That is why Quellos disclosed this risk and paid the Excess Carriers substantial premiums to provide coverage for claims alleging wrongful acts or omissions in the provision of tax planning and strategy services. CP 94. *Rowley v. USAA Life Ins. Co.*, 670 F. Supp. 2d 1199, 1204 (W.D. Wash. 2009); *Olson v. Bankers Life Ins. Co. of Neb.*, 63 Wn.2d 547, 552 388 P.2d 136 (1964).

**V. THE TRIAL COURT CORRECTLY REFUSED TO HOLD THAT THE CONTINUITY DATE EXCLUSION BARS COVERAGE.**

The trial court correctly rejected the Excess Carrier contention that the Continuity Date Exclusion in § 4(II)(4) of the 2004-05 AISLIC Policy entitles them to summary judgment. This exclusion provides that the AISLIC policy, and the Excess Policies by extension, do not apply "to any actual or alleged Wrongful Act occurring prior to the Continuity Date specified in Item 6 of the Declarations, if on or before such Continuity

Date any Insured knew of such Wrongful Act or could have reasonably foreseen that such Wrongful Act could lead to a claim.” CP 47-95, Declarations, Item 6. The Excess Carriers now contend that the applicable Continuity Date for the POINT claims is August 25, 2000, the date specified for Quellos Group, LLC in Endorsement 8 to the 2004-05 AISLIC Policy,<sup>14</sup> and that this Continuity Date bars coverage because Greenstein and Wilk designed the POINT transaction in 1999 and implemented these transactions beginning in 2000. F.B. 45-46.

Endorsement 8, however, establishes separate Continuity Dates for each insured affiliate, and the evidence presented below established that the only Quellos entities that performed services related to the POINT transactions were Quellos Custom, Quadra Financial, and Quellos Financial. CP 1179 at ¶6. The Continuity Dates for these entities, which all predate the design of the POINT transactions, are as follows:

Quadra Financial Group, LP:	November 7, 1994
Quellos Financial Advisors, LP:	July 1, 1997
Quellos Custom Strategies, LLC:	March 24, 1999

The Continuity Dates for Quadra Financial and Quellos Financial long predate the creation of the POINT strategy by a number of years. As of March 24, 1999, the Continuity Date prescribed for Quellos Custom, the

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<sup>14</sup> In the trial court, the Excess Carriers instead contended that the applicable continuity date was September 20, 2000, the date stated in item 6 of the Declaration of the 2004-05 AISLIC Policy.

design of the POINT still had not occurred, and no POINT transaction had been carried out for any individual investor. CP 1178-79 ¶¶3, 6.

Hoping to sidestep these earlier Continuity Dates, the Excess Carriers contend that Quellos only seeks “sums incurred on behalf of Quellos Group LLC, which is the only plaintiff in this litigation.” F.B. 45-46. However, the First Amended Complaint states that Quellos Group, LLC brought suit “on behalf of itself and its affiliated companies” for losses incurred as a result of investigations and lawsuits threatened or commenced against the insured companies and individuals. CP 146.

Read together, the terms of the Continuity Date Exclusion and Endorsement 8 dictate that application of the Exclusion depends upon what entity can be charged with commission of the alleged Wrongful Act. The Exclusion refers to the Continuity Date originally specified for the Named Insured, Quellos Group, LLC, in item 6 of the Declaration to the 2004-05 AISLIC Policy. CP 47. Endorsement 8, in turn, expands the definition of “Insured,” which did not encompass Quadra Financial, Quellos Financial, or Quellos Custom (or directors or officers acting on their behalf), to include these (and other) affiliates of the Named Insured (and these affiliates’ representatives), “subject to the corresponding Continuity Date.” CP 53, 78. Because the AISLIC Policy, and Excess Policies following form to it, cover the POINT losses only because

Endorsement 8 expanded coverage to these Quellos affiliates and their representatives, the Continuity Dates the Endorsement specifies for these entities must control application of the Continuity Date Exclusion.

The Continuity Date Exclusion plainly does not bar coverage here because the POINT transaction had not yet been designed by March 24, 1999, the latest continuity date specified for the insured Quellos affiliates that provided services with respect to POINT, and because no insured entity or individual could have known or reasonably have foreseen that the yet-to-be-designed transaction could lead to claims.

#### **CONCLUSION**

Quellos respectfully requests that this Court affirm the trial court's February 10, 2012 Order granting in part and denying in part Defendants' summary judgment motion regarding policy exclusions.

Respectfully submitted,  
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**CERTIFICATE OF SERVICE**

I hereby certify that on September 10, 2012, I filed with the Court of Appeals of the State of Washington, Division 1, the foregoing, **Brief Of Appellant And Cross-Respondent Quellos Group, LLC, In Response To Brief Of Respondent And Cross-Appellant Federal Insurance Company**, and served a copy on the following counsel of record:

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NO. 68478-7

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON  
DIVISION I

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QUELLOS GROUP LLC, *Appellant/Cross-Respondent*,

v.

FEDERAL INSURANCE COMPANY and INDIAN HARBOR  
INSURANCE COMPANY, *Respondents/Cross-Appellant*.

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**UNPUBLISHED CASES CITED IN BRIEF OF APPELLANT AND  
CROSS-RESPONDENT QUELLOS GROUP, LLC, IN RESPONSE  
TO BRIEF OF RESPONDENT AND CROSS-APPELLANT  
FEDERAL INSURANCE COMPANY**

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2012 SEP 10 PM 3:51

CLERK OF APPELLATE COURT  
STATE OF WASHINGTON

ORIGINAL

--- F.Supp.2d ---, 2011 WL 2530690 (D.D.C.), 112 Fair Empl.Prac.Cas. (BNA) 1153  
(Cite as: 2011 WL 2530690 (D.D.C.))

United States District Court,  
District of Columbia.  
CAPITOL SPECIALITY INSURANCE CORPOR-  
ATION, Plaintiff,  
v.  
SANFORD WITTELS & HEISLER, LLP, et al.,  
Defendants.

Civil Action No. 10-2079 (ESH).  
June 27, 2011.

**Background:** Insurer sued insured law firm and an attorney, seeking declaratory relief from coverage of a malpractice claim under a claims-made-and-reported liability policy issued to the firm. Insurer moved for summary judgment.

**Holdings:** The District Court, Ellen Segal Huvelle, J., held that:

- (1) District of Columbia law, rather than New York law, governed;
- (2) term "first policy" within the meaning of a condition precedent to coverage unambiguously did not refer to a past policy which was not renewed;
- (3) condition precedent to coverage was not satisfied; and
- (4) insurer was not estopped from denying coverage.

Motion granted.

West Headnotes

[1] Insurance 217 ↪2913

217 Insurance

217XXIII Duty to Defend

217k2912 Determination of Duty

217k2913 k. In General; Standard. Most

Cited Cases

Insurance 217 ↪3349

217 Insurance

217XXVII Claims and Settlement Practices  
217XXVII(C) Settlement Duties; Bad Faith  
217k3346 Settlement by Liability Insurer  
217k3349 k. Insurer's Settlement Du-  
ties in General. Most Cited Cases

Under District of Columbia law, insurer had no duty to defend or settle a claim where there was no coverage for the claim under the policy.

[2] Action 13 ↪17

13 Action

13II Nature and Form

13k17 k. What Law Governs. Most Cited

Cases

Under District of Columbia choice of law rules, the court must first determine if there is a conflict between the laws of the relevant jurisdictions; only if such a conflict exists must the court then determine, pursuant to District of Columbia choice of law rules, which jurisdiction has the more substantial interest in the resolution of the issues.

[3] Insurance 217 ↪1091(4)

217 Insurance

217III What Law Governs

217III(A) Choice of Law

217k1086 Choice of Law Rules

217k1091 Particular Applications of

Rules

217k1091(3) Liability Insurance

217k1091(4) k. In General. Most

Cited Cases

Under District of Columbia choice of law rules, District of Columbia law, rather than New York law, governed insurer's action for declaratory relief from coverage on a claims-made-and-reported liability policy issued to a law firm sued for malpractice in connection with its handling of a class action against the Department of Commerce, despite claim that the policy was negotiated and delivered to insureds at their New York address; District of Columbia had a more substantial interest in the lit-

--- F.Supp.2d ----, 2011 WL 2530690 (D.D.C.), 112 Fair Empl.Prac.Cas. (BNA) 1153  
(Cite as: 2011 WL 2530690 (D.D.C.))

igation, and in any event there was no conflict between the laws of New York and District of Columbia.

**[4] Insurance 217 ↪3147**

217 Insurance

217XXVII Claims and Settlement Practices

217XXVII(B) Claim Procedures

217XXVII(B)2 Notice and Proof of Loss

217k3143 Necessity

217k3147 k. Compliance as Condition Precedent. Most Cited Cases

**Insurance 217 ↪3167**

217 Insurance

217XXVII Claims and Settlement Practices

217XXVII(B) Claim Procedures

217XXVII(B)2 Notice and Proof of Loss

217k3166 Effect of Noncompliance

with Requirements

217k3167 k. In General. Most Cited

Cases

Under District of Columbia law, where an insurance policy expressly makes compliance with its terms a condition precedent to liability on the part of the insurer, failure to comply with the notice provision will release the insurer of liability on the policy.

**[5] Insurance 217 ↪2266**

217 Insurance

217XVII Coverage—Liability Insurance

217XVII(A) In General

217k2263 Commencement and Duration of Coverage

217k2266 k. Claims Made Policies.

Most Cited Cases

Under District of Columbia law, for purposes of a condition precedent to coverage under a policy, providing that, "prior to the inception date of the first policy issued by the Company if continuously renewed," no insured had any basis to believe that any insured had breached a professional duty or

committed an act or omission which might reasonably be expected to be the basis of a claim, the term "first policy" unambiguously did not refer to a past policy which was not renewed, but referenced a subsequently issued policy.

**[6] Insurance 217 ↪1713**

217 Insurance

217XIII Contracts and Policies

217XIII(A) In General

217k1711 Nature of Contracts or Policies

217k1713 k. Policies Considered as Contracts. Most Cited Cases

**Insurance 217 ↪1805**

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1805 k. In General. Most Cited Cases

Under District of Columbia law, an insurance policy is a contract between the insured and the insurer, and in construing it a court must first look to the language of the contract.

**[7] Insurance 217 ↪2098**

217 Insurance

217XV Coverage—in General

217k2096 Risks Covered and Exclusions

217k2098 k. Exclusions and Limitations in General. Most Cited Cases

Under District of Columbia law, exclusion provisions in insurance policies must be enforced even if the insured did not foresee how the exclusion operated; otherwise courts will find themselves in the undesirable position of rewriting insurance policies and reallocating assignment of risks between insurer and insured.

**[8] Insurance 217 ↪1809**

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1809 k. Construction or Enforcement

--- F.Supp.2d ----, 2011 WL 2530690 (D.D.C.), 112 Fair Empl.Prac.Cas. (BNA) 1153  
(Cite as: 2011 WL 2530690 (D.D.C.))

**as Written. Most Cited Cases**

Under District of Columbia law, when the language of insurance contracts is clear and unambiguous, they will be enforced by the courts as written, so long as they do not violate a statute or public policy.

**[9] Insurance 217 ↪1808**

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1808 k. Ambiguity in General. Most Cited Cases

**Insurance 217 ↪1832(1)**

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1830 Favoring Insureds or Beneficiaries; Disfavoring Insurers

217k1832 Ambiguity, Uncertainty or Conflict

217k1832(1) k. In General. Most Cited Cases

Under District of Columbia law, ambiguities in insurance contracts are resolved favorably to the insured, but an insurance contract is not ambiguous merely because the parties do not agree on the interpretation of the contract provision in question; rather, a contract is ambiguous only if reasonable people may fairly and honestly differ in their construction of the terms because the terms are susceptible of more than one meaning.

**[10] Insurance 217 ↪2266**

217 Insurance

217XVII Coverage—Liability Insurance

217XVII(A) In General

217k2263 Commencement and Duration of Coverage

217k2266 k. Claims Made Policies. Most Cited Cases

Under District of Columbia law, insureds under

a claims-made-and-reported liability policy issued to a law firm had prior knowledge of a breach of professional duty, as well as a reasonable expectation on what transpired in an employment discrimination class action from which a malpractice claim arose, and thus, a condition precedent to coverage under the policy was not satisfied; the correct standard was the objective, reasonable attorney one, not whether a lawyer in fact had a subjective belief that a malpractice action was probable, and the dismissal of the action because of attorney error would clearly have put a lawyer on notice of the possibility of a malpractice claim.

**[11] Insurance 217 ↪3110(2)**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3105 Claims Process and Settlement

217k3110 Denial or Disclaimer of Liability on Policy

217k3110(2) k. Failure, Delay, or Inadequacy. Most Cited Cases

**Insurance 217 ↪3120**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3120 k. Nonwaiver Agreements and Reservation of Rights. Most Cited Cases

Under District of Columbia law, insurer was not estopped from denying coverage for a malpractice claim under a claims-made-and-reported liability policy issued to a law firm, despite allegation that it did not timely disclaim coverage, as the insurer issued an adequate reservation of rights prior to assuming control of the defense, and insureds were not actually prejudiced; there was no showing that any monetary loss undermined insureds' ability to defend themselves, and insureds took a miscalculated risk in preemptively and independently hiring counsel without first seeking permission from the insurer.

--- F.Supp.2d ---, 2011 WL 2530690 (D.D.C.), 112 Fair Empl.Prac.Cas. (BNA) 1153  
(Cite as: 2011 WL 2530690 (D.D.C.))

**[12] Insurance 217 ↪3111(1)**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3105 Claims Process and Settlement

217k3111 Defense of Action Against Insured

217k3111(1) k. In General. Most Cited Cases

Under District of Columbia law, prejudice is required for estoppel on the basis of an insurer's assumption of the defense of an action against the insured.

**[13] Insurance 217 ↪3111(1)**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3105 Claims Process and Settlement

217k3111 Defense of Action Against Insured

217k3111(1) k. In General. Most Cited Cases

Under District of Columbia law, insurer has a duty to defend a lawsuit brought against its insured but that does not necessarily estop the insurer from declining coverage at some reasonable point if the insurer reserves its right to do so.

**[14] Insurance 217 ↪3111(2)**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3105 Claims Process and Settlement

217k3111 Defense of Action Against Insured

217k3111(2) k. Defense Without Reservation of Rights. Most Cited Cases

Under District of Columbia law, insurer who defends an insured without an appropriate disclaimer and reservation of rights is barred from disclaiming coverage.

**[15] Insurance 217 ↪3111(2)**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3105 Claims Process and Settlement

217k3111 Defense of Action Against Insured

217k3111(2) k. Defense Without Reservation of Rights. Most Cited Cases

Under District of Columbia law, when an insurer assumes complete control of the insured's defense without a reservation of rights, prejudice is assumed as a matter of law for purposes of an estoppel claim.

**[16] Insurance 217 ↪3120**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3120 k. Nonwaiver Agreements and Reservation of Rights. Most Cited Cases

Under District of Columbia law, generally, reservation of rights language should indicate specific coverage defenses or else the insurer may be barred from raising them later.

**[17] Insurance 217 ↪3111(1)**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3105 Claims Process and Settlement

217k3111 Defense of Action Against Insured

217k3111(1) k. In General. Most Cited Cases

Under District of Columbia law, for purposes of an estoppel claim, actual prejudice may be shown if the insurer's participation in the defense harmed or hindered the insureds by undermining their ability to defend themselves.

**[18] Insurance 217 ↪3419**

217 Insurance

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217XXVIII Miscellaneous Duties and Liabilities  
217k3416 Of Insurers  
217k3419 k. Bad Faith in General. Most  
Cited Cases

District of Columbia law does not recognize a cause of action for bad faith breach of an insurance contract.

Marc Evan Rindner, Richard Albert Simpson, Wiley Rein, LLP, Washington, DC, for Plaintiff.

Stefanie Roemer, Sanford, Wittels & Heisler, LLP, Washington, DC, Barry R. Ostrager, Courtney A. Welshimer, Elisa Alcabas, Simpson, Thatcher & Bartlett, New York, NY, for Defendants.

#### MEMORANDUM OPINION

ELLEN SEGAL HUVELLE, District Judge.

\*1 Plaintiff Capitol Specialty Insurance Corporation (“Capitol Specialty”) brings this action against Sanford Wittels & Heisler, LLP and David Sanford (collectively “Defendants”) seeking declaratory relief from coverage on a claims-made-and-reported liability insurance policy issued to the law firm for the policy period of December 10, 2007 to December 10, 2008 (the “Policy”). Plaintiff seeks a judicial determination that the Policy does not provide coverage for a legal malpractice action now pending against Sanford Wittels for which plaintiff is currently providing legal representation.

Before the Court is plaintiff’s motion for summary judgment on its claim for declaratory relief. For the reasons set forth herein, the Court will grant plaintiff’s motion for summary judgment.

#### BACKGROUND

##### I. FACTS

Plaintiff Capitol Specialty is a corporation organized and existing under the laws of the State of Wisconsin, with its principal place of business in Appleton, WI. (Compl. ¶ 4.) Capitol Specialty transacts insurance business in the District of Columbia. (*Id.*) Defendant Sanford Wittels is a law

firm organized and existing under the laws of the State of New York that regularly transacts business from its Washington, D.C. office. (*Id.* ¶ 5.) Co-defendant David Sanford is a principal officer of the firm and is licensed to practice law in the District of Columbia. (*Id.* ¶ 6; Sanford Declaration [“Sanford Dec.”].)

##### A. *Howard v. Gutierrez*

In 2004, defendants, in conjunction with the law firm of Grant E. Morris, agreed to represent three individuals (the “Clients”) in a racial discrimination suit against the United States Department of Commerce (“DOC”). (Plaintiff’s Statement of Undisputed Facts [“Pl.’s Facts”] ¶ 1.) On October 5, 2005, defendants filed a suit, captioned *Howard v. Gutierrez*, No. 1:05-cv-01968 (D.D.C. Oct. 5, 2005) (“Discrimination Action”), on behalf of the Clients individually and as representatives of a putative class of similarly-situated African American employees. (*Id.* ¶¶ 1–2.) According to local rules of the United States District Court, the law firm had 90 days from the date of filing the complaint to file for class certification.<sup>FN1</sup>

On March 17, 2006, DOC moved to strike the class claims on the ground that the Clients had missed the filing deadline for class certification. (Pl.’s Facts ¶ 4.) On June 23, 2006, defendants filed an amended complaint and a motion to extend the class certification deadline. (*Id.* ¶ 5.) DOC renewed its motion to strike in July 2006, arguing under Local Civil Rule 23.1(b), a motion for class certification was timely as long as it was filed within 90 days of an amended complaint, as opposed to the original complaint. (Defs.’ Opp’n to Summ. J. [“Defs.’ Opp’n”], Ex. D.) The court was not persuaded by this argument. On February 6, 2007, Judge Kennedy granted the DOC’s motion to strike the class claims, observing that defendants had inexplicably delayed filing its motion for additional time until three months after DOC had filed its first motion to strike. *Howard v. Gutierrez*, 474 F.Supp.2d 41, 56–57 (D.D.C.2007) (Bates, J.). Defendants then moved to reinstate the class claims

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or, in the alternative, to certify the question for interlocutory appeal.<sup>FN2</sup> (Pl.'s Facts ¶ 9.) On September 7, 2007, Judge Kennedy denied defendants' motion, noting that defendants did not rely on their reading of the local rule "until after they realized they had already missed the filing deadline by more than two and a half months" and that instead, they "hoped, through the filing of an amended complaint, to resurrect their ability to file a motion that they already knew was already several months out of time." *Howard v. Gutierrez*, 503 F.Supp.2d 392, 395-96 (D.D.C.2007). The court also observed that defendants' "post hoc rationalizations" for missing the certification deadline did little to conceal the fact that defendants "ha[d] no excuse beyond attorney mistake for their failure to file a timely motion for class certification." *Id.* at 396. Following this ruling, the Clients retained new counsel and pursued their individual claim against DOC. (Defs.' Opp'n at 8.) Defendants did not hear anything further from the Clients until March 20, 2008. (*Id.*)

#### B. Defendants' Insurance Policies with Capitol Specialty

\*2 Capitol Specialty first issued defendants a liability insurance policy for the policy period December 10, 2004 to December 10, 2005. (Pl.'s Facts ¶ 13; Defs.' Opp'n at 7.) This policy was not renewed by defendants, and for the next two years, defendants were insured by a different company. (*Id.*) As of December 10, 2007, Capitol Specialty became defendants' legal malpractice insurer again, issuing the Policy that underlies this dispute. (*Id.* at ¶ 21.) The Policy has been continuously renewed by defendants. (Compl. ¶ 19.) It includes a \$7 million per claim limit, a \$7 million aggregate limit of liability, inclusive of claim expenses, and a \$100,000 retention for each and every claim made during the policy period. (Compl. ¶ 20 and, Ex. A.)

Section § I.A. of the Policy, as amended by Endorsement No. 2, sets forth the conditions precedent to coverage:

[I]t is a condition of precedent to coverage under this policy that the act or omission occurred:

1. during the Policy Period; or
2. on or after December 10, 2004, provided that all of the following conditions are met:

(a) the Insured did not notify any prior insurer of such act or omission or Related Act or Omission; and

(b) prior to the inception date of the first policy issued by the Company if continuously renewed, no Insured had any basis (1) to believe that any Insured had breached a professional duty; or (2) to foresee that any such act or omission or Related Act or Omission might reasonably be expected to be the basis of a Claim against any Insured; and

(c) there is no policy that provides insurance to the Insured for such liability or Claim.

(Pl.'s Facts ¶ 23; Compl., Ex. A) (emphasis added).

Prior to the Policy's issuance, defendants signed a Renewal Application for Lawyers Professional Liability Insurance ("Application") and Warranty Statement.<sup>FN3</sup> (Compl., Exs. I and J.)

In its Application, signed November 1, 2007, defendants denied awareness of "any circumstances, allegations, tolling agreements or contentions as to any incident which may result in a claim being made against the Applicant or any of its past or present Owners, Partners, Shareholders, Corporate Officers, Associates, Employed Lawyers, Contract Lawyers or Employees or predecessors in business." (Compl., Ex. I.) (emphasis added). The Warranty Statement, signed December 6, 2007, provided:

[A]fter diligent inquiry of all attorneys proposed for this insurance, [Applicant] warrants that as of December 6, 2007, all claims or suits, as well as facts, incidents, circumstances, acts, errors or omissions that could give rise to a claim have been reported.

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It is also warranted that after diligent inquiry of all attorneys proposed for this insurance, that as of December 6, 2007 the Applicant is not aware of *any* claims or suits, or any facts, incidents, circumstances, acts, errors or omissions that *could* give rise to a claim against any attorney of the firm, the firm or its predecessors.

\*3 ...

These warranties are *material* to the acceptance of coverage by Darwin Professional Underwriters, Inc. and the insurers for whom it acts ... Further, Sanford Wittels & Heisler, LLP acknowledges that *no coverage* will be available under insurance placed by Darwin Professional Underwriters, Inc. for any claim, suit, incident, or other circumstance which should have been disclosed.

(Pl.'s Facts ¶ 18; Compl., Ex. J) (emphasis added).

### C. The Malpractice Action

On March 20, 2008, defendants received a letter from an attorney, Fred Goldberg ("Goldberg Letter") on behalf of the Clients. (Pl.'s Mem. for Summ. J. ["Pl.'s Mem."], Ex. 7D; Defs.' Facts ¶ 28.) In this letter, Goldberg stated:

As you are aware, as a result of your failure to meet the Local Rule requirement with regard to class certification, they and the class have been economically harmed. There are also issues which have been brought to my attention with regard to failure to communicate a bona fide settlement offer from the defendant.

(*Id.*)

Defendants provided Capitol Specialty with a copy of this letter on April 4, 2008, which Capitol Specialty acknowledged by letter dated April 10, 2008. (Pl.'s Facts ¶ 28.) On May 7, 2008, Capitol Specialty sent defendants a letter stating that it would be treating this matter as a "notice of circumstances which may give rise to a claim." (Pl.'s Mem., Ex. 7E.) That letter also included the follow-

ing reservation of rights:

[Capitol Specialty's] position with respect to these matters is based on the information provided to date, and is subject to further evaluation as additional information becomes available. [Capitol Specialty] respectfully reserves all of its rights and defenses under the Policy and available at law, including the right to assert additional Policy terms and provisions which may become applicable as new information is learned.

(*Id.*)

On January 21, 2010, Clients filed a legal malpractice action against defendants in the Superior Court for the District of Columbia. (Pl.'s Facts ¶ 30; Complaint, *Howard v. Sanford Wittels & Heisler, LLP*, No.2010-ca-00311-M (D.C.Super.Ct. January 21, 2010) ["Malpractice Action"]). On February 19, 2010, defendants notified Capitol Specialty of the Malpractice Action. (Pl.'s Mem., Ex. 7F.) By letter dated March 23, 2010, Capitol Specialty acknowledged receipt of the notification and advised defendants that "[a]s set forth below, coverage is available to Sanford Wittels & Heisler LLP for this matter," and suggested that "the Policy be reviewed together with this letter" because this letter "does not modify any of the terms and conditions of the Policy." (Pl.'s Mem., Ex. 7G.) The letter also quoted from Section § I.A. of the Policy, including the conditions precedent to coverage and reiterated Capitol Specialty's reservation of rights. (*Id.*)

On April 8, 2010, defendants retained Michelle Roberts of Akin Gump Strauss Hauer & Feld ("Akin Gump") to represent it in the Malpractice Action, paying an initial \$10,000 retainer as well as later additional fees of \$6,714. (Defs.' Facts ¶ 32(c); Sanford Decl. ¶ 15.) By letter dated May 11, 2010, Capitol Specialty informed defendants that under the Policy it had a "right and duty to defend any Claim seeking Damages that are covered by this policy." (Pl.'s Mem., Ex. 7H.) Capitol Specialty further informed defendants that it did not consent to defendants' choice of counsel, and that it had re-

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tained Eccleston and Wolf, P.C. to defend defendants in the Malpractice Action. (*Id.*) At the same time, Capitol Specialty noted that if defendants do not want Capitol Specialty to defend, “we will disengage counsel and close this matter.” (*Id.*) The same reservation of rights was reiterated in this letter. (*Id.*) According to defendants, they have to date recouped only \$2,134.76 of the \$16,714 they paid to Akin Gump. (Defs.’ Facts at ¶ 32(d).)

\*4 On November 8, 2010, Capitol Specialty advised defendants that it had concluded “tentatively” that the Policy did not cover the Malpractice Action:

Since learning of the potential claim and then the actual claim, [Capitol Specialty] has been handling this matter under a reservation of rights.

...

Based on its review of the court records regarding the Firm’s handling of the Howard plaintiffs’ underlying lawsuit, [Capitol Specialty] has tentatively concluded that no coverage is available for the Claim for the reasons explained below. However, before making a final decision, [Capitol Specialty] will afford the Insured an opportunity to provide an explanation and any supporting documents and authority if they disagree with [Capitol Specialty’s] tentative conclusion. [Capitol Specialty] also will continue to provide a defense, subject to a full and complete reservation of rights, including the right to withdraw from the defense and the right to seek repayment of all amounts paid by [Capitol Specialty].

(Pl.’s Mem., Ex. 9.)

[1] Since then, Capitol Specialty’s law firm has continued representing defendants. Capitol Specialty rejected a settlement offer made by the Clients in a letter dated March 2, 2011.<sup>FN4</sup>

## II. PROCEDURAL HISTORY

On December 8, 2010, Capitol Specialty commenced this suit seeking a declaratory judgment

that it need not provide coverage for the Malpractice Action.<sup>FN5</sup> Capitol Specialty’s complaint alleges that defendants were aware that their failure to meet a class certification deadline in the class action suit could result in a claim. (Pl.’s Mem. at 2.) But because defendants did not notify Capitol Specialty of this incident prior to the inception date of the Policy, Capitol Specialty alleges that they are barred from seeking coverage under the condition precedent provision. (*Id.*) Capitol Specialty further alleges defendants are barred from coverage because they did not disclose this potential claim on their Warranty Statement and Application. (*Id.*) Capitol Specialty also seeks recovery of claim expenses expended in defense of the underlying malpractice action.

Defendants filed a counterclaim for a declaratory judgment that Capitol Specialty is obligated to provide coverage on the Malpractice Action. Defendants also filed counterclaims for breach of contract with respect to the duty to defend and indemnify, duty to negotiate a settlement within the Policy limits, bad faith denial of coverage, and bad faith refusal to settle or negotiate a settlement. (Defs.’ Answer & Counterclaim at 50–74 [“Defs.’ Answer”].)

On February 18, 2011, Capitol Specialty filed the instant motion for summary judgment. Defendants oppose summary judgment and demand a jury trial.

## ANALYSIS

Capitol Specialty argues that it is entitled to summary judgment on two independent grounds (1) there is no coverage for the Malpractice Action because defendants failed to satisfy all conditions precedent and; (2) there is no coverage for the Malpractice Action because defendants provided a false warranty to Capitol Specialty.<sup>FN6, FN7</sup>

\*5 Defendants argue that all conditions precedent and other requirements for coverage have been met, waived or are inapplicable. Defendants also contend that Capitol Specialty is estopped from

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denying coverage because defendants relied on Capitol Specialty's defense to their detriment, and as a result, this caused prejudice to defendants.

### I. SUMMARY JUDGMENT STANDARD

A motion for summary judgment shall be granted “ ‘if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact, and that the moving party is entitled to a judgment as a matter of law.’ ” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986) (quoting Fed.R.Civ.P. 56(c)). Thus, a moving party is entitled to summary judgment “against ‘a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial.’ ” *Waterhouse v. District of Columbia*, 298 F.3d 989, 992 (D.C.Cir.2002) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986)).

As the non-moving parties, defendants are “entitled to the benefit of all reasonable inferences from the evidence,” *Talavera v. Shah*, 638 F.3d 303, 308 (D.C.Cir.2011), and the evidence “is to be viewed in the light most favorable to” them. *Talavera*, 638 F.3d at 310 (internal citations omitted). The non-moving party's opposition, however, must consist of more than mere unsupported allegations or denials and must be supported by affidavits or other competent evidence setting forth specific facts showing that there is a genuine issue for trial. *Celotex*, 477 U.S. at 324, 106 S.Ct. 2548; Fed.R.Civ.P. 56(e). If the non-movant fails to point to “affirmative evidence” showing a genuine issue for trial, *Anderson*, 477 U.S. at 257, 106 S.Ct. 2505, or “[i]f the evidence is merely colorable, or is not significantly probative,” summary judgment can be granted. *Id.* at 249–50, 106 S.Ct. 2505 (internal citations omitted).

### II. CHOICE OF LAW

[2] Under District of Columbia law, the Court must first determine if there is a conflict between

the laws of the relevant jurisdictions. *Eli Lilly & Co. v. Home Ins. Co.*, 764 F.2d 876, 882 (D.C.Cir.1985) (citing *Fowler v. A & A Co.*, 262 A.2d 344, 348 (D.C.1970)); *Duncan v. G.E. W., Inc.*, 526 A.2d 1358, 1363 (D.C.1987). Only if such a conflict exists must the court then determine, pursuant to District of Columbia choice of law rules, which jurisdiction has the “more substantial interest” in the resolution of the issues. See *Nationwide Mut. Ins. Co. v. Richardson*, 270 F.3d 948, 953 (D.C.Cir.2001); *Eli Lilly & Co.*, 764 F.2d at 882; *Greycoat Hanover F St. Ltd. P'ship v. Liberty Mut. Ins. Co.*, 657 A.2d 764, 767–68 (D.C.1995).

[3] Here, defendants cite *Liberty Mutual Insurance Co. v. Travelers Indemnity Co.* to support the application of New York law because the Policy was negotiated and delivered to defendants at their New York address. *Liberty Mut. Ins. Co.*, 78 F.3d 639, 642 (D.C.Cir.1996) (“[I]nsurance contracts are governed by the substantive law of the state in which the policy is delivered.”) Subsequent decisions have called this rule into question. For instance, in *Young Women's Christian Association of the National Capital Area v. Allstate Insurance Co.*, the D.C. Circuit distinguished *Liberty Mutual* and suggested conflict of laws analysis should be based on the jurisdiction with the more substantial interest in the litigation:

\*6 It is not altogether clear that *Liberty Mutual* correctly characterized the District of Columbia's choice of law rules. This court's decision in *Nationwide Mutual Insurance Co.*, applying the District of Columbia Court of Appeals decision in *Greycoat Hanover* suggests that the District of Columbia applies the law of the jurisdiction with the more substantial interest in the litigation, in considering what law to apply to insurance policies. *Nationwide Mut. Ins. Co. v. Richardson*, 270 F.3d 948, 953 (D.C.Cir.2001); cf. *Ideal Elec. Sec. Co. v. Int'l Fid. Ins. Co.*, 129 F.3d 143, 148 (D.C.Cir.1997). *Liberty Mutual* addressed neither *Greycoat Hanover* nor the more substantial interest test, relying instead on D.C. Court of Ap-

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peals decisions involving life insurance policies rather than liability policies. *Liberty Mut.*, 78 F.3d at 642 (citing *Levin v. John Hancock Mut. Life Ins. Co.*, 41 A.2d 841 (D.C.1945), and *Raley v. Life & Cas. Ins. Co. of Tenn.*, 117 A.2d 110 (D.C.1955)). Those District of Columbia cases are specific, however, to life insurance policies and rely on Supreme Court cases holding that the place of delivery of life insurance policies determines what state law should apply.

*Young Women's Christian Ass'n of the Nat'l Capital Area, Inc.*, 275 F.3d 1145, 1150 n. 1 (D.C.Cir.2002).

Based on this analysis, the Court will apply the laws of the District of Columbia as this is the jurisdiction with the more substantial interest in the litigation. Notwithstanding a substantial interest analysis, however, the law of the District of Columbia would also apply because both parties assert that there is no conflict between the laws of New York and District of Columbia. (Defs.' Opp'n at 16, n. 9; Pl.'s Reply at 2, n. 3.) *Sloan v. Urban Title Services Inc.*, 689 F.Supp.2d 94, 105 (D.D.C.2010) ("Where no true conflict exists, the court applies the law of the District of Columbia by default.")

### III. CONDITION PRECEDENT PROVISION PRECLUDES COVERAGE

[4][5] "Where the policy expressly makes compliance with its terms a condition precedent to liability on the part of the insurer, failure to comply with the notice provision will release the insurer of liability on the policy." *Lee v. Travelers Ins. Co.*, 184 A.2d 636, 638 (D.C.1962). Capitol Specialty argues that the Policy does not cover the Malpractice Action because defendants cannot satisfy an unambiguous condition precedent to coverage for acts or omissions that occurred prior to the Policy Period. Specifically, Capitol Specialty alleges that defendants had notice about a potential claim as early March 2006 when the Department of Commerce first moved to strike the class claims in the Discrimination Action on the grounds that defendants had missed a filing deadline. This notice was

reinforced in February 2007, when Judge Kennedy dismissed the class claim based on defendants' missed deadline, and again in September 2007, when the Court soundly rejected defendant's arguments for reconsideration. (*Id.*) As all of this occurred prior to the Policy Period, Capitol Specialty asserts that defendants cannot satisfy the condition that:

\*7 prior to the inception date of the first policy ... no insured had any basis (1) to believe that any Insured had breached a professional duty; or (2) to foresee that any such act or omission or Related Act or Omission might reasonably be expected that any Insured had breached a professional duty or that any act or omission or Related Act or Omission might reasonably be expected to be the basis of a Claim against any Insured.

(Compl., Ex. A.)

Defendants claim that the condition precedent language of the Policy is ambiguous because it is not clear if the clause "prior to the inception of the first Policy" refers to the 2007–2008 or the 2004–2005 Policy. They further claim that the Malpractice Action was not foreseeable, and therefore, they had no prior knowledge of the claim before the issuance of the Policy.

#### A. Subsection 2(b) Is Not Ambiguous

[6][7][8][9] "An insurance policy is a contract between the insured and the insurer, and in construing it [a court] must first look to the language of the contract." *Cameron v. USAA Prop. & Cas. Ins. Co.*, 733 A.2d 965, 968 (D.C.1999). Exclusion provisions "must be enforced even if the insured did not foresee how the exclusion operated," *Ross*, 420 B.R. at 48, otherwise courts will find themselves in the undesirable position of "rewrit[ing] insurance policies and reallocat[ing] assignment of risks between insurer and insured." *Chase v. State Farm Fire & Cas. Co.*, 780 A.2d 1123, 1127–28 (D.C.2001). Under District of Columbia law, when the language of insurance contracts is "clear and unambiguous, they will be enforced by the courts as

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written, so long as they do not 'violate a statute or public policy.' " *Hartford Accident & Indem. Co. v. Pro-Football, Inc.*, 127 F.3d 1111, 1114 (D.C.Cir.1997) (quoting *Smalls v. State Farm Mut. Auto. Ins. Co.*, 678 A.2d 32, 35 (D.C.1996)). "[A]mbiguities in insurance contracts are resolved favorably to the insured," *Columbia Cas. Co. v. Columbia Hosp.*, 633 F.Supp. 697, 700 (D.D.C.1986) (quoting *Continental Cas. Co. v. Beelar*, 405 F.2d 377, 378 (D.C.Cir.1968)), but an insurance contract "is not ambiguous merely because the parties do not agree on the interpretation of the contract provision in question." " *Travelers Indem. Co. of Illinois v. United Food & Commercial Workers Int'l Union*, 770 A.2d 978, 986 (D.C.2001) (quoting *Holland v. Hannan*, 456 A.2d 807, 815 (D.C.1983)). Rather, a contract "is ambiguous only if 'reasonable people may fairly and honestly differ in their construction of the terms because the terms are susceptible of more than one meaning.'" " *National R.R. Passenger Corp. v. Lexington Ins. Co.*, 445 F.Supp.2d 37, 41 (D.D.C.2006) (quoting *Nat'l R.R. Passenger Corp. v. Lexington Ins. Co.*, 2003 WL 24045159, at \*5 (D.D.C. May 20, 2003)), *af'd*, 249 Fed.Appx. 832 (D.C.Cir.2007)

In the instant case, defendants argue that the term "first policy" in subsection 2(b) is ambiguous because it is unclear if the phrase "prior to the inception date of the first policy issued by [Capitol Insurance] if continuously renewed" refers to the 2004–2005 policy or the 2007–2008 policy. (Defs.' Opp'n at 24–25; Compl., Ex. A.) Faced with that ambiguity, defendants argue that "first policy" should be favorably construed as referring to the 2004–2005 Policy. See *Columbia Cas. Co.*, 633 F.Supp. at 700 (holding that ambiguities in insurance contracts should be favorably construed to the insured). Defendants then argue that because the "first policy" issued was the 2004–2005, and it was not "continuously renewed," neither the 2004–2005 policy nor the 2007–2008 policy fall within the terms of subsection 2(b) because neither is the "first policy issued by [Capitol Specialty] if continuously

renewed." (Defs.' Opp'n at 25.) Thus, under defendants' proposed interpretation, they would be covered for an "act or omission" that occurred "on or after December 10, 2004" and before December 10, 2007, as long as conditions 2(a) and 2(c) were met.

\*8 Capitol Specialty argues that the Policy is not ambiguous because "first policy" is not susceptible to more than one reasonable interpretation. *Chase*, 780 A.2d at 1127–28 ("Policy language is not genuinely ambiguous unless 'it is susceptible of more than one reasonable interpretation.'" (quoting *American Bldg. Maint. Co. v. L'Enfant Plaza Prop., Inc.*, 655 A.2d 858, 861 (D.C.1995)). As defendants acknowledge, the 2004–2005 policy was never renewed. Hence, it would be nonsensical and self-defeating for the provision to refer to a past policy that both parties acknowledge was never renewed. Additionally, defendants' reading of this clause would translate into Capitol Specialty assuming complete liability for the timeframe between December 10, 2005 and December 10, 2007, even though Capitol Specialty was not the insurer during that time. Capitol Specialty contends that this is facially unreasonable and would undermine the principle underlying prior knowledge provisions which are designed to protect insurance companies from insuring entities that do not disclose known errors or issues. (Pl.'s Reply at 4.) " 'The insurance company is entitled to protect itself against the professional who, recognizing his past error or omission, rushes to purchase a 'claims-made' policy before the error is discovered and a claim is asserted against him.'" *Ross*, 420 B.R. at 54 (quoting *Zuckerman v. Nat'l Union Fire Ins. Co.*, 100 N.J. 304, 495 A.2d 395, 403–404 n. 3 (1985)). The Court agrees.

The fact that defendants have come up with an alternative reading of the Policy language is not enough to establish that "reasonable people ... may fairly and honestly differ in their construction of the terms," *Nat'l R.R. Passenger Corp.*, 445 F.Supp.2d at 41, where the defendants' proposed in-

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terpretation would strip the Policy of any limitations on coverage for acts between December 10, 2005 and December 10, 2007. Thus, defendants' interpretation of the "first policy" clause is simply not a reasonable reading of that clause. If, however, the "first policy" language refers to the 2007–2008 Policy, as Capitol Specialty argues, the Policy covers acts or omissions that occurred on or after December 10, 2004, and prior to December 10, 2007, *as long as* Sanford had no reasonable basis to foresee a claim against them prior to December 10, 2007. This interpretation also renders actual meaning to the "if continuously renewed" language, whereas under defendants' interpretation it would have no meaning. Because Capitol Specialty offers the only reasonable interpretation of the Policy language, the Policy is unambiguous. Therefore, the Court concludes that "first policy" unambiguously refers to the 2007–2008 policy period.

#### **B. Defendant Cannot Meet the Condition Precedent to Coverage in Subsection 2(b)**

[10] Even if the Policy is not ambiguous, defendants argue that they have satisfied the condition precedent in subsection 2(b) because they had no reasonable expectation that the Client would bring a malpractice claim. (Def's. Opp'n at 8–9.) Defendants base their argument on the Clients' prior course of conduct and discussions before the Clients' termination of defendants as their counsel. (*Id.*) Plaintiff counters that defendants had prior knowledge of a breach of professional duty, as well as a reasonable expectation on what transpired in the Discrimination Action. The Court agrees.

\*9 As Capitol Specialty points out, the Policy expressly stated a second precedent to coverage: that no Insured had a "basis ... to believe that any Insured had breached a professional duty." Missing a filing deadline that results in the dismissal of the class action claim could easily qualify as a breach of a professional duty. *See In re Belmar*, 319 B.R. 748, 755 (Bankr.D.D.C.2004) ("[T]here is no genuine issue that the defendants breached that standard of care by failing to timely file an opposition or

seek an extension of time in which to file such an opposition."); *Cameron*, 649 A.2d at 294 ("[C]ounsel has a duty to pay attention to filing deadlines and not to let one go by in any pending case without doing whatever needs to be done.").

Defendants argue that the Malpractice Action was not reasonably foreseeable because they had no reason to believe that the Clients would bring a malpractice suit. (*Id.*) Specifically, defendants point to the fact that the Clients expressed their understanding that the Court's dismissal of the class claims could be appealed at a later time, and the Clients further stated their intent to proceed with the individual claims and appeal the Court's decision to strike the class claims at the end of litigation, to support their position. (Sanford Declaration ¶ 8.) But as Capitol Specialty points out that the correct standard is the objective, reasonable attorney one, not whether the lawyer in fact had a subjective belief that a malpractice action was probable. *See Ross*, 420 B.R. at 49 ("whether the [insured] could have reasonably foreseen a malpractice claim is an objective test that can be determined as a matter of law."); *Colliers Lanard & Axilbund v. Lloyds of London*, 458 F.3d 231, 237 (3d Cir.2006) ("[W]e conclude that this part of the exclusion gives rise to an objective test: whether a reasonable professional in the insured's position might expect a claim or suit to result."). Moreover, "the question whether the insured has acted reasonably becomes a question of law only when reasonable persons can draw but one inference...." *Travelers*, 770 A.2d at 991 (citing *Starks v. North East Ins. Co.*, 408 A.2d 980, 982 (D.C.1979)). Here, the dismissal of a lawsuit because of attorney error would clearly put a lawyer on notice of the possibility of a malpractice claim. *See Ross*, 420 B.R. at 55 (holding a law firm's failure to file a timely answer resulting in a default judgment could reasonably be expected to form the basis for a malpractice claim); *Cameron v. Washington Metro. Area Transit Auth.*, 649 A.2d 291, 294 (D.C.1994) (finding an attorney "has a duty to pay attention to filing deadlines...."); *O'Neil v. Bergan*, 452 A.2d 337, 341–43

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(D.C.1982) (holding that “allowing the statute of limitations to run on the client’s claim” is an example of obvious malpractice that does not require expert testimony to establish a standard of care).

As such, the Court concludes that the acts or omissions underlying the Malpractice Action establish as a matter of law that defendants had a basis to “believe that any Insured had breached a professional duty,” or to “foresee that any such act or omission ... might reasonably be expected to be the basis of a Claim against the Insured.” (Compl., Ex. A.) Therefore, defendants cannot satisfy the subsection 2(b) condition precedent to coverage and there is no coverage for the Malpractice Action under the Policy.

#### IV. ESTOPPEL

\*10 [11][12] Having concluded that the Policy does not cover the Malpractice Action, the question remains whether, as defendants argue, Capitol Specialty is estopped from denying coverage because it first disclaimed coverage in November 2010. “Estoppel generally results when an insurance company assumes the defense of an action [and] to prevail on this basis, the insured is required, in some jurisdictions, to show prejudice and in other jurisdictions prejudice will be presumed.” *Athridge v. Aetna Cas. and Sur. Co.*, 604 F.3d 625, 630 (D.C.Cir.2010) (quoting *Diamond v. Utica Mut. Ins.*, 476 A.2d 648, 654 (D.C.1984)). Under District of Columbia law, prejudice is required for estoppel. *Athridge v. Aetna Cas. and Sur. Co.*, 2006 WL 2844690, at \*2 (D.D.C. September 29, 2006) (“[W]ithout prejudice ... [a] claim for estoppel fails as a matter of law.”), *aff’d*, 604 F.3d 625 (D.C.Cir.2010).

[13][14][15][16] District of Columbia case law suggests prejudice may be shown in one of two ways: (1) by a rebuttable presumption of prejudice when an insured assumes complete control over the insured’s defense if there is no reservation of rights or (2) by evidence of actual prejudice. *Athridge*, 604 F.3d at 629–630. Because the Court concludes Capitol Specialty issued an adequate reservation of

rights to defendants prior to assuming control of their defense,<sup>FN8</sup> the Court will turn to a determination of actual prejudice.

[17] Actual prejudice may be shown if the insurer’s participation in the defense harmed or hindered the insured by undermining their ability to defend themselves. *Id.*; see also *In re Himmelfarb’s Estate* 345 A.2d 477, 483 (D.C.1975) (“An essential element of estoppel is prejudice caused by detrimental reliance.”). In *Diamond*, the court did not find evidence of actual prejudice because there was no showing that pre-trial preparation was prejudiced, necessary witnesses had become unavailable, settlement negotiations had been hindered or that the insured had been lulled into reliance on the insurer. *Diamond*, 476 A.2d at 658.

Here, defendants allege that Capitol Specialty is estopped from denying coverage because Capitol Specialty: (1) advised defendants that coverage is available for this claim; (2) undertook their defense in the Malpractice Action; (3) waited an unreasonably long time between first receiving notice of the claim and disclaiming coverage; and (4) prejudiced their defense in the Malpractice Action.<sup>FN9</sup> (Defs.’ Opp’n at 19–20.) The first three points are not evidence of prejudice because Capitol Specialty provided defense to defendants subject to an appropriate reservation of rights. See *supra* note 8. The fourth point asserts prejudice, but defendants fail to demonstrate any evidence of actual prejudice in the handling of their case beyond vague and conclusory allegations of such prejudice. Defendants allege that they incurred legal fees and costs, and were deprived of their preferred counsel. However, they do not allege or point to any evidence that the representation provided by Capitol Specialty hindered the defense of their claim or that the counsel was inadequate or ineffective.

\*11 Defendants first argue that because of their reliance on Capitol Specialty’s defense, they incurred legal fees and costs in excess of \$87,000. (Defs.’ Opp’n at 13.) But the Policy clearly states that there is a standard \$100,000 deductible in the

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Policy per each claim. (Compl., Ex. A.) Moreover, defendants do not show how this monetary loss undermined their ability to defend themselves. Second, defendants allege prejudice because they had to terminate their preferred counsel of Michelle Roberts from Akin Gump and also incurred outstanding legal fees. (Defs.' Facts at 9.) But according to the Policy, Capitol Specialty "has the right and duty to defend any claim seeking damages that are covered by the policy made against the Insured even if any of the allegations of the Claim are groundless, false or fraudulent." (Pl.'s Compl., Ex. A at § I.B.) As such, defendants took a miscalculated risk in preemptively and independently hiring counsel without first seeking permission from Capitol Specialty. It is also of note that Michelle Roberts was terminated in May 2010 only one month after defendants signed the contract with Akin Gump and only six months before Capitol Specialty disclaimed coverage.

More tellingly, defendants offer no criticism of Eccleston & Wolf nor do they allege any facts of poor representation or malpractice. On the contrary, defendants admit that the class claims in the Malpractice Action were dismissed by the District of Columbia Superior Court. (Defs.' Opp'n at 10, n. 7.) And similar to the insured party in *Diamond*, defendants did not object to the conditional defense nor did they question the reservation of rights, even while remaining in contact with Capitol Specialty.

Accordingly, defendants have not demonstrated actual prejudice. See *Athridge v. Aetna*, 510 F.Supp.2d 1, 8 (D.D.C.2007) ("Plaintiffs' contentions of ways in which prejudice *could have been created* cannot overcome their inability to show that any prejudice *was created* ...."). As such, the Court concludes that defendants cannot, as a matter of law, invoke the defense of estoppel.

#### CONCLUSION

[18] For the foregoing reasons, plaintiff's motion for summary judgment is granted. A separate order will accompany this Memorandum Opinion.  
FN10

FN1. Local Civil Rule 23.1(b) provides:

Within 90 days after the filing of a complaint in a case sought to be maintained as a class action, unless the court in the exercise of its discretion has extended this period, the plaintiff shall move for a certification under Rule 23(c)(1), Federal Rules of Civil Procedure, that the case may be so maintained.

FN2. In several instances, defendants contest Capitol Specialty's Statement of Undisputed Facts by saying the facts stated are either incomplete or an improper characterization. For example, Capitol Specialty states in ¶ 9 that defendants moved to reinstate the class claim and certify the question for interlocutory appeal. Defendants dispute this statement as incomplete because on February 21, 2007, defendants also filed a Petition for Permission to Appeal pursuant to Rule 23(f) in the United States Court of Appeals for the District of Columbia. (Defs.' Facts ¶ 9.) The Court does not believe this properly constitutes a dispute or incomplete fact and accordingly cites to Capitol Specialty's facts in instances such as this.

FN3. Defendants dispute plaintiff's characterization that the Application and Warranty were reviewed or considered by Capitol Specialty prior to the issuance of the Policy, noting that the Application was for "Certain Underwriters' at Lloyd's" and Hub International, and the Warranty was sent to Strategic Insurance Agency and (Defs.' Statement of Facts ["Defs.' Facts"] ¶¶ 12–20.) Capitol Specialty counters that Endorsement No. 3 to the Policy clearly states that the Application would be "treated as the Application for this Policy." (Pl.'s Reply in Support of Summ. J. ["Pl.'s Reply"] at 9, n. 7; Compl., Ex. A.) Nonetheless, as is clear from the discussion

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herein, this purported dispute is not relevant to the resolution of this case.

FN4. Defendants allege that Capitol Specialty refused to negotiate a settlement offer made jointly to defendants and the law firm of Grant E. Morris that specifically contemplated that defendants' insurer would fund no more than the \$7 million limit of the Policy and that Morris' insurer would fund the remaining \$1 million. (Defs.' Opp'n at 14.) Capitol Specialty argues that it has no duty to defend or settle a claim if there is no coverage for the claim under the Policy. (Pl.'s Reply at 12.) See *Am. Nat'l Red Cross v. Traveler's Indem. Co. of R.I.*, 896 F.Supp. 8, 11 (D.D.C.1995) ("An insured's claim of bad faith breach of contract against its insurer fails if coverage for the underlying claim does not exist.") The Court agrees.

FN5. Defendants filed a motion to transfer to the District Court for the Southern District of New York pursuant to 28 U.S.C. § 1404(a), which this Court denied. (Dkt. No. 4.)

FN6. Citing D.C.Code § 31-4314, Capitol Specialty also argues it could abrogate the policy based on defendants' false representation in the Warranty and Application, even if this misrepresentation was unintentional. D.C.Code § 31-4314 provides that a false statement on an insurance application does not bar the right to recovery unless "such false statement was made with intent to deceive or unless it materially affect[s] either the acceptance of the risk or the hazard assumed by the company." D.C.Code § 31-4314 (2011); See *Ross v. Cont'l Cas. Co.*, 420 B.R. 43 (D.C.2009) (holding this statute did not bar insurer's denial of coverage for legal malpractice claim because the insured, prior to inception date of policy, had reason to believe

that an act or omission might reasonably be expected to be the basis of a claim); *Burlington Ins. Co. v. Okie Dokie Inc.*, 398 F.Supp.2d 147, 157 (D.D.C.2005) (holding an insurer has a right to rely on statements made in an insurance application). Moreover, even if defendants' misrepresentation had been unintentional, under District of Columbia law, Capitol Specialty could still abrogate the policy if the misrepresentation materially affected the hazard assumed by the insurer. See also *Blair v. Inter-Ocean Ins. Co.*, 589 F.2d 730, 732 (D.C.Cir.1978).

FN7. Defendants contest Capitol Specialty's reliance on the Warranty and Application in declining coverage, noting that an insurer waives its rights to assert other defenses when it does fails to do so in the original assertion. See *Continental Cas. Co. v. Hartford Fire Ins. Co.*, 116 F.3d 932, 939 n. 8 (D.C.Cir.1997) (internal citations omitted). The Court need not reach the issue of waiver since, as explained herein, the failure to satisfy the condition precedent is determinative of the outcome in this case.

FN8. An insurer has a duty to defend a lawsuit brought against its insured but that does not necessarily estop the insurer from declining coverage at some reasonable point if the insurer reserves their rights to do so. See *Athridge v. Aetna Cas. and Sur. Co.*, 510 F.Supp.2d 1 (D.D.C.2007), *aff'd*, 604 F.3d 625 (D.C.Cir.2010); *Diamond*, 476 A.2d at 648. But an insurer who defends an insured without an appropriate disclaimer and reservation of rights is barred from disclaiming coverage. *Continental Cas. Co. v. Hartford Fire Insurance Co.*, 116 F.3d 932, 939 (D.C.Cir.1997) (citing *National Union Fire Ins. Co. v. Aetna Cas. & Sur. Co.*, 384

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F.2d 316, 318 (D.C.Cir.1967)). When an insurer assumes complete control of the insured's defense without a reservation of rights, prejudice is assumed as a matter of law. *Walker v. American Ice Co.*, 254 F.Supp. 736, 742 (D.D.C.1966). Generally, reservation of rights language should indicate specific coverage defenses or else the insurer may be barred from raising them later. *Central Armature Works, Inc. v. American Motorists Ins. Co.*, 520 F.Supp. 283, 288 n. 4 (D.D.C.1980); *New Appleman on Insurance Law* § 16-03(3)(d)(i) (2010). Recognizing that identification of coverage issues requires time, however, this Court has held that a reservation of rights is sufficient as long as the insurer conducts an investigation and analysis with "reasonable diligence and promptly notifies the insured" once the process is complete. *Central Armature Works, Inc.*, 520 F.Supp. at 288 n. 4; see also Allan D. Windt, *Insurance Claims and Disputes* § 2:14 (5th ed. 2011) (When an insurer assumes an insured's defense, it can reserve all of its rights through a reservation of rights letter if it has not had a reasonable opportunity to analyze the applicability of coverage). In *Diamond*, 476 A.2d at 654-56, the court concluded the nine-month period between receiving notice of a malpractice claim and disclaiming coverage was not unreasonable. Nor did the court find that the six-month period between sending a reservation of rights letter and disclaiming coverage as unreasonable. Here, as in *Diamond*, nine months elapsed between Capitol Specialty receiving the notice of the Malpractice Action in February 2010 and disclaiming coverage in November 2010. The Court concludes this is not an unreasonable time frame, nor is the eight-month time period between issuing the reservation of rights and disclaiming coverage. Although defendants attempt

to shift the date of notice to April 2008 by arguing that they first gave notice through the Goldberg letter, this is not persuasive as even defendants admit that because the clients "waited almost two years before actually filing a lawsuit against [defendants] ... [it] further reinforce[d] [their] belief that losing [the] motion to reinstate the class claims was not reasonably likely to give rise to a claim." (Defs.' Opp'n at 11.) Thus, the Court is not persuaded that the time between February and November was of a sufficient length of time to be prejudicial to defendants.

FN9. Defendants also argue that Capitol Specialty is barred from disclaiming coverage because they indicated that "coverage is available to Sanford Wittels Heisler LLP for this matter" in the March 23, 2010 letter acknowledging notice of the suit against defendants. (Defs.' Opp'n at 11; Pl.'s Mem., Ex. 7G.) But in that letter, Capitol Specialty specifically emphasized that any action taken in support of defendants with regards to the Malpractice Action would also be subject to a reservation of rights

FN10. As the Court noted above (*see supra* note 4), defendants' counterclaims fall out because there is no underlying coverage. Moreover, District of Columbia law does not recognize a cause of action for bad faith breach of an insurance contract. See *Fireman's Fund Ins. Co. v. CTIA-The Wireless Ass'n*, 480 F.Supp.2d 7, 9 ("The Court finds ... that the District of Columbia would not recognize a tort cause of action for bad faith breach of an insurance contract.")

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*Capitol Specialty Ins. Corp. v. Sanford Wittels & Heisler, LLP*

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Only the Westlaw citation is currently available.

United States District Court, W.D. Washington,  
at Tacoma.

CAROLINA CASUALTY INSURANCE COM-  
PANY, Plaintiffs,

v.

Dennis G. OTT, individually; Dennis G. Ott, P.S.,  
Defendants.

No. C09-5540 RJB.

May 7, 2010.

West KeySummaryInsurance 217 ↔ 2266

217 Insurance

217XVII Coverage--Liability Insurance

217XVII(A) In General

217k2263 Commencement and Duration  
of Coverage

217k2266 k. Claims Made Policies.

Most Cited Cases

Legal malpractice insurer had no duty to defend or indemnify its insured, an attorney, on a matter that he knew about but failed to disclose when insurance was obtained. The policy provided that it would not cover claims for wrongful acts which were made prior to the effective date of the policy which the insured could reasonably foresee would arise but did not disclose. It was undisputed that prior to the effective date of the policy the insured had fabricated letters in order to defend himself in a previous grievance filed against him with the bar. A reasonable attorney with knowledge of these facts would have understood that a claim might arise out of the insured's handling of the matter.

Paul E. Fogarty, Diana Marie Dearmin, Dearmin Fogarty PLLC, Seattle, WA, Robert A. Chaney, Lewis Brisbois Bisgaard & Smith, Chicago, IL, for Plaintiff.

Jeffrey M. Thomas, Pamela J. Devet, Gordon

Tilden Thomas & Cordell LLP, Seattle, WA, Robert Joseph Penfield, Penfield Legal Services PLLC, Marysville, WA, for Defendants.

ORDER ON PLAINTIFF CAROLINA CASUALTY INSURANCE COMPANY'S MOTION FOR SUMMARY JUDGMENT

ROBERT J. BRYAN, District Judge.

\*1 This matter comes before the court on Plaintiff Carolina Casualty Insurance Company's Motion for Summary Judgment (Dkt.17). The court has considered the relevant pleadings and the file herein.

*FACTUAL BACKGROUND*

The following facts are undisputed unless otherwise noted: In July 2003, lawyer Dennis G. Ott or Dennis G. Ott, P.S. (Collectively, "Ott") filed a lawsuit on behalf of Steven F. McCoy and Peggy L. McCoy, husband and wife, in the Superior Court of Lewis County, Washington. Dkt. 1, Exhibit C; Dkt. 23. Through Ott, the McCoy's asserted claims against the estate of the owner of a rock quarry on property adjacent to the McCoy's home (the "Hartstrom lawsuit"). *Id.* In February 2005, the court clerk in the Hartstrom lawsuit notified Ott that the lawsuit would be dismissed for want of prosecution unless, within thirty days, action of record was taken or application was made to the court. *Id.* In March 2005, the suit was dismissed for want of prosecution. *Id.*

In September 2007, Steven McCoy filed a grievance with Washington State Bar Association ("WSBA") against Ott concerning his handling of the Hartstrom lawsuit. *Id.* In his response to the bar grievance, Ott attached copies of letters dated March 24, 2004, and February 18, 2005, which Ott represented he had sent to the McCoy's to confirm that they had asked him to place the lawsuit on hold (March 24, 2004 letter), and subsequently, to advise them that the case could be dismissed if they did not proceed (February 15, 2005 letter). *Id.* At the

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time, Ott knew that he had fabricated these letters. Dkt. 1, Exhibit A.

On November 2, 2007, Ott received a letter from the McCoys' new attorney requesting turnover of the file concerning Ott's representation of the McCoys in the Hartstrom lawsuit. Dkt. 1 Exhibit C; Dkt. 23.

In April of 2008, Ott applied for an insurance policy with Carolina Casualty Insurance Company ("Carolina Casualty"). *Id.* When Ott applied for the policy, he did not disclose any facts relating to the dismissal of the Hartstrom lawsuit or the pending bar grievance filed by the McCoys. Dkt. 23. Ott contends that "[a]t that time Mr. Ott did not believe that the McCoys would file any action other than the pending disciplinary matter." Dkt. 28. The insuring agreement of the Carolina Casualty policy, effective April 16, 2008 to April 16, 2009, provides that the policy covers claims for Wrongful Acts that are first made and reported during the policy period, provided that prior to the effective date of the policy, "the Insured did not know, or could not reasonably foresee, that such Wrongful Act might reasonably be expected to be the basis of a Claim." Dkt. 18; Dkt. 23. The policy defines "Wrongful Act" as "any actual or alleged act, omission, or Personal Injury arising out of Professional Services rendered by an Insured ..." Dkt. 23.

In January 2009, the WSBA Disciplinary Counsel recommended that the WSBA Disciplinary Review Committee order the McCoys' grievance to hearing. Dkt. 23.

\*2 In March 2009, the McCoys filed a legal malpractice action against Ott (the "McCoy" matter) in the Superior Court of Lewis County, Washington. Dkt. 1, Exhibit C; Dkt. 23. In the McCoy matter, the McCoys assert claims of legal malpractice/negligence, breach of fiduciary duty, breach of contract, breach of the implied covenant of good faith and fair dealing, and negligent infliction of emotional distress. Dkt. 1, Exhibit A. On March 16, 2009, Ott tendered the action to his insurer, Caro-

lina Casualty, who agreed to defend him in the McCoy matter. *See* Dkt. 28. Carolina Casualty hired attorney Joel Wright of Lee, Smart, Cook, Martin & Patterson, P.S., Inc. to defend Ott. *See* Dkt. 29, Decl. of Pamela J. DeVet, Exhibit A. At some point, Carolina Casualty hired the firm Lewis Brisbois Bisgaard & Smith-LLP as coverage counsel to investigate coverage issues with regard to Ott's policy. Dkt. 32, Second Aff. of Robert A. Chaney.

Carolina Casualty contends that on June 8, 2009, it sent a reservation of rights letter to Ott by email and U.S. Postal Mail. Dkt. 33, Second Aff. of Robert Irish. Carolina Casualty states that in the letter it quoted the insuring agreement and specifically reserved its right on the basis of the policy's prior knowledge limitation:

"The McCoys allege that on March 16, 2005, their lawsuit against the Hartstrom Estate was dismissed for want of prosecution. The plaintiffs [the McCoys] further allege that they filed a grievance with the Washington State Bar Association Office of Disciplinary Counsel concerning your handling of the lawsuit. Although the date of filing is not alleged, the grievance was apparently filed in or prior to January 2008. These matters occurred prior to the effective date of the policy effective April 16, 2008 to April 16, 2009, the first policy issued to you by Carolina Casualty. Accordingly, Carolina Casualty reserves its right to decline coverage on the basis that prior to the effective date of the policy, you knew or could have reasonably foreseen that the Wrongful Acts alleged by the McCoys might be the basis of a Claim against you. If that is the case, the Claim would not fall within the insuring agreement of the policy and Carolina Casualty would have no duty to defend or indemnify you with respect to the McCoys' lawsuit.

Reference to the above policy provision is not intended as a waiver of any of Carolina Casualty's rights under the policy. Carolina Casualty reserves its rights under all terms and conditions of the policy, whether referred to herein or not, in

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connection with its defense and investigation of this matter. Carolina Casualty also reserves its right to modify, supplement, and/or amend this coverage letter at any time in the future to assert any defense, which may now or later be applicable. Further, Carolina Casualty reserves the right to file a declaratory judgment action for a declaration of its obligation to provide coverage for the McCoy's lawsuit, if any, and/or seek rescission of the policy."

\*3 *Id.* at Exhibit A. Carolina Casualty highlights that it sent the letter eight weeks after it retained defense counsel for Ott and 13 days after the defendants filed an answer in the McCoy matter. *Id.* Ott is silent on the subject of Carolina Casualty's June 8, 2009 letter. Dkt. 31. However, Ott does agree that Mr. Irish mentioned the possibility of a coverage claim against Ott to defense counsel in the McCoy matter on two occasions (via email): (1) on June 11, 2009, Mr. Irish told defense counsel "Also, our cov'g counsel is continuing to eval. for cov'g," and (2) on August 5, 2009, Mr. Irish told defense counsel, "We may bring a DJ cov'g action against the IN. Will let you know if we decide to pursue that." Dkt. 29, Decl. of Pamela J. DeVet. Despite those communications, Ott contends that Carolina Casualty "has already had exclusive control of the defense [of the McCoy matter] for over a year," and has "failed to allege or produce any evidence that it undertook a defense under a reservation of rights." Dkt. 28.

Ott also contends that Carolina Casualty's claims attorney,<sup>FN1</sup> Robert Irish, obtained information about the bar proceedings against Ott in conjunction with the defense of the McCoy matter and then inappropriately used that information in this matter. *Id.* Carolina Casualty contends that "Carolina Casualty (Monitor Liability Managers) did not ever provide Carolina Casualty's coverage counsel, Lewis Brisbois Bisgaard & Smith LLP, with a copy of the Aff. of Dennis G. Ott Resigning from Membership in the Washington State Bar Association, or the Statement of Alleged Misconduct

Under ELC 9.3(b)(1) ..." Dkt. 32, Second Aff. of Robert A. Chaney. Carolina Casualty further contends that "[n]o claim representative of Carolina Casualty (Monitor Liability Managers) ever advised coverage counsel of the existence of these documents or requested that coverage counsel obtain a copy of the documents to support Carolina Casualty's coverage position." *Id.*

FN1. Robert Irish is employed as a Senior Claims Attorney with Monitor Liability Managers, Inc. ("Montitor"), and Monitor acts as a managing underwriting agent and in that capacity underwrites policies and handles claims for Carolina Casualty. Dkt. 17-3, Aff. of Robert Irish.

In June 2009, Ott filed a Notice of Resignation in Lieu of Disbarment with the WSBA. *Id.* Attached to his notice, Ott submitted an affidavit admitting to facts relating to his handling of matters for various clients, including the McCoys. *Id.* Ott admitted in the affidavit that the March 24, 2004 and February 15, 2005 letters were fabricated, and that he had not advised the McCoys of the dismissal of the Hartstrom lawsuit. *Id.* Ott also acknowledged that he had received the November 2, 2007 letter from the McCoys' new attorney requesting turnover of the file concerning Ott's representation of the McCoys, and that he did not respond to that letter. *Id.*

On September 4, 2009, with the McCoy matter pending in state court, Carolina Casualty initiated this action against its insured, Ott, seeking a declaration that it has no duty to defend or indemnify Ott in the McCoy matter. Dkt. 1.

#### PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

On January 29, 2010, Carolina Casualty filed its motion for summary judgment (Dkt.17), and contended that there can be no genuine issue of material fact that, prior to the effective date of the policy, any attorney with Ott's knowledge of various undisputed facts could have reasonably fore-

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seen that the McCoys might make a claim. Dkt. 17. Carolina Casualty also requested that the court enter a declaratory judgment that Carolina Casualty has no obligation to reimburse Ott for defense costs incurred in the bar grievance proceeding because the bar grievance proceeding began before the beginning of the policy period.

\*4 On February 11, 2010, the defendant filed a Motion to Stay (Dkt.18), and requested that the court stay this proceeding during the determination of the McCoy matter in state court. On February 12, 2010, the defendant filed a Motion to Enlarge Time to Respond to Motion for Summary Judgment (Dkt.20), requesting that the court move his due date for response to the motion for summary judgment to a date after the court ruled on the motion to stay. On February 19, 2010, the parties filed their Stipulated Motion and Order Re Defendant Ott's Motion to Enlarge Time (Dkt.20) to Respond to Motion for Summary Judgment (Dkt.17), agreeing to set the due date for the defendant's response to the motion for summary judgment for ten court days from the date of the denial of the defendant's motion to stay, should the court deny stay. Dkt. 22. On March 26, 2010, the court denied the defendant's motion to stay (Dkt.26) and renoted Carolina Casualty's summary judgment motion for April 23, 2010 (Dkt.27).

On April 9, 2010, Ott filed its Opposition of Dennis G. Ott and Dennis G. Ott P.S. to Plaintiff's Motion for Summary Judgment (Dkt.28). Ott argues that (1) Carolina Casualty cannot discharge its defense obligations in the McCoy matter because it has not provided evidence that it properly reserved its rights or it should be estopped from denying defense, and (2) the issue of whether a policyholder knew or should have known of a potential claim at the time the policy was procured is a question of fact that cannot be decided on summary judgment. Dkt. 28.

On April 20, 2010, Carolina Casualty filed Plaintiff Carolina Casualty Insurance Company's Reply in Support of Motion for Summary Judgment

(Dkt.31). Carolina Casualty argues that summary judgment is available, and should be granted, because (1) it properly reserved its rights and should not be estopped from relying on the insuring agreement for a coverage defense, and (2) because there is no genuine issue of material fact that, prior to the effective date of the policy, any attorney with Ott's knowledge of various undisputed facts could have reasonably foreseen that the McCoys might make a claim. Dkt. 31.

#### STANDARD

Summary judgment is proper only if the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). The moving party is entitled to judgment as a matter of law when the nonmoving party fails to make a sufficient showing on an essential element of a claim in the case on which the nonmoving party has the burden of proof. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1985). There is no genuine issue of fact for trial where the record, taken as a whole, could not lead a rational trier of fact to find for the nonmoving party. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986) (nonmoving party must present specific, significant probative evidence, not simply "some metaphysical doubt."). See also Fed.R.Civ.P. 56(e). Conversely, a genuine dispute over a material fact exists if there is sufficient evidence supporting the claimed factual dispute, requiring a judge or jury to resolve the differing versions of the truth. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 253, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986); *T.W. Elec. Service Inc. v. Pacific Electrical Contractors Association*, 809 F.2d 626, 630 (9th Cir.1987).

\*5 The determination of the existence of a material fact is often a close question. The court must consider the substantive evidentiary burden that the nonmoving party must meet at trial-e.g., a prepon-

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derance of the evidence in most civil cases. *Anderson*, 477 U.S. at 254, *T.W. Elect. Service Inc.*, 809 F.2d at 630. The court must resolve any factual issues of controversy in favor of the nonmoving party only when the facts specifically attested by that party contradict facts specifically attested by the moving party. The nonmoving party may not merely state that it will discredit the moving party's evidence at trial, in the hopes that evidence can be developed at trial to support the claim. *T.W. Elect. Service Inc.*, 809 F.2d at 630 (relying on *Anderson*, *supra*). Conclusory, unspecific statements in affidavits are not sufficient, and "missing facts" will not be "presumed." *Lujan v. National Wildlife Federation*, 497 U.S. 871, 888-89, 110 S.Ct. 3177, 111 L.Ed.2d 695 (1990).

#### DISCUSSION

Ott sets forth two reasons why he believes summary judgment is unavailable: (1) Carolina Casualty cannot discharge its defense obligations in the McCoy matter because it has not provided evidence that it properly reserved its rights or it should be estopped from denying defense, and (2) the issue of whether a policyholder knew or should have known of a potential claim at the time the policy was procured is a question of fact that cannot be decided on summary judgment. Dkt. 28. The court will discuss, in turn, each argument.

##### *1. Carolina Casualty properly defended Ott under a reservation of rights*

As described above, Ott argues that Carolina Casualty cannot discharge its defense obligations because it has not provided evidence that it properly reserved its rights when it accepted defense of the McCoy matter, or because Carolina Casualty is estopped from discharging its defense obligations. Dkt. 28. Ott contends that the lack of proof of reservation of rights shows waiver of that right. *Id.* Further, Ott argues that Carolina Casualty is estopped from denying its defense obligations because the length of time for which Carolina Casualty has assumed defense prevents Carolina Casualty from withdrawing that defense. *Id.* Additionally, Ott ar-

gues that Carolina Casualty is estopped from denying its defense obligations because it acted in bad faith by commingling information obtained in its defense of Ott with information used against Ott in this coverage action, including the January 13, 2009 letter from the WSBA containing the results of its grievance investigation and Ott's resignation affidavit. Dkt. 28; Dkt. 29, Decl. Of Pamela J. DeVet. Ott alleges further bad faith on the basis of "Carolina Casualty's secretive approach to notifying Mr. Ott of the case against him, including waiting 6 weeks to serve him," which Ott contends "evidences a breach of the duty to deal honestly with its policyholder." *Id.*

In response, Carolina Casualty contends that it provided a proper reservation of rights in its letter to Ott on June 8, 2009. Dkt. 33, Second Aff. of Robert Irish. Carolina Casualty argues that the length of time it provided defense for Ott was not long enough to prejudice Ott, and, therefore, Carolina Casualty is not estopped from denying defense. Dkt. 31. Further, Carolina Casualty argues that it has not commingled Ott's defense and this coverage action because it retained separate counsel for each matter and counsel did not share information, and, therefore, it is not estopped from denying its defense obligations. Dkt. 32, Second Aff. of Robert A. Chaney.

\*6 Under Washington law, when an insurer is unsure of its obligation to defend in a given instance, it may defend under a reservation of rights while seeking a declaratory judgment that it has no duty to defend. *Truck Ins. Exch. v. VanPort Homes, Inc.*, 147 Wash.2d 751, 761, 58 P.3d 276 (2002). A reservation of rights is a means by which the insurer avoids breaching its duty to defend while seeking to avoid waiver and estoppel. *Id.* "When that course of action is taken, the insured receives the defense promised, and, if coverage is found not to exist, the insurer will not be obligated to pay." *Id.* (citing *Kirk v. Mt. Airy Ins. Co.*, 134 Wash.2d 558, 563 n. 3, 951 P.2d 1124 (1998)).

The Ninth Circuit has considered how the law

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of waiver and estoppel applies in Washington when an insurance company is accused of waving or breaching its duty to defend its insured. *See Underwriters at Lloyds v. Denali Seafoods, Inc.*, 927 F.2d 459 (9th Cir.1991). With regard to waiver, the Ninth Circuit determined that waiver can preclude an insurance company from raising a coverage defense after it agreed to defend an action without reserving rights. *Id.* at 462 (*internal citations omitted*). However, because waiver is the voluntary or intentional relinquishment of a known right, the insured must show substantial evidence of the insurer's intent to effect a waiver. *Id.* Failure to reserve rights due to error or oversight does not show the requisite intentional decision to waive a coverage defense. *Id.*

Estoppel, unlike waiver, does not focus on the intent of the insurer; it arises as a matter of law to preclude an insurer from asserting a right or defense when it would be inequitable to permit the assertion. *Id.* When determining whether an insurer is estopped from denying coverage, the focus is on the insured's justifiable reliance and whether or not it was prejudiced by the insurer's actions. *Id.* Except in extreme cases, actual prejudice must be proven in Washington to estop an insurer from asserting a coverage defense. *Id.* Any case in which the insurer actually acted in bad faith is an extreme case, therefore, courts will presume prejudice in any case in which the insurer acted in bad faith. *Safeco Ins. Co. of Am. v. Butler*, 118 Wash.2d 383, 391, 823 P.2d 499 (1992). An insurer can avoid acting in bad faith by fulfilling the following criteria: First, the company must thoroughly investigate the cause of the insured's claim. *Tank v. State Farm Fire & Cas. Co.*, 105 Wash.2d 381, 388, 715 P.2d 1133 (1986). Second, it must retain competent defense counsel for the insured, and both retained defense counsel and the insurer must understand that only the insured is the client. *Id.* Third, the company has the responsibility for fully informing the insured not only of the reservation-of-rights defense itself, but of all developments relevant to his policy coverage and the process of the lawsuit. *Id.* Finally, an insur-

ance company must refrain from engaging in any action which would demonstrate a greater concern for the insurer's monetary interest than for the insured's financial risk. *Id.*

\*7 An insurer's bad faith gives rise to a tort action for bad faith, *Smith v. Safeco Ins. Co.*, 150 Wash.2d 478, 484, 78 P.3d 1274 (2003), or an estoppel from denying a defense that was undertaken under a reservation of rights, *Butler*, 118 Wash.2d at 391, 823 P.2d 499. An insurer is entitled to summary judgment of a policyholder's bad faith claim, and therefore is not estopped from denying its defense obligations, if there are no disputed material facts pertaining to the reasonableness of the insurer's conduct under the circumstances, or if the insurance company is entitled to prevail as a matter of law on the facts construed most favorable to the nonmoving party. *Smith*, 150 Wash.2d at 484, 78 P.3d 1274.

Even without a showing of bad faith, an insurer may still be estopped from suddenly denying coverage when the insurer has conducted the defense for a long period of time so as to prejudice the insured. *See Transamerica Ins. Group v. Chubb and Son, Inc.*, 16 Wash.App. 247, 554 P.2d 1080 (1976) (insurer was estopped from denying coverage when it had "irrevocably fixed the course of events concerning the insured's lawsuit for the first 10 months in which the insurer had defended the insured"); *but c. f.*, *Denali Seafoods*, 927 F.2d at 463 (insurer was not estopped from denying coverage after defending without a reservation of rights for four months). Whether an insurer's acts prejudice the insured is a question of fact and the traditional summary judgment standards apply. *Butler*, 118 Wash.2d at 395, 823 P.2d 499.

#### a. Reservation of Rights

Ott has not shown any genuine issue of material fact as to whether Carolina Casualty properly defended him under a reservation of rights. Ott contends that Carolina Casualty has not shown evidence of its reservation of rights, but Carolina Casualty has provided such evidence through its June 8,

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2009 letter reserving rights (Dkt. 33, Second Aff. of Robert Irish). Ott has not refuted this evidence through affidavit, declaration, or otherwise. Accordingly, Carolina Casualty should be deemed to have provided Ott with a proper reservation of rights.

*b. Waiver*

Ott has not asserted any facts that would show Carolina Casualty's voluntary or intentional relinquishment of its right to assume Ott's defense under a reservation of rights; therefore, Ott has not shown a genuine issue of material fact as to whether Carolina Casualty waived the reservation it provided. Accordingly, Carolina Casualty should be deemed not to have waived its ability to deny defense.

*c. Estoppel*

Ott also has not shown any genuine issue of material fact that Carolina Casualty should be estopped from denying defense. Ott has not raised an issue of material fact as to (i) whether the length of time for which Carolina Casualty provided his defense has prejudiced him so as to estop Carolina Casualty from denying defense, or (ii) whether Carolina Casualty acted in bad faith and allegedly commingled information obtained in its defense of Ott with information used against Ott in this coverage action so as to estop Carolina Casualty from denying defense.

*ii. Estoppel because of Length of Time of Defense*

\*8 First, Ott has not raised an issue of material fact as to whether the length of time for which Carolina Casualty provided his defense has prejudiced him so as to estop Carolina Casualty from denying defense. Carolina Casualty has shown that it sent its June 8, 2009 letter reserving rights less than three months after Ott tendered his claim, just eight weeks after Carolina Casualty retained defense counsel for Ott, and just 13 days after Ott provided answer in the McCoy matter. This brief period of defense before a reservation of rights is well within the Ninth Circuit's limitations on an insurer's defense prior to a reservation of rights. See *Denali Seafoods*, 927 F.2d at 463 (insurer was not es-

topped from denying coverage after defending without a reservation of rights for four months). Accordingly, the length of time Carolina Casualty provided defense without a reservation of rights should not estop it from denying defense.

*iii. Estoppel because of Bad Faith*

Second, Ott has not raised an issue of material fact as to whether Carolina Casualty acted in bad faith and allegedly commingled information obtained in its defense of Ott with information used against Ott in this coverage action so as to estop Carolina Casualty from denying defense. In support of his argument Ott cited *Ellwein v. Hartford Accident and Indem. Co.*, 142 Wash.2d 766, 15 P.3d 640 (2001), for the proposition that it is bad faith for an insurer to commingle coverage litigation against its insured with its liability representation of its insured. Ott's reliance on *Ellwein* is misplaced. That case is distinguishable from the matter at hand. In *Ellwein*, the insurer represented its insured in an automobile accident liability case but also represented itself as the uninsured motorist payor when it assumed the defense of the adversary uninsured motorist. *Ellwein*, 142 Wash.2d 766, 15 P.3d 640 (2001). It was in that context that the court commented, as Ott quotes, "we find it particularly troubling that the insurer may 'commingle' the liability representation with the UIM file in such a way." *Id.* at 782, 15 P.3d 640. The court found disturbing the insurer's commingling of the insured's liability representation with the insurer's liability opposition in the same matter. *Id.* Here, unlike in *Ellwein*, Ott is contending that Carolina Casualty commingled its insured's liability representation in one matter with Carolina Casualty's coverage claims in a separate matter.

In this posture, Carolina Casualty nevertheless must act in good faith by hiring an attorney to defend Ott, and that defense counsel must understand that it is Ott, and not Carolina Casualty, who is the client. *Tank*, 105 Wash.2d at 388, 715 P.2d 1133. But, Carolina Casualty is also entitled to provide Ott's defense under a reservation of rights and it is

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entitled to seek a declaratory judgment that it has no duty to defend. *Truck*, 147 Wn.2d 761. In doing so, Carolina Casualty must act in good faith by fully informing the insured of the reservation of rights defense and all development relevant to the policy coverage and the process of the lawsuit. *Tank*, 105 Wash.2d at 388, 715 P.2d 1133. Carolina Casualty must also refrain from engaging in any action that would show greater interest for its own risk than for the insured's risk. *Id.*

\*9 Ott has not raised an issue of fact as to whether Carolina Casualty acted in bad faith according to the requirements above. Carolina Casualty has shown that it properly hired two sets of counsel, one set to handle each matter. Contrary to Ott's contention, Mr. Irish's communication with both sets of counsel does not "support[ ] the conclusion of commingling of the files." Ott has not provided sufficient, specific allegations of commingling that would show Carolina Casualty's greater interest for its own risk. Ott merely provided an affidavit stating that he provided documents related to his bar discipline to his defense counsel in the McCoy matter, who was provided to him by Carolina Casualty under the direction of Mr. Irish (a claims attorney for Carolina Casualty). Ott's affidavit asserts that his defense counsel provided the bar discipline documents to Mr. Irish, but the affidavit does not assert that Mr. Irish in turn provided these documents to Carolina Casualty's separate coverage counsel in this matter. This missing fact cannot be assumed in Ott's favor. *See Lujan*, 497 U.S. at 888-89. Moreover, Carolina Casualty has provided the missing fact in affidavit and stated that "Carolina Casualty (Monitor Liability Managers) did not ever provide Carolina Casualty's coverage counsel, Lewis Brisbois Bisgaard & Smith LLP, with a copy of the Aff. of Dennis G. Ott Resigning from Membership in the Washington State Bar Association, or the Statement of Alleged Misconduct Under ELC 9.3(b) (1) ..." and that "[n]o claim representative of Carolina Casualty (Monitor Liability Managers) ever advised coverage counsel of the existence of these documents or

requested that coverage counsel obtain a copy of the documents to support Carolina Casualty's coverage position." Dkt. 32, Second Aff. of Robert A. Chaney. Accordingly, Carolina Casualty's handling of Ott's defense and this coverage action should not estop it from denying its defense obligations.

Ott also alleges that Carolina Casualty showed bad faith on the basis of "Carolina Casualty's secretive approach to notifying Mr. Ott of the case against him, including waiting 6 weeks to serve him" (Dkt.28). Ott's contention of "secretive" notification is unsupported by the record. Ott agrees that Mr. Irish alerted Ott's defense counsel of the possibility of a coverage claim against Ott on two occasions (via email): (1) on June 11, 2009, Mr. Irish told defense counsel "Also, our cov'g counsel is continuing to eval. for cov'g," and (2) on August 5, 2009, Mr. Irish told defense counsel, "We may bring a DJ cov'g action against the IN. Will let you know if we decide to pursue that." Dkt. 29, Decl. of Pamela J. DeVet. Carolina Casualty has also shown that it alerted Ott of the potential for a coverage action in its June 8, 2009 letter reserving rights. Carolina Casualty then filed this coverage action against Ott and served him within 120 days after the complaint was filed as required by Fed.R.Civ.P. 4(m). These actions do not show a secretive approach to notifying Ott of the case against him. Accordingly, Carolina Casualty's methods of informing Ott of the coverage claim against him should not estop it from denying defense.

*2. Carolina Casualty does not have a duty to defend or indemnify Ott in connection with the McCoy matter*

\*10 As described above, Carolina Casualty argues that on the basis of the undisputed facts there can be no genuine question of material fact that prior to the April 16, 2008 effective date of the policy, any reasonable attorney in Ott's position could have foreseen that the McCoy's might make a claim for damages. Dkt. 17. Carolina Casualty argues that the McCoy's claim does not fall within the insuring agreement of the policy and Carolina Casualty does

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not have a duty to defend or indemnify Ott in connection with the McCoy matter. *Id.* In response, Ott argues that he believed, as other reasonable attorneys could, that the McCoys would not make a claim against him or that the claim would end with the WSBA. Dkt. 28.

Ott further contends that the issue of whether the prior knowledge limitation of the policy applies is a question of fact that must be decided by a jury and cannot be decided on summary judgment. *Id.* Carolina Casualty contends that the issue can be decided on summary judgment and argues that Ott's subjective belief about the McCoys' potential claim is irrelevant. Dkt. 31.

#### a. Insuring Agreement

The insuring agreement of the Carolina Casualty policy, effective April 16, 2008 to April 16, 2009, provides that the policy covers claims for "Wrongful Acts" that are first made and reported during the policy period, provided that prior to the effective date of the policy, "the Insured did not know, or could not reasonably foresee, that such Wrongful Act might reasonably be expected to be the basis of a Claim." Dkt. 18; Dkt. 23. The policy defines "Wrongful Act" as "any actual or alleged act, omission, or Personal Injury arising out of Professional Services rendered by an Insured ..." Dkt. 23. This type of exclusionary language is known as a prior knowledge limitation, and similar prior knowledge limitations have been construed by Washington courts to require the insured to disclose any acts or omissions that the insured could have reasonably foreseen might be a basis for a claim against him or her. *See Tewell, Thorpe & Findlay, Inc., P.S. v. Cont. Cas. Co.*, 64 Wash.App., 571, 825 P.2d 724 (1992); *O'Connell & Assocs. v. Transamerica Indem. Co.*, 61 Wash.App. 103, 110, 809 P.2d 231 (1991). Other courts have found similarly. *See Mt. Airy v. Thomas*, 954 F.Supp. 1073 (W.D.Pa.1997), *aff'd*, 149 F.3d 1165 (3d Cir.1998).

These limitations use the phrase "reasonably foresee" in order to mandate an objective, reasonable attorney standard. *See id.*; *see also Allstate Ins.*

*Co. V. Peasley*, 131 Wash.2d 420, 430, 932 P.2d 1244 (2007) (interpreting the meaning of the phrase "reasonably foresee"). Under the reasonable attorney standard, an insured "may not successfully defend on the ground that he was uniquely unaware of ethical and fiduciary principles that all lawyers would know or that he did not understand the implications of conduct and events that any reasonable lawyer would have grasped." *Selko v. Home Ins. Co.*, 139 F.3d 146 (3d Cir.1998). Such subjective beliefs "could too easily be related after the fact to excuse any attorney's failure to report known potential claims." *Mt. Airy v. Thomas*, 954 F.Supp. 1073, 1079 (W.D.Pa.1997), *aff'd*, 149 F.3d 1165 (3d Cir.1998). Further, the language of such clauses does not require the prediction of claims with "absolute certainty or exactitude," and "the foreseeability of a claim is distinct from the question of whether a foreseeable claim has any merit." *Tewell*, 64 Wash.App. at 576-77, 825 P.2d 724.

\*11 The above case law establishes that in considering the coverage limits of the Carolina Casualty policy this court must decide whether an attorney with Ott's knowledge of various events could reasonably anticipate, at the policy's effective date, that the McCoys might make a claim against him. Ott's subjective beliefs as to whether the McCoys would file a claim or the merits of the claim are not dispositive in this matter. Therefore, Ott's argument that he did not suspect the McCoys' claim against him does not itself place the matter within the coverage of the insuring agreement.

It is undisputed that prior to the effective date of the policy, the Superior Court of Lewis County, Washington dismissed the Hartstrom lawsuit for want of prosecution; that Ott did not inform the McCoys of the dismissal; that Steven McCoy filed a grievance with the WSBA; that in Ott's response to the bar grievance he filed two fabricated letters from him to the McCoys; and that the McCoys retained new counsel who requested that Ott provide them with a copy of the client file. A reasonable attorney with Ott's knowledge of these facts would

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have understood that a claim might arise out of Ott's handling of the Hartstrom matter. Therefore, under the terms of the insuring agreement, Ott was required to notify Carolina Casualty of that potential claim, regardless of his subjective prediction about the outcome of the McCoy's bar grievance. Because Ott did not notify Carolina Casualty of the potential claim, the McCoy matter does not fall within the insuring agreement of the policy and Carolina Casualty does not have a duty to defend or indemnify Ott in connection with the McCoy matter. Accordingly, Carolina Casualty's motion for summary judgment should be granted.

*b. Prior Knowledge Limitation on Summary Judgment*

Ott challenges the court's authority to make a determination of the application of the prior knowledge limitation to the facts at hand. Dkt. 28. Ott cites the court's reversal of summary judgment in *O'Connell & Assocs. v. Transamerica Indem. Co.*, 61 Wash.App. 103, 110, 809 P.2d 231 (1991), as proof of his proposition that a jury determination is required. Ott's reliance on *O'Connell* is misplaced. In *O'Connell*, the court reversed summary judgment and remanded for trial where the insured, under a similar prior knowledge limitation, did not disclose a potential claim when the insured, who was an insurance broker, only knew that his clients were dissatisfied with the life insurance policies they purchased; knew that they threatened to report the matter to the Insurance Commissioner; and disputed whether he had received a letter from his clients' attorney voicing that the clients were dissatisfied because they felt the broker had committed an error. *O'Connell*, 61 Wash.App. 103, 809 P.2d 231. The facts known to the broker in *O'Connell* are not comparable to the undisputed facts known by Ott in this matter. In *O'Connell* it was disputed whether the broker knew or should have known that his clients accused him of a wrongful act. Here, it is undisputed that Ott knew the McCoy's accused him of wrongful acts.

\*12 Further, neither *O'Connell* nor *Tewell*,

*Thorpe & Findlay, Inc., P.S. v. Cont. Cas. Co.*, 64 Wash.App., 571, 825 P.2d 724 (1992), stand for the rule that the language of the prior knowledge limitation automatically excludes the possibility of a summary judgment ruling. To the contrary, *O'Connell* suggests that summary judgment may be appropriate under some set of facts. Moreover, courts in many jurisdictions have granted summary judgment to insurers on the basis of prior knowledge limitations in insuring agreements. See, e.g., *Coregis Ins. Co. v. McCollum*, 961 F.Supp. 1572 (M.D.Fla.1997), *aff'd*, 172 F.3d 881 (11th Cir.1999); *Carosella & Ferry, P.C. v. TIG Ins. Co.*, 189 F.Supp.2d 249 (E.D.Pa.2001). Accordingly, this court has authority to make a determination on summary judgment of the application of the prior knowledge limitation to the facts at hand, and Carolina Casualty's motion for summary judgment should be granted.

Carolina Casualty also requested that the court enter a declaratory judgment that Carolina Casualty has no obligation to reimburse Ott for defense costs incurred in the bar grievance proceeding because the bar grievance proceeding began before the beginning of the policy period. Dkt. 17. Carolina Casualty's policy provides that it will cover expenses related to defense of an insured in a proceeding before a licensing board only "if such legal fees, costs, or expenses are incurred after notice is first received by the Insured during the Policy Period." *Id.* Carolina Casualty explains that Ott received notice of the bar grievance no later than November 6, 2007, which was the date he responded to the bar grievance, and that date occurred before the beginning of the policy period on April 16, 2008. *Id.* Ott has not responded to this argument. Accordingly, Carolina Casualty should not be obligated to reimburse Ott for defense costs incurred in the bar grievance proceedings and declaratory judgment should be entered in Carolina Casualty's favor.

Accordingly, it is hereby **ORDERED** that Plaintiff Carolina Casualty Insurance Company's Motion for Summary Judgment (Dkt.17) is **GRAN-**

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**TED.** Declaratory judgment is hereby granted as follows: Carolina Casualty has no duty to defend or indemnify Dennis G. Ott and Dennis G. Ott P.S. in the McCoy matter under the insurance policy at issue in this case and is not obligated to reimburse Ott for defense costs incurred in the bar grievance proceedings. This case is dismissed.

The Clerk is directed to send uncertified copies of this Order to all counsel of record and to any party appearing *pro se* at said party's last known address.

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(Cite as: 2008 WL 2065835 (S.D.Tex.))

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Only the Westlaw citation is currently available.

United States District Court,  
S.D. Texas,  
Corpus Christi Division.  
Dr. Max GOUVERNE, Plaintiff,

v.

CARE RISK RETENTION GROUP, INC., Defendant.

Civil Action No. 2-07-206.  
May 13, 2008.

Paul Dodson, Huseman, Dodson & Hummell, Corpus Christi, TX, for Plaintiff.

Larry D. Thompson, Robert G. Smith, Jr., Lorange & Thompson, PC, Houston, TX, for Defendant.

**MEMORANDUM OPINION & ORDER**

JOHN D. RAINEY, District Judge.

\*1 Pending before the Court is Defendant Care Risk Retention Group, Inc.'s ("Care") Motion for Summary Judgment (Dkt.# 33). After considering the motion, response and applicable law, the Court is of the opinion that the motion should be DENIED.

**Factual Background**

Plaintiff brought a breach of contract lawsuit against Care based on the cancellation of his professional liability insurance policy. Care cancelled the policy because Plaintiff failed to disclose a potential medical malpractice claim on his insurance application.<sup>FN1</sup> Specifically, Plaintiff performed a facelift on Cheryl Harned on March 11, 2004 in his surgical suite ("Harned Incident").<sup>FN2</sup> Harned experienced a hematoma during the surgery, which Plaintiff corrected at that time. After Harned was discharged, Plaintiff received a telephone call from her. He went to her hotel room and observed an even larger hematoma. Plaintiff took Harned to the hospital where he attempted to evacuate the hematoma.

The anesthesiologist administering paralytic drugs could not secure an airway, and Harned turned blue. Plaintiff attempted an emergency tracheotomy. Blood obstructed Harned's throat and Plaintiff cut down with a scalpel, mistaking her vertebrae for her trachea. He broke the scalpel off in her vertebrae and applied the tracheostomy hook with such force that he fractured two of Harned's vertebrae. Plaintiff learned the next morning that she could not move her left side.

FN1. Dkt. # 36, Ex.1, PL 00018.

FN2. See Operative Report, Dkt. # 33, Ex. 1 and Ex. 12, p. 4 for all the details of the Harned Incident.

On June 27, 2004, Plaintiff received an email from Harned, which he maintains caused him to believe that he would not be sued by Harned. The email stated, in part:

This brings up the whole subject of "blame". All my family concurs with me that you should NEVER have been put in the position you were put in to do the tracheotomy. Once you were in the situation, you are guilty only of doing everything possible to save my life. Yes, there have been a horde of issues that happened because of what you did and how you did it. Nevertheless, I expect to sing and talk and swallow and run as good as before, or at least close to that. From day one, I believed in you and trusted you not only with my life, but also with my hopes for my future. You never have, and never will, violate my trust.<sup>FN3</sup>

FN3. Dkt. # 36, Ex. 1, PL 00035.

Plaintiff received a records request for Harned's records on May 26, 2005,<sup>FN4</sup> which according to Care, should have alerted Plaintiff that a medical malpractice lawsuit was possible.

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FN4. Dkt. # 33, Ex. 2.

In August 2005, Plaintiff submitted his application for a professional liability insurance policy with Care, in which Plaintiff failed to disclose the Harned Incident. Plaintiff signed four different forms, which Care argues demonstrate, as a matter of law, that Plaintiff misrepresented material facts and/or breached warranties of the policy:

(1) Application for Prior Acts Coverage, signed on August 12, 2005, asked Plaintiff "Do you have knowledge or information of any potential or actual claim or suit that may be brought against you or of any incidents?" Plaintiff answered "No." Above the signature line was written: "I declare that I know of no potential or actual claims, suits or incidents presently pending which have not been reported to my previous carrier(s) ... I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL, AND COMPLETE. I UNDERSTAND THAT IF PRIOR ACTS COVERAGE IS OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION, IT IS VOID." FN5

FN5. *Id.* Ex 3.

\*2 (2) Applicant's Authorization and Certification, signed on August 12, 2005, stated above the signature line: "ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL, AND COMPLETE. I UNDERSTAND THAT: (1) IF THE POLICY IS ISSUED, THIS IS DONE BY CARE IN RELIANCE UPON THESE REPRESENTATIONS, AND (2) ANY POLICY OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION IS VOID." FN6

FN6. *Id.* Ex. 4; Plaintiff signed this same Authorization and Certification again on August 22, 2005. *Id.* Ex. 7.

(3) Application for Professional Liability Insurance for Physicians and Surgeons, signed on August 22, 2005, asked "ARE YOU AWARE OF ANY ACTS, ERRORS, OMISSIONS OR CIRCUMSTANCES WHICH MAY RESULT IN A MALPRACTICE CLAIM OR SUIT BEING MADE OR BROUGHT AGAINST YOU?" Plaintiff answered "No." Above the signature line, the Application also provided: "WARRANTY: It is warranted to the Insurer that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein." FN7

FN7. *Id.* Ex. 6, CARE 00047. Plaintiff signed the same application and gave the same negative response to the above question on October 12, 2005. *Id.* Ex. 9.

(4) Statement of No Known Claims/Losses, signed on August 22, 2005 declared that Plaintiff: "(1) ha[d] no known losses or claims that have not been reported to my prior insurance carrier; (2) ha[d] no knowledge or information relating to a MEDICAL INCIDENT which could reasonably result in a claim, that has NOT been reported to a prior insurance carrier; (3) ha[d] no knowledge of ANY REQUEST FOR MEDICAL RECORDS which might result in a claim...." FN8

FN8. *Id.* Ex. 8. Plaintiff signed the same form again on October 12, 2005. *Id.* Ex. 10.

The policy issued on August 19, 2005, and the relevant provisions provided:

*General Terms, Conditions and Exclusions:*

"In consideration of payment of the premium and in reliance upon the statements made in the Application, which is made a part of and deemed attached to this Policy and which you and the Insureds warrant as being true, complete and accurate ... we agree as follows [insuring provisions]" FN9

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FN9. *Id.* Ex. 5, p. 3-4.

*Definitions:*

“Application ... All such applications, attachments and materials are deemed attached to and incorporated into this Policy. YOU WARRANT THAT ALL SUCH INFORMATION IS TRUE, COMPLETE AND ACCURATE.”  
FN10

FN10. *Id.* at 5.

*Representations and Severability:*

“In issuing this Policy, we relied upon the statements and representations in the Application. The Insureds warrant that all such statements and representations are true and deemed material to the acceptance of risk or the hazard assumed by us under this Policy.”

“The Insureds agree that in the event any such statements or representations are untrue, this Policy will not afford any coverage with respect to any Insured who knew the facts that were not truthfully disclosed in the Application, ...”  
FN11

FN11. *Id.* at 20.

Plaintiff asserts January 13, 2006 was the first time he realized a claim related to the Harned Incident would be filed against him. On that date, he received a letter from Harned's attorney giving him statutory notice that a medical malpractice claim was being filed against him.<sup>FN12</sup> The lawsuit was filed on February 16, 2006 and Plaintiff submitted a claim to Care.<sup>FN13</sup> After being notified about the claim on March 14, 2006, a Care representative sent Plaintiff a reservation of rights letter on March 21, 2006. Care withdrew its defense on April 28, 2006, rescinded the policy and refunded Plaintiff's premium.<sup>FN14</sup> Plaintiff brought the instant lawsuit on March 22, 2007.

FN12. Dkt. # 36, Ex. 1, PL 000357.

FN13. *Id.* at PL 000258.

FN14. *Id.* at PL 000118.

\*3 Care now seeks summary judgment arguing Plaintiff warranted that his responses were true and correct, and the warranty formed the basis of Care issuing coverage. Plaintiff's warranty was a condition precedent to coverage under the policy, which has not been satisfied. Also, based on the outrageous medical events that took place, Plaintiff was aware that the incident “could” or “may” result in a claim against him as described in the Care application. Plaintiff's failure to disclose this incident was a misrepresentation that was “material to the risk” and “contributed to the contingency or event on which the policy became due and payable.” TEX. INS.CODE § 705.004. Plaintiff asserts that genuine issues of material fact exists as to Care's breach of warranty and misrepresentation defenses.

**Summary Judgment Standard**

Summary judgment is proper if “the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” FED. R. CIV. P. 56(c); *Christopher Village, L.P. v. Retsinas*, 190 F.3d 310, 314 (5th Cir.1999). The mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment, there must be an absence of any genuine issue of material fact. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). An issue is “material” if its resolution could affect the outcome of the action. *Daniels v. City of Arlington, Tex.*, 246 F.3d 500, 502 (5th Cir.2001), *cert. denied*, 534 U.S. 951, 122 S.Ct. 347, 151 L.Ed.2d 262 (2001).

The moving party bears the initial burden of informing the court of all evidence demonstrating the absence of a genuine issue of material fact.

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*Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). Only when the moving party has discharged this initial burden does the burden shift to the non-moving party to demonstrate that there is a genuine issue of material fact. *Id.* at 322. If the moving party fails to meet this burden, then they are not entitled to a summary judgment and no defense to the motion is required. *Id.*

“For any matter on which the non-movant would bear the burden of proof at trial ..., the movant may merely point to the absence of evidence and thereby shift to the non-movant the burden of demonstrating by competent summary judgment proof that there is an issue of material fact warranting trial.” *Transamerica Ins. Co. v. Avenell*, 66 F.3d 715, 718-19 (5th Cir.1995); *Celotex*, 477 U.S. at 323-25. To prevent summary judgment, the non-movant must “respond by setting forth specific facts” that indicate a genuine issue of material fact. *Rushing v. Kan. City S. Ry. Co.*, 185 F.3d 496, 505 (5th Cir.1999).

When considering a motion for summary judgment, the Court must view the evidence in the light most favorable to the non-movant and draw all reasonable inferences in favor of the non-movant. *In re Segerstrom*, 247 F.3d 218, 223 (5th Cir.2001); *Samuel v. Holmes*, 138 F.3d 173, 176 (5th Cir.1998). The court must review all of the evidence in the record, but make no credibility determinations or weigh any evidence, disregard all evidence favorable to the moving party that the jury is not required to believe, and give credence to the evidence favoring the nonmoving party as well as to the evidence supporting the moving party that is uncontradicted and unimpeached. *Willis v. Moore Indep. Sch. Dist.*, 233 F.3d 871, 874 (5th Cir.2000). However, the non-movant cannot avoid summary judgment simply by presenting “conclusory allegations and denials, speculation, improbable inferences, unsubstantiated assertions, and legalistic argumentation.” *TIG Ins. Co. v. Sedgwick James of Wash.*, 276 F.3d 754, 759 (5th Cir.2002); *Little v.*

*Liquid Air Corp.*, 37 F.3d 1069, 1075 (5th Cir.1994) (en banc).

## Discussion

### A. Misrepresentation

\*4 Care argues that Plaintiff's failure to disclose the Harned Incident on his insurance application was a misrepresentation that was “material to the risk” and “contributed to the contingency or event on which the policy became due and payable.” TEX. INS.CODE § 705.004. Chapter 705 of the Texas Insurance Code deals with “Misrepresentations by Policyholders.” Specifically, § 705.004 addresses misrepresentations in a policy application and provides the following:

(a) An insurance policy provision that states that false statements made in the application for the policy or in the policy make the policy void or voidable:

(1) has no effect; and

(2) is not a defense in a suit brought on the policy.

(b) Subsection (a) does not apply if it is shown at trial that the matter misrepresented:

(1) was material to the risk; or

(2) contributed to the contingency or event on which the policy became due and payable.

(c) It is a question of fact whether a misrepresentation made in the application for the policy or in the policy itself was material to the risk or contributed to the contingency or event on which the policy became due and payable.

Thus, the Texas Insurance Code allows an insurer to void coverage based on a misrepresentation on the insurance application if the misrepresentation was material to the risk and contributed to the event on which the policy became due. The Texas Supreme Court has held that five elements must be pled and proved before an insurer may deny cover-

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age because of a misrepresentation on an application for insurance: (1) a representation by the insured, (2) falsity of the representation; (3) reliance thereon by the insurer; (4) intent to deceive by the insured, and (5) materiality of the representation. *Mayer v. Mass. Mut. Life Ins. Co.*, 608 S.W.2d 612, 616 (Tex.1980). Fact issues generally exist as to the materiality of the representation and the insured's intent to deceive. *Id.* at 616; *Cartusciello v. Allied Life Ins. Co. of Tx.*, 661 S.W.2d 285, 288 (Tex.App.-Houston [1st Dist.] 1983, no writ).

In the instant case, Plaintiff has presented evidence creating a fact question as to whether Plaintiff intended to deceive Care on his application for insurance. Plaintiff denies that he had an intent to deceive Care. Based on his communications with Harned, he claims he did not believe that she would sue him.<sup>FN15</sup> Further, he maintains if he did believe a lawsuit was possible he would have filed a claim with his previous insurance carrier before the policy expired. He repeatedly asserts that when he signed the Care insurance application, he did not anticipate that he would be sued by any of his patients. Thus, he believed he was truthfully answering all of Care's inquiries.

FN15. Dkt. # 36, Ex. 1, Affidavit of Dr. Max Gouverne.

#### B. Warranty

Care also asserts that Plaintiff breached the warranty that the statements in his application were true, which was a condition precedent to coverage under the policy. In an insurance contract, a warranty is a statement made by the insured, which is susceptible of no construction other than that the parties mutually intended that the policy should not be binding unless such statement be literally true. *Lane v. Travelers Indem. Co.*, 391 S.W.2d 399, 402 (Tex.1965). Generally, provisions in insurance contracts that turn on the truth or falsity of answers in an insurance application are treated as representations because warranties which cause forfeiture are disfavored under Texas law. *Allied Bankers Life Ins. Co. v. De La Cerda*, 584 S.W.2d 529, 532

(Tex.Civ.App.-Amarillo 1979, writ ref 'd n.r.e.). However, a policy provision that expressly provides that coverage does not exist unless the applicant's statements are true operates as a warranty or condition precedent. *Riner v. Allstate Life Ins. Co.*, 131 F.3d 530, 536-37 (5th Cir.1997) (inserting an unambiguous warranty "demonstrating that the parties intended the contract to rise or fall on the literal truth of an insured's certification" available under Texas law as a condition precedent to coverage); *Cartusciello*, 661 S.W.2d at 287 (recognizing that certificates of insurance may be so worded so that warranties of good health are established). When the term in question is susceptible of only one reasonable construction, the courts must give the words their plain meaning. *Puckett v. U.S. Fire Ins. Co.*, 678 S.W.2d 936, 938 (Tex.1984).

\*5 In the instant case, the policy could not state any more clearly that the insured warranted, as a condition of coverage, that the statements he has provided in his application were true, complete and accurate. Specifically, the Application, signed by Plaintiff, provided: "WARRANTY: It is warranted to the Insurer that the information contained herein is true and that is shall be the basis of the policy of insurance and deemed incorporated therein."<sup>FN16</sup> The policy also explicitly included the warranty language in the insuring clause (i.e. "in reliance upon the statements made in the Application, which is made a part of and deemed attached to this Policy and which you and the Insureds warrant as being true, complete and accurate"<sup>FN17</sup>). Additionally, the Definitions section defined "Application" as ... "All such applications, attachments and materials are deemed attached to and incorporated into this Policy. YOU WARRANT THAT ALL SUCH INFORMATION IS TRUE, COMPLETE AND ACCURATE."<sup>FN18</sup> Finally, the Representations provision clearly stated: "In issuing this Policy, we relied upon the statements and representations in the Application. The Insureds warrant that all such statements and representations are true and deemed material to the acceptance of risk or the hazard assumed by us under this Policy. The Insureds agree

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that in the event any such statements or representations are untrue, this Policy will not afford any coverage with respect to any Insured who knew the facts that were not truthfully disclosed in the Application, ..." <sup>FN19</sup> Thus, Care has included warranty language in the application and policy, incorporated the application into the policy, and conditioned coverage on the truthfulness of the statements in the insurance application. See *Lane v. Travelers Indem. Co.*, 391 S.W.2d 399, 402 (Tex.1965) (finding no warranty because there was no express declaration in the policy regarding warranties, there was no provision that the policy would only be effective if the statements were true and there was no provision that the policy would be void if the statements were untrue).

FN16. Dkt. # 33, Ex. 6, CARE 00047.

FN17. *Id.* Ex. 5, pp. 3-4.

FN18. *Id.* at 5.

FN19. *Id.* at 20.

While the Court finds that a warranty exists in the policy, a question of fact still exists as to whether Plaintiff breached the warranty by providing untruthful information in his application. Plaintiff warranted that the responses in his application were true, complete and accurate. Care maintains that Plaintiff provided an untrue response to the question "are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you," to which he responded "No." <sup>FN20</sup> The literal truth of this question hinges, at least in part, on the insured's subjective belief that a suit may be brought against him. A New York district court confronted a similar issue when an insurer sought to void coverage based on a misrepresentation in the application because the insured answered "No" to the question "whether any facts or circumstances had occurred in the past year 'that might give rise to a claim or suit.'" *Chicago Ins. Co. v. Halcond*, 49 F.Supp.2d 312, 315 (S.D.N.Y.1999). Finding an is-

sue of fact, the *Halcond* court reasoned, "the carrier's question to the prospective insured call[ed] for the applicant's opinion or otherwise evoke[d] his or her state of mind. In those circumstances, the applicant's response cannot be said to be a misrepresentation unless the applicant has not truthfully portrayed his or her mental state." *Id.*

FN20. *Id.* Ex. 6, CARE 00047 (emphasis added).

\*6 According to Plaintiff, he did not believe that a suit would be brought against him by any of his patients at the time he signed the Care application. While the outrageous medical facts and the patient's record request could have alerted Plaintiff to the possibility of a lawsuit, Plaintiff's belief, based on the lapse of time and his communications with the patient, that a suit would not be brought against him is certainly relevant and creates a fact issue for the jury to consider. <sup>FN21</sup>

FN21. This same holding applies to the warranties made in the Statement of No Known Claim/Losses (i.e. Plaintiff declared he "ha[d] no knowledge or information relating to a MEDICAL INCIDENT which could reasonably result in a claim, that has NOT been reported to a prior insurance carrier; (3) ha[d] no knowledge of ANY REQUEST FOR MEDICAL RECORDS which might result in a claim...."). *Id.* Ex. 8.

#### Conclusion

For these reasons, the Court finds genuine issues of material fact as to whether Plaintiff made misrepresentations in his insurance application or breached any warranties under the policy by giving untrue responses in his application. Accordingly, Defendant Care Risk Retention Group, Inc.'s Motion for Summary Judgment (Dkt.# 33) is DENIED.

It is so ORDERED.

S.D.Tex.,2008.

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END OF DOCUMENT

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Only the Westlaw citation is currently available.

United States District Court,  
S.D. Ohio,  
Western Division.  
SCHWARTZ MANES RUBY & SLOVIN, L.P.A.,  
Plaintiff,  
v.  
MONITOR LIABILITY MANAGERS, LLC and  
Carolina Casualty Insurance Company, Defendants.

No. 1:09cv790.  
Aug. 17, 2011.

Donald Bernard Hordes, Robert Goldman Block,  
Schwartz, Manes & Ruby, Cincinnati, OH, for  
Plaintiff.

Timothy Brian Schenkel, Freund Freeze & Arnold,  
Cincinnati, OH, Michelle Mary Bracke, Lewis Bris-  
bois Bisgaard & Smith LLP, Chicago, IL, for De-  
fendant.

ORDER GRANTING DEFENDANTS' MOTION  
FOR SUMMARY JUDGMENT AND DEFEND-  
ANTS' MOTION TO STRIKE THE EXPERT AF-  
FIDAVIT OF THOMAS CHATHAM  
SUSAN J. DLOTT, Chief Judge.

\*1 This matter is before the Court on the Mo-  
tion for Summary Judgment of Defendants Monitor  
Liability Managers, LLC ("Monitor") and Carolina  
Casualty Insurance Company ("Carolina")  
(collectively, "Defendants") (doc. 18) and Defend-  
ants' Motion to Strike the Expert Affidavit of  
Thomas Chatman (doc. 25). For the following rea-  
sons, both motions are GRANTED.

#### I. BACKGROUND<sup>FN1</sup>

FN1. Except as otherwise indicated, back-  
ground facts are drawn from Defendants'  
proposed undisputed facts (doc. 20) to the

extent they are admitted in SMRS's re-  
sponse thereto (doc. 31).

In April of 2002, Plaintiff Schwartz Manes  
Ruby & Slovin, L.P.A. ("SMRS") was retained to  
represent Barbara Kissel in connection with a prop-  
erty dispute filed by her stepmother, Clara Kissel;  
that case was captioned *Kissel v. Kissel*, Kenton  
County Circuit Court, 02 CI 0792 (the "Kissel mat-  
ter"). SMRS associate Harry Sudman originated the  
Kissel matter. Because Sudman was not licensed to  
practice law in Kentucky, he assigned the Kissel  
matter to another SMRS associate, David Snyder.  
(Levin Aff. ¶ 18.)<sup>FN2</sup> Snyder left SMRS in 2003. (  
*Id.* ¶ 15.) Sudman left SMRS in October of 2005. (  
*Id.*) From April 5, 2002 through September 15,  
2004, SMRS billed 11.96 hours to the Kissel mat-  
ter. (Doc. 26-1, Ex. L.) And after September 15,  
2004, no SMRS attorney performed work on the  
Kissel matter.

FN2. The Affidavit of Debbe Levin is at-  
tached as Exhibit A to Plaintiff's Opposi-  
tion Memorandum, doc. 21-1 at 2-7.

In 2005, SMRS failed to appear at the sched-  
uled trial in the Kissel matter. On March 14, 2006,  
the Kentucky court entered judgment in favor of  
Clara Kissel and against Barbara Kissel. On March  
17, 2008, SMRS returned the remainder of Barbara  
Kissel's retainer. Upon receiving the check from  
SMRS, Barbara Kissel retained new counsel, Paul  
Vesper. On May 29, 2008, Vesper requested a copy  
of Kissel's file from SMRS. On June 15, 2008, Ves-  
per informed SMRS that the Kissel file contained a  
notice notifying SMRS of the 2005 trial date. He  
further informed SMRS that the Kentucky court  
had entered judgment in Clara Kissel's favor. Ves-  
per then asked for an explanation as to why SMRS  
failed to represent Barbara Kissel in the 2005 trial.

SMRS received Vesper's letter on June 18,  
2008. Based on this letter, SMRS attorney Debbe  
Levin undertook an internal investigation into the

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firm's representation of Barbara Kissel. (Levin Aff. ¶ 11.) Levin obtained a copy of the docket for the Kissel matter from the Kenton County Circuit Court. (*Id.* ¶ 12.) Levin was unable to determine whether any attorney at SMRS received notice from the court regarding the 2005 trial date. (*Id.* ¶ 17.) Levin's investigation revealed the following: Snyder returned the Kissel file to Sudman when Snyder left SMRS in 2003; Sudman asked Cincinnati attorney Geoffrey Damon to take the Kissel matter when Sudman left SMRS in October of 2005 (*id.* ¶ 20); and Damon had no recollection of talking with Sudman about the Kissel case and denied that he had agreed to take over the file. (*id.* ¶ 21). On July 10, 2008, SMRS notified its insurance agent, Fred Wittenbaum of SP Agency, that Barbara Kissel might assert a legal malpractice claim against it.

\*2 On July 24, 2008, Carolina issued Lawyers Professional Liability Policy Number 9849712 to SMRS for the policy period of June 29, 2008 to June 29, 2009 (the "Carolina Policy").<sup>FN3</sup> Although SMRS did not receive a written copy of the Carolina Policy until on or about August 6, 2008 (Levin Aff. ¶ 25), SMRS was informed in documents dated June 12, 2008 and June 24, 2008 that a "copy of the Proposal Forms and a specimen copy of the Policy Form" could be downloaded from Defendants' website (doc. 26-1 at 17-30).

FN3. The Carolina Policy is attached as Exhibit C to Defendants' Answer, Doc. 3-3 at 4-11.

The relevant portion of the Carolina Policy reads as follows:

#### I. Insuring Agreement

This policy shall pay on behalf of the Insured all Damages and Claims Expenses that the Insured shall become legally obligated to pay, arising from any Claim first made against an Insured during the Policy Period and reported to the In-

surer in writing during the Policy Period or within 60 days thereafter, for any Wrongful Act, provided that prior to the inception date of the first Lawyer's Professional Liability Insurance Policy issued by the Insurer to the Named Insured, which has been continuously renewed and maintained in effect to the inception of this Policy Period, the Insured did not know, or could not reasonably foresee that such a Wrongful Act might reasonably be expected to be the basis of a Claim.

(Doc. 3-3 at 5.) The Carolina Policy defines "Claim" as "a written demand for monetary or non-monetary relief, including, but not limited to, a civil, criminal, administrative or arbitration proceeding.... A Claim shall be deemed to have been first made at the time notice of the Claim is first received by any Insured." (Doc. 3-3 at 6.) The Carolina Policy defines "Wrongful Act" as "any actual or alleged act, omission, or Personal Injury arising out of Professional Services rendered by an Insured or by any person for whose acts or omissions the Insured is legally responsible." (Doc. 3-3 at 7.)

On January 18, 2009, Barbara Kissel filed suit against SMRS, Sudman, and Snyder in Kenton County Circuit Court; that case was captioned *Kissel v. Schwartz Maes & Ruby Co., L.P.A., et al*, Kenton County Circuit Court, 09 CI 165. In that case, Barbara Kissel claims that SMRS committed legal malpractice by, *inter alia*, failing to appear at her 2005 trial and failing to disclose the resulting adverse judgment. Defendants initially undertook defense of the malpractice action under a reservation of rights, and later withdrew representation and denied coverage on SMRS's claim. (Doc. 2-1 at 17.)

On September 30, 2009, SMRS filed a complaint against Defendants in state court, seeking a declaratory judgment that Defendants are obligated to provide SMRS with a defense and coverage in the malpractice action. (Doc. 1-1.) Defendants timely removed the suit to this Court on October 29, 2009. (Doc. 1.) On March 7, 2011, Defendants

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moved for summary judgment on SMRS's claims. (Doc. 18.) Defendants argue that summary judgment should be granted because the undisputed facts show that prior to the effective date of the Carolina Policy, SMRS could have reasonably foreseen that Barbara Kissel might make a malpractice claim against the firm.

## II. SUMMARY JUDGMENT STANDARD

\*3 Summary judgment is appropriate if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. See Fed.R.Civ.P. 56(c). On a motion for summary judgment, the movant has the burden of showing that no genuine issues of material fact are in dispute, and the evidence, together with all inferences that can permissibly be drawn therefrom, must be read in the light most favorable to the party opposing the motion. See *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 585–87, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986). The moving party may support the motion for summary judgment with affidavits or other proof or by exposing the lack of evidence on an issue for which the non-moving party will bear the burden of proof at trial. See *Celotex Corp. v. Catrett*, 477 U.S. 317, 324, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986).

In responding to a summary judgment motion, the nonmoving party may not rest upon the pleadings but must go beyond the pleadings and “present affirmative evidence in order to defeat a properly supported motion for summary judgment.” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 257, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). The nonmoving party “must set forth specific facts showing there is a genuine issue for trial.” Fed.R.Civ.P. 56(e). The task of the Court is not “to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial.” *Liberty Lobby*, 477 U.S. at 249. A genuine issue for trial exists when the evidence is not “so one-sided that one party must prevail as a matter of law.” *Id.* at 252.

## III. ANALYSIS

Defendants' Motion for Summary judgment is GRANTED because (A) the Carolina Policy's foreseeable claim exception is binding on SMRS; (B) the Carolina Policy unambiguously excludes any claim arising out of a wrongful act occurring prior to the effective date of the policy if the insured knew or could have reasonably foreseen that such act might be the basis of a claim; and (C) the undisputed facts show that prior to the effective date of the Carolina Policy, SMRS knew or could have reasonably foreseen that SMRS's handling of the Kissel matter might be the basis of a claim. Defendants' Motion to Strike the Expert Affidavit of Thomas Chatman is GRANTED because Chatham's interpretation of the Carolina Policy is not an appropriate topic for expert testimony.

### A. SMRS is Bound by the Carolina Policy's Foreseeable Claim Exception.

In response to Defendants' Motion for Summary Judgment, SMRS claims that it is not bound by the foreseeable claim exception found in the Carolina Policy's Insuring Agreement because it did not see this language until after the insurance coverage commenced. This argument is unavailing. Although SMRS did not receive a written copy of the Carolina Policy until on or about August 6, 2008, SMRS was informed in documents dated June 12, 2008 and June 24, 2008 that a “copy of the Proposal Forms and a specimen copy of the Policy Form” could be downloaded from the Defendants' website. The policy forms and the specimen copy remained relatively unchanged and freely available for review. Further, although SMRS did not receive its written policy until August 6, 2008, nothing in the record indicates that SMRS took issue with the policy's language until more than a year later when it filed the pending Complaint against Defendants.

\*4 Second, SMRS was familiar with this type of claims-made policy and the foreseeable claim exception contained therein. For five years prior to its purchase of the Carolina Policy, SMRS had a professional liability insurance policy through Zurich. The Zurich Policy, like most professional

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liability policies, contained foreseeable claim exception language similar to that contained in the Carolina Policy.<sup>FN4</sup> For these reasons, SMRS is bound by the foreseeable claim exclusion contained in the Carolina Policy.

FN4. The language in the Zurich Policy "Insuring Agreement" reads as follows: "It is a condition precedent to coverage under this policy that the act or omission occurred: 1. during the Policy Period; or 2. prior to the Policy Period, provided that all of the following four conditions are met: a) the Insured did not notify any prior insurer of such act or omission or Related Act or Omission; and b) prior to the inception date of the first policy issued by the Company if continuously renewed, no Insured had any basis (1) to believe that any Insured had breached a professional duty; or (2) to foresee that any such act or omission or Related Act or Omission might reasonably be expected to be the basis of a Claim against any insured." (Zurich Policy, doc. 26-1, at (I)(A)).

#### B. The Carolina Policy is Not Ambiguous.

SMRS next argues that it is not bound by the foreseeable claim exception because the Carolina Policy is ambiguous and susceptible to multiple interpretations. Specifically, SMRS argues that the Carolina Policy can be read to provide coverage for claims made in the first policy year even if the insured could have foreseen the claim prior to the policy's inception date. (Doc. 21 at 13.)

As a preliminary matter, this case is before the Court on diversity jurisdiction, and consequently, Ohio law applies. See *Erie R. Co. v. Tompkins*, 304 U.S. 69, 78 (1939); *Westfield Ins. Co. v. Tech Dry, Inc.*, 336 F.3d 503, 506 (6th Cir.2003). When interpreting an insurance policy, words and phrases "must be given their natural and commonly accepted meaning." *U.S. Fed. & Guar. Co. v. Lightning Rod Mut. Ins. Co.*, 80 Ohio St.3d 584, 687 N.E.2d 717, 719 (Ohio 1997); see also *Watkins v. Brown*,

97 Ohio App.3d 160, 646 N.E.2d 485, 487 (Ohio Ct.App.1994) ("[c]ontract terms are to be given their 'natural and usual' meaning if they are not defined in the policy, unless it is clear from the policy that the parties intended to use some specialized or technical definition").

Generally, provisions susceptible to more than one interpretation "will be construed strictly against the insurer and liberally in favor of the insured." *King v. Nationwide Ins. Co.*, 35 Ohio St.3d 208, 519 N.E.2d 1380, 1380-81 (6th Cir.1988). However, this rule of construction is inapplicable where policy language is "unambiguous or where ambiguity can be resolved through ordinary rules of interpretation." *Scott v. Am. Nat'l Fire Ins. Co., Inc.*, 216 F.Supp.2d 689, 693 (N.D. Ohio 2002). Furthermore, "an ambiguity does not arise merely because the parties disagree regarding the interpretation of specific provisions." *Westport Ins. Corp. v. Coffman*, No. C2-05-1152, 2009 WL 243096, \*4 (S.D. Ohio Jan.29, 2009). An interpretation that renders any provision of the policy meaningless or is inconsistent with the intent of the policy is not reasonable and does not constitute an "ambiguity" requiring construction. *Hedmond v. Admiral Insur. Co.*, No. 02AP-910, 2003 WL 21791589, \*6 (Ohio App. Aug. 5, 2003). Nor can the court interpret the policy in a manner which would result in an extension of coverage. *United States v. A.C. Strip*, 868 F.2d 181, 185 (6th Cir.1989).

Here, SMRS argues that the ambiguity exists in the italicized phrase:

\*5 This policy shall pay on behalf of the Insured all Damages and Claims Expenses that the Insured shall become legally obligated to pay, arising from any Claim first made against an Insured during the Policy Period and reported to the Insurer in writing during the Policy Period or within 60 days thereafter, for any Wrongful Act, provided that prior to the inception date of the first Lawyer's Professional Liability Insurance Policy issued by the Insurer to the Named Insured, *which has been continuously renewed and*

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*maintained in effect to the inception of this Policy Period*, the Insured did not know, or could not reasonably foresee that such a Wrongful Act might reasonably be expected to be the basis of a Claim.

(Doc. 3-3 at 5 (emphasis added.)) SMRS argues that this phrase can be interpreted to mean that Carolina is "relieved of its obligation to cover and defend against pre-coverage claims made against an insured only in cases where there had been a history of coverage through successive Carolina liability policies written on behalf of the insured with seamless renewals contract after contract ." (Doc. 21 at 13-14.) SMRS also argues that the policy can be read to provide coverage for claims made in the first policy year even if the insured could have foreseen the claim prior to the policy's inception date.

This interpretation is inconsistent with both the plain language and the intent of the policy. First, the plain language of the Carolina Policy provides that the foreseeable claim exception applies if the insured's notice of a wrongful act predates inception of the first policy issued by Carolina. Second, the intent of the policy language is to exclude from coverage wrongful acts of which the insured had notice and which the insured could have reasonably foreseen prior to the inception date of the policy. SMRS's suggested reading would render the exclusion meaningless for any claim made during the first year of the policy. Such a construction is impermissible. For these reasons, the Court finds that the Carolina Policy unambiguously excludes any claim arising out of a wrongful act occurring prior to the effective date of the policy if the insured knew or could have reasonably foreseen that such act might be the basis of a claim.

#### **C. The Carolina Policy Excludes from Coverage Kissel's Malpractice Claim.**

Defendants contend that prior to the inception date of the Carolina Policy, SMRS had knowledge of circumstances which could reasonably be expected to give rise to a claim against it and, consequently, there is no duty to defend or indemnify

SMRS in the underlying malpractice suit. SMRS contends that the reasonableness of its beliefs is a factual issue that cannot be resolved on summary judgment.

As discussed in the previous section, the Carolina Policy excludes from coverage any claim arising out of a wrongful act that occurred prior to the effective date of the policy if SMRS knew or could have reasonably foreseen that such act might be the basis of a claim. The policy period began on June 29, 2008. The undisputed facts show that prior to the policy period, SMRS knew that (1) SMRS was counsel of record for Barbara Kissel at all relevant times during the Kissel matter, (2) SMRS did not appear at Barbara Kissel's 2005 trial, (3) judgment was entered against Barbara Kissel on March 14, 2006, and (4) Barbara Kissel's new counsel believed SMRS was responsible for the adverse judgment. Given these circumstances, the Court finds that SMRS either knew or could have reasonably foreseen that SMRS's handling of the Kissel matter might be the basis of a malpractice claim. The undisputed facts render any failure to appreciate the potential claim entirely unreasonable. Because SMRS either knew or could have reasonably foreseen that SMRS's handling of the Kissel matter might be the basis of a malpractice claim, the Carolina Policy excludes from coverage the underlying malpractice suit.

#### **D. The Chatham Report is Not Admissible.**

\*6 Defendants also move to strike the affidavit of SMRS's expert, Thomas Chatham. (Doc. 25.) Defendants contend that Mr. Chatham's opinion regarding the interpretation and application of the Carolina Policy is not an appropriate topic for expert testimony.

"The interpretation of an insurance contract involves a question of law to be decided by a judge." *Leber v. Smith*, 70 Ohio St.3d 548, 553, 639 N.E.2d 1159 (1994). Where an insurance contract is unambiguous, "it is error to allow expert testimony regarding the meaning of the contract." *The Way Int'l Inc. v. Executive Risk Indem., Inc.*, No. 3:07cv294,

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2009 WL 3157402, \*4-5 (S.D. Ohio Jan. 27, 2009). Given this Court's conclusion that the Carolina Policy is unambiguous, it is clear that evidence of a contrary opinion is inadmissible. *See id.; Thomas Noe, Inc. v. Homestead Ins. Co.*, 173 F.3d 581, 583 (6th Cir. 1999) (holding that, where an insurance policy exclusion was unambiguous, evidence of an expert witness's conclusion to the contrary is not admissible).

#### IV. CONCLUSION

For the foregoing reasons, both Defendants' Motion for Summary Judgment (doc. 18) and Defendants' Motion to Strike the Expert Affidavit of Thomas Chatham (doc. 25) are GRANTED.

IT IS SO ORDERED.

S.D. Ohio, 2011.  
Schwartz Manes Ruby & Slovin, L.P.A. v. Monitor  
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**C**

This case was not selected for publication in the Federal Reporter.

Not for Publication in West's Federal Reporter See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also Ninth Circuit Rule 36-3. (Find CTA9 Rule 36-3)

United States Court of Appeals,  
 Ninth Circuit.  
 TEXAS FARMERS INSURANCE COMPANY,  
 Plaintiff–Counter–Defendant–Appellant,  
 v.  
 LEXINGTON INSURANCE COMPANY, Defendant–Counter–Claimant–Appellee.

No. 08–55835.

Argued and Submitted Oct. 8, 2009.

Filed May 21, 2010.

**Background:** Primary insurer brought action against excess insurer, seeking declaration as to insurers' responsibility for amount of settlement in insured's underlying medical malpractice action. The United States District Court for the Central District of California, Dean D. Pregerson, J., declared that primary insurer was responsible for full amount of settlement. Primary insurer appealed.

**Holdings:** The Court of Appeals held that:

- (1) insured's diabetes was "occurrence" triggering coverage under primary occurrence policy;
- (2) primary insurer was responsible for full amount of settlement of claim under occurrence policy;
- (3) patient's \$3.2 million settlement did not exhaust primary occurrence insurer's \$5 million per-claim liability limit so as to trigger coverage under insurer's excess reinsurance policy; and
- (4) excess insurer was not obliged to "follow the settlement" and pay share of primary insurer's settlement obligation.

Affirmed.

## West Headnotes

**[1] Insurance 217 ↪2275**

## 217 Insurance

## 217XVII Coverage—Liability Insurance

## 217XVII(A) In General

## 217k2273 Risks and Losses

217k2275 k. Accident, occurrence or event. Most Cited Cases

Under California law, insured's diabetes had progressed to point of causing kidney damage that should have been detected by her physicians had they not failed to seek nephrology consult, and thus, was "occurrence" triggering coverage under insured's primary occurrence policy.

**[2] Insurance 217 ↪2268**

## 217 Insurance

## 217XVII Coverage—Liability Insurance

## 217XVII(A) In General

## 217k2267 Insurer's Duty to Indemnify in

General

217k2268 k. In general. Most Cited Cases

Under California law, settlement of patient's claims in her underlying medical malpractice action against insured, a health care organization, included patient's negligence claim against doctor arising out of eye surgeries, as well as claim that organization's negligent treatment of patient's diabetes caused her kidney damage requiring her to undergo dialysis, and thus, primary insurer was responsible for full amount of settlement of claim under occurrence policy.

**[3] Insurance 217 ↪2396**

## 217 Insurance

## 217XVII Coverage—Liability Insurance

217XVII(B) Coverage for Particular Liabilities

217k2394 Excess and Umbrella Liability Coverage

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217k2396 k. Scope of coverage. Most Cited Cases

Patient's \$3.2 million settlement of her medical malpractice claim against health care organization did not exhaust primary occurrence insurer's \$5 million per-claim liability limit, and thus, coverage under insurer's excess reinsurance policy was not triggered.

[4] Insurance 217 ↪ 3615

217 Insurance

217XXXII Reinsurance

217k3613 Coverage

217k3615 k. Following fortunes, form, and settlement. Most Cited Cases

Under California insurance law, excess insurer was not primary insurer's reinsurer in connection with settlement of patient's medical malpractice action against health care organization in underlying action, and thus, was not obliged to "follow the settlement" and pay share of primary insurer's settlement obligation.

\*605 Patrick M. Howe, Esquire, Shea Stokes, San Diego, CA, Peter Owen Israel, Esquire, Robert Axel Olson, Esquire, Greines Martin Stein & Richland, LLP, Los Angeles, CA, for Plaintiff-Counter-Defendant-Appellant.

James R. Rogers, Esquire, Law Office of James R. Rogers, Solana Beach, CA, Vanessa Ann Countryman, Gibson, Dunn & Crutcher LLP, Washington, DC, Richard J. Doren, Esquire, Blaine H. Evanson, Julian Wing-Kai Poon, Esquire, Counsel, Gibson Dunn & Crutcher, LLP, Los Angeles, CA, for Defendant-Counter Claimant-Appellee.

Appeal from the United States District Court for the Central District of California, Dean D. Pregerson, District Judge, Presiding. D.C. No. 06-cv-8220-DDP-AJW.

Before: KLEINFELD and TALLMAN, Circuit Judges, and LAWSON,<sup>FN\*</sup> District \*606 Judge.

FN\* The Honorable David M. Lawson, United States District Judge for the Eastern District of Michigan, sitting by designation.

#### MEMORANDUM<sup>FN\*\*</sup>

FN\*\* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

\*\*1 Texas Farmers Insurance Company appeals from a summary judgment granted by the district court declaring that Texas Farmers is responsible for the full amount of a settlement of a medical malpractice claim. We have jurisdiction pursuant to 28 U.S.C. § 1291, and affirm.

Like the district court, we view this case as a dispute between a primary insurer (Texas Farmers) and an excess insurer (defendant Lexington Insurance Company), even though Lexington did not have a direct relationship with the insured, Kaiser Permanente. The actual excess carrier, Ordway Indemnity Ltd., which provided a \$10 million excess policy to Kaiser, ceded the risks involved in this case to Lexington by means of a "following-form" facultative reinsurance policy that Lexington issued to Ordway. Lexington, therefore, stood in Ordway's place with respect to the claims made by the underlying plaintiff. The central issue in the case focuses on the event(s) that triggered coverage under the respective policies and the claims that were included in the settlement.

It is undisputed that the malpractice plaintiff, Janice Kupukaa, who suffered from diabetic retinopathy, underwent two eye surgeries at Kaiser Permanente of Hawaii on July 9, 2001 and November 6, 2001, and those surgeries left her blind. It also is undisputed that Ms. Kupukaa had been treating with Kaiser Permanente for diabetes beginning in the late 1990s. On April 9, 1999, Texas Farmers issued to Kaiser Permanente a claims-made policy—transformed into an occurrence policy by

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endorsement—covering a one-year period with a liability limit of \$5 million per claim, and renewed the policy for another year. It reduced its coverage to \$1 million per claim on April 9, 2001, effective through April 9, 2002. Lexington (through Ordway) did not come on the risk until the 2001–2002 policy period. The district court properly characterized the legal issue as whether Texas Farmers's coverage was triggered prior to April 9, 2001, when the \$5 million liability limit was in effect, and before Lexington came on the risk.

When Janice Kupukaa and her husband, Joseph, filed their lawsuit against Kaiser Permanente and Dr. Steven Miller, their complaint was based entirely on Dr. Miller's negligence in performing the 2001 eye surgeries. But when the case moved to arbitration, the record is clear that the parties stipulated to add the claim that Kaiser Permanente's negligent treatment of Ms. Kupukaa's diabetes before 2001 caused kidney damage requiring her to undergo dialysis. There is no dispute that during her treatment at Kaiser Permanente, Ms. Kupukaa developed diabetic nephropathy that required dialysis and proliferative diabetic retinopathy that required eye surgery. So at the time of the settlement on February 28, 2007, both claims were on the table and both were resolved by the settlement agreement, in which the Kupukaas agreed to release "all claims which are, or might have been, the subject matter of the Arbitration." ER 435–36.

\*\*2 Texas Farmers argues that its retained defense counsel in the underlying tort case did not think much of the kidney damage claim, and the main purpose of the settlement was to discharge the eye surgery claim. It insists therefore that there is a factual dispute over which claims were settled. It also contends that even if the kidney damage claim were included in the settlement, there is no evidence that the \*607 claim arose before the 2001–2002 policy period because the occurrence language in its policy requires that the injury manifest itself during the coverage period. Texas Farm-

ers contends further that a claim for interrelated wrongful acts will be considered to have been made "on the earliest date written notice of such Claim is received by any Insured," Appellant's Br. at 31 (quoting ER 340), which was after April 9, 2001. Neither the relevant policy language, the record, nor the law favors these arguments.

First, Texas Farmers' policy "applies to claims or suits brought as a result of Wrongful Acts ... and/or Occurrences which take place during the Coverage Period." ER 393. The determination of the occurrence date is subject to the "Interrelated Wrongful Act" provision; interrelated wrongful acts are wrongful acts or occurrences "which are logically or causally connected and have as a common nexus any fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, events or transactions. Any such Interrelated Wrongful Acts shall be deemed to have happened at the time of the first Wrongful Act within those Interrelated Wrongful Acts." *Id.* at 367. Texas Farmers conceded in the district court that the kidney damage claims and the eye surgery claims were interrelated wrongful acts.

[1] Second, Texas Farmers's policy defines "occurrence" to mean "an accident." ER 370. There is no reference in the policy to a manifestation requirement. Applying California law (which the parties agree applies here), we have held that coverage under an occurrence policy is triggered when "the complaining party was actually damaged," not when the wrongful act was committed. *Smith v. Hughes Aircraft Co.*, 22 F.3d 1432, 1440 (9th Cir.1994), superseding 10 F.3d 1448 (quoting *Chu v. Canadian Indem. Co.*, 224 Cal.App.3d 86, 274 Cal.Rptr. 20, 25–26 (1990)). The record in this case shows that Ms. Kupukaa's diabetes had progressed to the point of causing kidney damage that should have been detected by her physicians in 1999 and 2000, had they not failed to seek a nephrology consult. SER 110–13, 115–21. That evidence is not disputed in this record.

[2] Third, as mentioned, the settlement docu-

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ments show that the settlement in this case included all the claims, including the kidney damage claims. Texas Farmers cites *Safeco Ins. Co. of Am. v. Sup. Ct.*, 140 Cal.App.4th 874, 881, 44 Cal.Rptr.3d 841 (2006), for the proposition that the scope of an insurer's duty to indemnify can remain open when the underlying dispute is resolved by settlement. True enough. But when a case settles, "the insurer's obligation to pay and the determination of coverage must be based upon the facts inherent in the settlement and, because this is a summary judgment proceeding, the undisputed facts." *In re Feature Realty Litig.*, 468 F.Supp.2d 1287, 1295 (E.D.Wash.2006). Although Texas Farmers insists that the eye surgery claim was the motive force behind Kaiser Permanente's willingness to settle, it is undisputed that the settlement included the kidney damage claim as well.

**\*\*3 [3]** Fourth, the "Interrelated Wrongful Act" provision establishes the trigger-of-coverage date "at the time of the first Wrongful Act," which in this case was prior to the 2001–2002 policy period. The argument that the effective trigger date is when the first written notice of a claim was received ignores the fact that Texas Farmers issued an endorsement that superseded the claims-made language and converted the contract to an occurrence policy. Therefore, Texas Farmers's \$5-million-per-claim liability limit was in effect on the imputed loss date. Because the \$3.2 million \*608 settlement with the Kupukaas did not exhaust the primary coverage, Ordway's excess policy—and Lexington's reinsurance obligation—were not triggered.

[4] Texas Farmers argues that as a reinsurer, Lexington was obliged to "follow the settlement" and pay a share of the obligation. The district court held that the follow-the-settlement doctrine did not apply in this situation, and we agree. That doctrine "prevents facultative reinsurers 'from second guessing good-faith settlements and obtaining de novo review of judgments of the reinsured's liability to its insured.'" *Nat'l Am. Ins. Co. v. Certain Under-*

*writers at Lloyd's London*, 93 F.3d 529, 535 (9th Cir.1996) (quoting *North River Ins. Co. v. CIGNA Reins. Co.*, 52 F.3d 1194, 1199 (3d Cir.1995)). Lexington was not Texas Farmers's reinsurer, and therefore it could incur no liability to Texas Farmers under the follow-the-settlement doctrine.

Finally, Texas Farmers argues for the first time on appeal that Ordway was not an excess carrier and that its coverage was concurrent, thereby creating a contribution obligation under the "other insurance" clause for losses exceeding \$1 million in primary coverage. We generally do not entertain an appellate argument that was not "raised sufficiently for the trial court to rule on it." *Arizona v. Components, Inc.*, 66 F.3d 213, 217 (9th Cir.1995) (internal citation and quotation marks omitted). "[A]rguments not raised by a party in its opening brief are deemed waived." *Smith v. Marsh*, 194 F.3d 1045, 1052 (9th Cir.1999) (citing *Brookfield Communications, Inc. v. West Coast Entm't Corp.*, 174 F.3d 1036, 1046 n. 7 (9th Cir.1999)).

Lexington has filed a motion to strike Texas Farmers's reply brief because it raises new arguments. We do not reach those arguments, having found them to be waived. The motion to strike the reply brief is denied as moot. The judgment of the district court is **AFFIRMED**.

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