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The Executive Summary

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A Wiley Rein & Fielding LLP Report on Developments Affecting Professional Liability Insurers

Trustee is an Entity Distinct from the Debtor for Purposes of the I v. I Exclusion

The United States Bankruptcy Court for the Southern District of New York recently concluded that a trustee is an entity separate and distinct from the debtor for purposes of the insured versus insured exclusion in a directors and officers liability policy. *In re County Seat Stores, Inc.,* 280 B.R. 319 (Bankr. S.D.N.Y. 2002).

The trustee of a corporation in bankruptcy under Chapter 11 commenced an adversary proceeding against seven former directors and officers of the debtor company, seeking damages in excess of $100 million. National Union denied coverage on the grounds that the trustee stands in the shoes of the debtor, and the exclusion for claims by one insured against another therefore bars coverage. The trustee and the directors and officers argued that the I v. I exclusion did not "extend to trustees in bankruptcy, in part because the trustee is not the same entity as the pre-petition company and also because the purpose of the [I v. I] clause-to prevent collusive suits-is not implicated." The trustee further argued that because the I v. I exclusion did not specifically define the term "insured" to include bankruptcy trustees, the exclusion was ambiguous.

The court first found that the I v. I language was not ambiguous since the "crucial language in the exclusion is 'brought by' which focuses solely on the identity of the party asserting the claim. If the trustee is asserting the claim, the exclusion is not triggered because he is not the company or an insured."

The court further agreed with the trustee in finding that it is a legal entity separate and distinct from the debtor: "When the trustee commences an action therefore, he is doing so on behalf of the estate in furtherance of his duty [under the Bankruptcy Code]. The fact that the claims that compromise the estate may have arisen pre-petition in favor of the debtor is inconsequential."

The court also noted that had the debtor not been in bankruptcy and had brought these same claims, "without doubt, the insured v. insured exclusion would apply to bar the claim because [the debtor] is an insured under the policy and is the 'Company' identified in the policy." However, the trustee is "an independent entity, acting as a genuinely adverse party to the defendant, officers and directors, [so] there is no threat of collusion."

The court further rejected National Union's assertion that trustees are akin to assignees and successors-in-interests, whose claims would be barred by the I v. I exclusion, reasoning that the trustee's position as an officer of the court and statutory entity did not implicate similar fears of collusion. ✦

Also in This Issue

Amended Complaint Does Not Constitute a New Claim

The U.S. Court of Appeals for the Fifth Circuit has held that (1) the addition of a negligent representation claim in an amended complaint does not constitute a new claim under a claims-made D&O policy, and (2) the insured officer's duty to notify the insurer was triggered by the initial filing of the action against him, and his failure to timely report the claim precluded coverage. *National Union Fire Ins. Co. v. Willis*, 2002 WL 1369092 (5th Cir. June 25, 2002).

The insurer sought a declaratory judgment that an officer was not entitled to coverage under any of its claims-made directors and officers policies in connection with a suit alleging fraud and tortious interference with contract that was first filed in 1998. The applicable policies covered the time period of March 1998 to March 1999, March 1999 to March 2000 and March 2000 to March 2001. In 2000, the plaintiffs filed a fourth amended petition, adding a claim for negligent misrepresentation against the insured. National Union was first notified of the lawsuit in February 2000. The insurer denied coverage, asserting that because National Union was not notified of the lawsuit until 2000, the claims were not timely reported.

The insured officer asserted that he was not required to notify the insurer until the fourth amended complaint since the earlier petitions asserted intentional torts that fell outside of the policy coverage. Thus, the insured claimed, the 2000 notification of the claim after the amended fourth complaint was under the 2000 policy. The court disagreed and found that the amended claim, which was based on the same facts as the alleged original complaint, was part of the initial lawsuit that fell under the 1998 policy. Thus, the insured should have given notice to the insurer "in 1998 when he was first made aware of circumstances that could reasonably be expected to give rise to a claim against him."

Moreover, the court found that in determining whether the original complaint was "potentially" covered, it was not necessary to undertake an analysis of whether a "reckless" act is equivalent to a "deliberate" act. "The gist of the original petition's factual allegations are that [the officer] made misrepresentations… These factual allegations are enough to implicate the 1998 policy." "Whether a director or officer ultimately is found to have committed a wrongful act based on the legal theory of tortious conduct, be it intentional or negligent, is irrelevant for requiring notification under the claims-made policy in this case." ✦

D&O Policy Proceeds Are Property of Bankruptcy Estate, But Directors Obtain Reimbursement of Defense Fees

A bankruptcy court in Massachusetts granted two directors' motion to lift the automatic stay in order to obtain payments from a directors and officers liability insurer for defense fees incurred in an action brought by a Chapter 7 trustee. *In re Cybermedica, Inc.*, 280 B.R. 12 (Bankr. D. Mass. 2002). The bankruptcy court found that the D&O policy at issue was property of the bankruptcy estate because it provided entity coverage but ruled that there was cause to lift the automatic stay to permit the directors to seek payments for defense fees.

A bankruptcy trustee brought suit against several directors of Cybermedica, Inc. and a hospital, seeking the return of the proceeds from several alleged fraudulent transfers from Cybermedica to the hospital and damages for asserted misrepresentations, breach of fiduciary duty, and deceptive and unfair trade practices. The directors sought coverage for the trustee's action, including payment of defense costs, under a directors and officers liability policy that provided direct coverage to the directors and officers as well as indemnification and entity coverage to Cybermedica. The insurer, Certain Underwriters at Lloyd's, London, agreed to pay the directors' defense costs; however, the trustee opposed the distribution of the D&O policy proceeds. Accordingly, the directors filed a motion to lift the automatic stay to permit them to seek payments for defense costs under the policy. The bankruptcy court granted the motion.

The court first held that the policy and its proceeds constituted property of the bankruptcy estate. The court reviewed the relevant case law and observed that the majority view is that the policy is the property of the estate. It also noted that courts disagree regarding whether the policy's proceeds are property of the estate. The court distinguished the case law, such as *Louisiana World Exposition, Inc. v. Federal Ins. Co. (In re Louisiana World Exposition Inc.)*, 832 F.2d 1391, 100-1401 (5th Cir. 1987), that holds that the proceeds of a D&O policy are not the property of the estate on the ground that the policies in those cases did not provide entity coverage to the debtor. The court reasoned that the proceeds of the policy at issue were the property of debtor's bankruptcy estate because the policy provided direct coverage to the debtor and thus the estate would be worth more with the policy proceeds included therein.

Having determined that the policy proceeds were property of the estate and that the automatic stay applied, the court determined that cause existed to grant the directors relief from the automatic stay. The court reasoned that the directors would be irreparably harmed if they

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No Coverage for Affirmative Claims Made by Insured

In a recent unpublished opinion, the California Court of Appeal found that a judge charged with misconduct by the California Commission on Judicial Performance (CJP) was not entitled to insurance coverage under a Judges' Professional Liability Insurance Policy for the legal expenses incurred in a suit she initiated against the CJP. *Patricia Gray v. Underwriters at Lloyd's, London*, 2002 Cal. App. LEXIS 6621 (Cal. App. Ct., 1st Dist. July 19, 2002).

During a March 2000 judicial election, the policyholder judge distributed campaign literature that was critical of her opponent. After her opponent filed a complaint with the CJP, the CJP commenced an investigation against her. The CJP gave notice to the policyholder of formal CJP proceedings for "willful misconduct in the office, conduct prejudicial to the administration of justice, improper action and dereliction of duty...[under] the California Constitution, providing for removal, censure or admonishment." The policyholder filed suit in federal court to enjoin the CJP proceedings. She tendered a claim for coverage for the fees incurred in the federal action under the Judges' Professional Liability Insurance Policy.

The insurer contended that the policy covered only claims and expenses incurred in *defending* proceedings brought by or before the CJP. The court agreed with the insurer and found that the insurance policy provided coverage for a defense to an action brought by or before the CJP, but did not obligate the insurer to prosecute a separate federal court action on behalf of the insured to halt CJP proceedings commenced against the insured. The court agreed, noting that "[w]hatever the meaning of 'defend' is consulted, we find no definition that includes 'prosecute.'... One word connotes reaction, while the other connotes initiation." Thus, the fees for the prosecution of an independent action brought against the CJP by the policyholder were not covered under the policy. ✦

Action Brought by Trustee to Enforce Judgment Against Insured Director Is Core Proceeding

The United States District Court for the District of Maine denied an insurer's motion to withdraw the reference and held that an action by a bankruptcy trustee to enforce a consent judgment against the insured director of the debtor was a core proceeding to be decided in bankruptcy court. *Executive Risk Indem., Inc. v. Brooks (In re Jackson Brooks Inst., Inc.)*, Adv. Proc. No. 02-2009 (Bankr. D. Me. July 31, 2002).

An action by a bankruptcy trustee against a director of the debtor was ultimately settled by the parties. The settlement provided that the parties would enter a stipulated judgment against the director and that the director would assign his indemnity claims to the trustee. The parties submitted the settlement to the bankruptcy court for approval, and the director's liability insurer opposed the settlement. In addition, the insurer filed an insurance coverage action against the director in the district court. The director removed the case to the bankruptcy court and filed a motion to dismiss, maintaining that the trustee was the real party in interest. The insurer then sought to withdraw the reference of the coverage action to the bankruptcy court and move the case back to district court. In the meantime, the trustee filed suit against the insurer in the bankruptcy court to enforce the underlying judgment. The bankruptcy court stayed all proceedings pending the resolution of the motion to withdraw the reference.

The district court considered numerous factors to resolve the motion to withdraw the reference. As an initial matter, the district court observed that although the coverage litigation does not "arise under the bankruptcy code," the underlying liability action arose, in part, under the bankruptcy code, and the trustee's action to enforce the bankruptcy judgment was within the bankruptcy court's jurisdiction. Further, the district court accepted the director's argument that the coverage action filed by the insurers was "in essence" a defense to the trustee's action to enforce the judgment. The district court also found that judicial economy supported the resolution of the action to enforce the judgment and the coverage action in the same forum since the same coverage issues would be litigated in both suits. The court also reasoned that the bankruptcy court had jurisdiction over both actions to enforce its judgments as well as to address any ancillary proceedings. Further, the debtor's and creditors' resources would be conserved if the litigation occurred in one forum, and, according to the district court, the litigation of both actions in the bankruptcy court would promote uniformity of bankruptcy administration and discourage forum shopping. Lastly, the insurer did not request a trial by jury. ✦

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Underwriting Documentation Required to Prove Materiality of Misrepresentation in Rescission Action

The federal court in Manhattan, applying New York law, recently ruled that to prevail on summary judgment in a rescission action, an insurer must provide documentary support, in the form of underwriting guidelines, manuals, or rules, for its contention that the alleged misrepresentations at issue were material. *Chicago Ins. Co. v. Kreitzer & Vogelman, et al.*, No. 97-CIV-08619 (RWS), 2002 WL 1446622 (S.D.N.Y. July 17, 2002). In so holding, the court rejected the insurer's argument that underwriting documentation need only be supplied if available.

In completing an application for malpractice insurance, an attorney failed to disclose that he was the subject of a disciplinary proceeding and that he was aware of numerous potential claims. After the attorney sought coverage for a legal malpractice claim, the insurer filed suit seeking a declaration that the policy was void *ab initio* as a result of material misrepresentations in the application.

The court denied the insurer's initial motion for summary judgment because the insurer failed to prove as a matter of law that the misrepresentations in the application were material. The court indicated that the insurer's submission of an affidavit of the underwriter regarding materiality was insufficient and that the insurer needed to provide documentary support for its materiality claim to prevail on summary judgment. Accordingly, the insurer filed a second motion for summary judgment, submitting an affidavit of an underwriting director. The affidavit reaffirmed that the insurer would not have issued the policy had it been aware of the true facts and indicated that there were no guidelines or policies in effect regarding the issue. In fact, the affiant stated that the guidelines leave the issue to the discretion of the underwriter. The insurer argued that documentary support for an insurer's claim that a misrepresentation is material is necessary only if such proof is available. The court rejected this argument and indicated that some proof beyond conclusory statements of an underwriter is necessary to prevail on summary judgment in a rescission action. ✦

Failure to Reveal Embezzlement Justifies Rescission

The United States Court of Appeals for the Fourth Circuit has ruled that the failure to reveal the embezzlement of $800,000 of client funds entitled an insurer to rescind a legal malpractice policy. *Westport Ins. Co. v. The Lydia S. Ulrich Testamentary Trust. et al.*, 2002 U.S. App. LEXIS 15354 (4th Cir. July 31, 2002).

The plaintiffs sought coverage under a legal malpractice liability policy issued to Craig Dunbar. Dunbar was an attorney formerly representing the plaintiffs. While serving as attorney for the plaintiffs, he embezzled over $800,000 of the clients' funds.

Dunbar apparently stole some of the money prior to his application for the legal malpractice liability policy. The policy application asked whether the insured was "aware of any circumstance, act, error, omission, or personal injury which might be expected to be the basis of a legal malpractice claim or suit..." Dunbar answered "no" to the question. Although plaintiffs conceded that Dunbar's answer was "material to the risk assumed," they argued that Dunbar's answer was nevertheless true, for Dunbar was not necessarily aware that his embezzlement would give rise to an actual legal malpractice claim.

The Fourth Circuit rejected the plaintiffs' argument because "the embezzlement of over $800,000 is a circumstance that 'might be the basis of a legal malpractice claim.'" The court therefore found that Dunbar was surely aware at the time of the application of at least "circumstances" that might be the basis of a legal malpractice claim.

Additionally, the Fourth Circuit rejected the plaintiffs' argument that the relevant question in the policy application created an ambiguity that must be construed against the insurer. The plaintiffs claimed that the language of the application suggested that the question was concerned "with claims brought by claimants, and leaves no space for acts, etc. that might become a claim." However, the Fourth Circuit noted that the policy application clearly stated that "[t]his form must be completed in its entirety for each claim or incident." Since the court found no doubt that "incidents" include circumstances that have not yet become a claim, Dunbar was required to report these circumstances on the application. ✦

Notice During Renewal Policy Period Deemed Sufficient

In an unpublished opinion, the United States Court of Appeals for the Ninth Circuit found that coverage existed for a claim made during a claims-made and reported policy period even though notice occurred during a later renewal policy period. *Oliver v. Coregis Ins. Co.*, 2002 U.S. App. LEXIS 14602 (9th Cir. July 9, 2002).

The plaintiff brought suit against the insurer seeking coverage for the amount of the malpractice judgment it obtained against its former attorney, an insured under the relevant policies. The plaintiff made his claim against the insured during the first period, and provided notice of the claim to the insurer during the period of a later renewal policy. The insurer argued that the notice did not satisfy the terms of the policy, which required that claims be made and reported during the relevant policy period.

The court found that an ambiguity existed as to when notice must be given; the applicable policy provision stated that coverage is limited to "claims which are first made against the named insured and reported to the company while the policy is in force." The court, construing the language in light most favorable to the insured, found that "a claim made and reported during the renewal period is made and reported while 'the policy is in force,' because the renewal is a 'renewal of' the original policy and not a new or different policy." ✦

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Legal Malpractice Actions Are Not Related; Aggregate And Not Per Claim Limit Applies

A federal court in Ohio recently ruled that three legal malpractice claims arising from an attorney's negligence in creating a corporation were not sufficiently related to constitute one claim under a professional liability policy. *Scott v. Am. Nat'l Fire Ins. Co.*, No. 5: 02-CV-0516, 2002 U.S. Dist. LEXIS 15688 (N.D. Ohio Aug. 19, 2002). Accordingly, the court determined that the policy's aggregate limit of liability and not its per claim limit of liability applied to the malpractice claims.

The insured attorney represented a golf equipment corporation and two investors in connection with the creation of the corporation. After the corporation failed, allegedly as a result of the insured's negligence, the investors and the corporation brought legal malpractice actions against the insured. The investors maintained that the insured failed properly and timely to incorporate the corporation, causing the investors to incur personal liability. The corporation claimed that the insured failed to transfer intellectual property rights in certain golf equipment and ensure that the United States Golf Association approved the golf equipment prior to the creation of the corporation. In the ensuing coverage litigation, the parties disputed whether the policy's limit of $200,000 per claim applied or whether the allegations gave rise to multiple claims, thus implicating the policy's $600,000 aggregate limit.

The court held that the aggregate limit of liability applied to the malpractice action because the actions did not constitute one claim under the policy. The relevant provision of the policy provided that "Claims alleging, based upon, arising out of or attributable to the same or related acts, errors, or omissions shall be treated as a single claim..." The court determined that the three actions were unrelated because the insured owed separate duties to the corporation and the two investors. Moreover, the court found that the corporation and investors each had "separate rights" that should have been protected by the insured. Lastly, the court reasoned that the insured's conduct resulted in "different and discrete harms" to the corporation and the investors. ✦

Failure to Report Claims Arising During Policy Period Bars Coverage

A federal district court, applying Pennsylvania law, has held that no coverage exists under "claims made and reported" professional liability policies where the policyholder fails to report the claim in the period in which it first arose. *Pizzini, et al. v. American Int'l Specialty Lines Ins. Co.*, No. 99-CV-3297 (E.D. Pa. June 28, 2002).

In 1995, Stephen Barry Shellington, an agent of Equitable Life Assurance Society of the United States, sold certificates of interest in various oil wells to the plaintiffs. When the oil ventures failed, one group of plaintiffs sought repayment of their investments, contacting Shellington by letter on August 30, 1995, and filing suit in Pennsylvania state court in October, 1995. On January 17, 1996, Shellington gave notice of the plaintiffs' claims to American International Specialty Lines Insurance Co. ("AISLIC"), the issuer of Equitable's 1995 and 1996 professional liability insurance policies. Another group of plaintiffs thereafter filed suit in March 1996. After the state court consolidated the suits, the parties eventually reached a settlement in which Shellington assigned his rights under the insurance policies to the plaintiffs. AISLIC denied coverage, and the plaintiffs subsequently sued AISLIC for breach of contract and bad faith.

According to the court the notice-prejudice rule does not apply to claims-made policies under Pennsylvania law.

The 1995 and 1996 policies provided coverage on a "claims made and reported" basis, indemnifying "only if [the] Claim is first made against the Insured and reported in writing to the Insurer during the Policy Period." The policies deemed claims to arise when "the Insured shall have knowledge or become aware of any Wrongful Act which could reasonably be expected to give rise to a Claim." Where two or more claims arise out of a "single act, error or omission," the policies treated the claims "as a single Claim" which "shall be considered first made during the Policy Period… in which the earliest Claim… was first made." The 1995 policy covered the period from January 1, 1995 to January 1, 1996, and the 1996 policy covered the period from January 1, 1996 to January 1, 1997.

AISLIC argued that Shellington had failed to report the plaintiffs' claims in the policy period in which they were first made. The court agreed, holding that Shellington's failure to notify AISLIC of the claim during the 1995 policy period precluded coverage under the 1995 policy. It also held that the 1996 policy offered no coverage since the claims arose in 1995. The court noted that even though one group of plaintiffs had filed suit in 1996, their claim had arisen out of the same acts as the 1995 claims, and the policy thus treated both claims as arising in 1995.

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Insured Had Reasonable Basis to Foresee Legal Malpractice Action

A federal district court has granted summary judgment in favor of an insurer, holding that, under Pennsylvania law, an exclusion in a lawyer's professional liability policy precluded coverage where the lawyer could have reasonably foreseen prior to the effective date of the policy that a prior act or omission could form the basis of a future claim. *Washko v. Westport Ins. Corp.*, No. 01-CV-4026, 2002 U.S. Dist. LEXIS 13822 (E.D. Pa. July 24, 2002).

Westport issued Joseph Washko a professional liability insurance policy that provided coverage for claims made and reported from May 1, 1999 to May 1, 2000. The policy contained an exclusion for "any act, error, omission, circumstance or personal injury occurring prior to the effective date of this policy if any insured at the effective date knew or could have reasonably foreseen that such act, error, omission, circumstance or personal injury might be the basis of a claim."

From 1997 to 1998, Washko had represented a client in state criminal proceedings, culminating in the client's conviction. Following the conviction, the client fired Washko, obtained new counsel, and filed a motion for post-verdict relief, alleging ineffective assistance of counsel, prosecutorial misconduct, and trial court error. In connection with this motion, in an October 1998 hearing, Washko gave testimony on his representation of the client, and was aware of the allegations of ineffective assistance. Following Washko's testimony, the client's new counsel allegedly informed Washko that he was "out of the woods." In November of 1998, the judge issued an opinion granting the client a new trial, basing his decision solely on the grounds of ineffective assistance of counsel. Prior to Westport's issuance of the professional liability policy, Washko learned that the judge had granted the motion for post-conviction relief, but was not aware of the grounds for the judge's decision. In December, 1999, the client filed a legal malpractice suit against Washko, and Washko sought and was denied coverage and defense under the policy. Coverage litigation ensued.

The court ruled in favor of the insurer. In so doing, the court rejected Washko's argument that the prior knowledge exclusion did not apply since he had not been aware that a finding of ineffective assistance was the basis for the court's decision granting his former client a new trial. It also rejected the lawyer's reliance on the statement by the client's new counsel that he was "out of the woods." The court held that the determinative factor was not the attorney's actual belief, but whether a reasonable attorney in possession of the facts known to Washko would have had a basis to believe that a future claim might arise. Prior to the effective date of the policy, Washko had known that his former client had fired him and was arguing ineffective assistance of counsel; Washko had given testimony concerning his representation of the former client; and Washko had learned that the court had granted the former client a new trial. The court concluded that a reasonable attorney in possession of these facts would have had reason to believe that a future claim of legal malpractice might arise out of the representation of the former client. The court therefore granted summary judgment in favor of the insurer. ✦

Fiduciary Shield Doctrine: No Jurisdiction Over Director in Rescission Action

A federal court in Texas has held that, absent additional contacts with Texas, the defendant's status as a director or officer of a Texas corporation did not create personal jurisdiction over the director or officer in a rescission action. *Admiral Ins. Co. v. Briggs, et al.*, No. 3:02-CV-0310-P, 2002 U.S. Dist. LEXIS 12030 (N.D. Tex. July 2, 2002). The court denied another director's motion to dismiss, finding that it had personal jurisdiction because the underlying securities action alleged that the director committed an intentional tort in Texas.

The insureds, two directors of a Texas corporation, were named as defendants in the underlying securities and real estate fraud action and a derivative action. One of the insureds was a director of the corporation and a citizen of California. The other insured was the president and chief executive officer of the company and a citizen of Virginia. The insureds sought coverage for the underlying litigation under a directors and officers liability policy. The insurer denied coverage based on material misrepresentations in the application process and based on a breach of the cooperation clause. Thereafter, the insurer filed a coverage action in Texas federal court. Both insureds claimed that the Texas court lacked personal jurisdiction under the fiduciary shield doctrine because their only contacts with Texas were made in their capacity as directors and officers of the corporation. The fiduciary shield doctrine provides that a state cannot exercise personal jurisdiction over corporate directors and officers if their only contacts with the state arise out of activities undertaken in their capacity as directors and officers.

The court first observed that the transaction of business on behalf of a Texas corporation as a corporate director or officer is not sufficient to establish personal jurisdiction under the fiduciary shield doctrine unless the director or officer committed fraudulent or wrongful acts that are personally beneficial in his or her capacity as a corporate officer or director – the fraud/alter ego exception. With respect to the California insured, the court found that the insurer had not shown any additional contacts with Texas that would establish personal jurisdiction. Moreover, the court rejected the insurer's argument that the fraud/alter ego exception to the fiduciary shield doctrine should apply. The court so held because fraud must be pled with particularity, and the underlying complaints contained only bare allegations of fraud without any specific instances of fraud by the California insured. Moreover, the court rejected the insurer's

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Fiduciary Shield Doctrine: No Jurisdiction Over Director in Rescission Action

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argument that the court had personal jurisdiction because the California insured had purposefully availed himself of Texas insurance law by requesting a defense pursuant to Texas insurance law in the underlying Texas case.

The court, however, did find personal jurisdiction over the Virginia insured based on the allegations of the underlying litigation that the Virginia insured tortiously interfered with a Texas citizen's lien on Texas property. The court observed that the Texas long arm statute specifically provided for personal jurisdiction over a nonresident who commits a tort in Texas. Despite the Virginia insured's minimal contacts with Texas, the court found that committing an intentional tort in Texas and the fact that the coverage action related to or arose out of the intentional tort was sufficient to support the exercise of personal jurisdiction over the insured. In so holding, the court recognized that the fiduciary shield "is removed if the individual's personal interests motivate his actions." Moreover, the court found that traditional notions of fair play and justice supported the court's exercise of jurisdiction because the Virginia insured could have reasonably foreseen being brought into a Texas court as a result of committing an intentional tort in Texas and because Texas had a strong state interest in "redressing" injuries that occur in Texas. ✦

Insureds Had Basis to Anticipate Legal Malpractice Claim

A federal district court in Indiana has held that there is no coverage for a legal malpractice claim based on an exclusion in a professional liability policy that barred coverage for claims that the insured had a basis to anticipate prior to the inception of the policy. *General Ins. Co. of Am. v. Boyd, et al.*, No. IP-00-1431-C M/F, 2002 U.S. Dist. LEXIS 13276 (S.D. Ind. July 9, 2002). The court applied an objective standard to determine the reasonableness of the insureds' belief regarding whether a claim would result.

The insureds were two attorneys who represented a couple as plaintiffs in an alleged race discrimination case. During the prosecution of the discrimination case, the junior attorney repeatedly violated discovery rules and orders of the court. As a result, in March 1999, the court dismissed the discrimination case as a sanction under Rule 37(b)(2) and Rule 40(b) of the Federal Rules of Civil Procedure. The court's opinion expressly stated that the junior attorney displayed "a willful bad faith pattern of disregarding discovery orders." Moreover, the opinion cited several examples of the junior attorney's improper conduct and described the junior attorney as having an "indifferent attitude" regarding the discovery rules and the court's orders. Lastly, the court acknowledged that a legal malpractice suit would be an appropriate response to the dismissal and would lessen the harshness of the sanctions. The court ordered the insureds to provide a copy of the opinion to their clients. Thereafter, the insureds appealed the dismissal and continued to represent the clients in settlement negotiations.

In August 1999, the insureds submitted a renewal application for a professional liability policy. In the application, the senior attorney responded that no insureds were "aware of any circumstances or actual or alleged wrongful acts which could result in a professional liability claim." Two months after the inception of the policy, the clients informed the insureds that they were no longer interested in pursuing a settlement or the appeal. The clients then filed a legal malpractice action against the insureds and their law firm.

The professional liability insurer denied coverage for the legal malpractice action based on material misrepresentations in the application and an exclusion that barred coverage for claims arising out of wrongful acts which the insured had knowledge of or for a claim that the insured "had any basis to reasonably anticipate" prior to the inception of the policy. The insurer filed suit and sought a declaration that there was no coverage for the legal malpractice claim.

In ruling for the carrier, the court focused on the issue whether a reasonable lawyer in the insureds' position "would have had 'any basis' to anticipate that the dismissal of the underlying case might give rise to the...legal malpractice action" prior to the inception of the policy in August 1999. The court found that a reasonable lawyer would have anticipated the legal malpractice action because of (1) the dismissal of the discrimination action; (2) the court's criticisms of the junior attorney's conduct in its opinion; and (3) the court's acknowledgement that a legal malpractice action would be appropriate. Moreover, the court rejected the insureds' arguments that they had no basis to anticipate a claim because the clients did not express displeasure with their services prior to the inception of the policy; the issue was not whether the client intended to file a legal malpractice action, but rather whether the insureds had a reasonable basis to anticipate a claim. The insureds also argued that they had no basis to foresee a claim at the time the policy incepted because they believed that the dismissal would be reversed on appeal or that the discrimination action would settle. The court responded that neither event had occurred, and there was no guarantee that either event would occur at the time the insureds completed the application. ✦

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Lack of Timely Notice, Anticipated Claims Exclusion Bar Coverage

A Maryland federal court has held that no coverage exists under two professional liability policies because the policyholder failed to provide timely notice to the insurer and because the claim was barred by an exclusion precluding coverage for circumstances that the policyholder could have reasonably foreseen might be the basis of a claim. *Maynard v. Westport Ins. Co.*, 208 F. Supp. 2d 568 (D. Md. 2002).

Plaintiffs retained the attorney to process a Chapter 13 bankruptcy petition prior to foreclosure on their home. The attorney failed to timely file for Chapter 13, and the plaintiffs lost their home. The plaintiffs sued the attorney for malpractice and secured a default judgment against her.

The attorney was insured under two successive "claims made and reported" policies, the first from January 13, 1998 to January 13, 1999 ("Policy One") and the second from January 13, 1999 to January 13, 2000 ("Policy Two"). The insurer received notice of plaintiffs' legal malpractice claim against the attorney on April 6, 1999 when it received a copy of the plaintiffs' complaint filed with the District of Columbia Bar Counsel in April 1998. The insurer sent a letter to the attorney stating that it would likely deny coverage based on an exclusion ("Exclusion B") that precluded coverage for "any claim based upon, arising out of, attributable to, or directly or indirectly resulting from...[a]ny act, error, omission, circumstance...occurring prior to the effective date of this POLICY if an INSURED at the effective date knew or could have reasonably foreseen that such act, error, omission, circumstance...might be the basis of a CLAIM."

In their subsequent declaratory judgment action against the insurer, plaintiffs argued that the malpractice claim was covered under Policy One because plaintiffs initiated the D.C. Bar Counsel complaint within that policy period. The plaintiffs also asserted that although the insurer did not receive notice of the Bar Counsel complaint until April 1999, the attorney's belated notice did not result in a forfeiture of coverage because the insurer was not prejudiced by the delay.

The court rejected plaintiffs' arguments and found that the delay in notice precluded coverage under Policy One. According to the court, the language of the notice provision "clearly and unambiguously" mandates that a claim must be both made and reported to the insurer to fall within the coverage of the policy. Under such "claims made and reported" policies, the court held, the insurer does not need to demonstrate actual prejudice in order to deny coverage based on untimely notice.

According to the court, the language of the notice provision "clearly and unambiguously" mandates that a claim must be both made and reported to the insurer to fall within the coverage of the policy.

The court also found that coverage was precluded under the language of Exclusion B in Policy Two because "an objectively reasonable attorney knew or should have known that the Plaintiffs had a potential legal malpractice claim based upon their April 1998 letter to the Bar Counsel." The filing of the complaint should have therefore put the insured on notice prior to the effective date of Policy Two.

The court also rejected the plaintiffs' argument that the insurer waived its right to rely upon Exclusion B because it did not expressly deny coverage of the claim against the attorney. The court noted that the insurer sent a letter to the attorney stating that it would likely deny coverage based on Exclusion B one month after receiving notice of the claim. The letter also instructed the attorney that she should take all steps to avoid a default. Additionally, the court noted that the insurer sent three additional letters to the attorney informing her that the insurer would rely on Exclusion B to deny coverage. ✦

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Defense Required for Action Under Consumer Fraud Statute

A United States district court in Chicago has determined that a professional liability insurer must defend a suit under Illinois's Consumer Fraud Act because it could encompass claims for negligent conduct. *Connecticut Indemnity Co. v. Auto Europe, Inc., et al.*, 2002 U.S. Dist. LEXIS 14438 (N.D. Ill. Aug. 6, 2002).

DER Travel was insured under a travel agent's professional liability policy. The policy provided DER Travel with insurance coverage for "any negligent act, error, or omission of the insured or any other person for whose acts the named insured is legally liable in the conduct of travel agency operations..." DER Travel was named as a defendant in an action alleging that it violated the Illinois Consumer Fraud and Deceptive Business Practices Act by improperly calculating the value-added tax due on car rentals in Europe. It sought coverage for the suit under its policy. The insurer denied coverage under the policy on the grounds that the alleged fraud was intentional.

In the subsequent coverage suit, the United States District Court for the Northern District of Illinois found that the insurer did have a duty to defend DER Travel in the Consumer Fraud Act case. Noting that " '[i]f the complaint states a claim that is within, or even potentially or arguably within, the scope of coverage provided by the policy,' the insurer is obligated to defend the insured...", the court found that "[t]he insurer may properly refuse to defend only if it is clear from the face of the complaint that the alleged misconduct is not covered under the insurance policy."

The court found that the underlying complaint could encompass a claim for negligent misrepresentation. Since the Consumer Fraud Act does not require proof of intent to deceive, an innocent or negligent misrepresentation is sufficient to establish liability under the Consumer Fraud Act. Because the underlying complaint was ambiguous as to whether it alleged a violation of the Consumer Fraud Act through intentional or negligent misrepresentations, the court resolved this ambiguity in favor of the insured. ✦

Lack of Prejudice Bars Cooperation Clause Defense

In an unpublished opinion, the United States Court of Appeals for the Fourth Circuit, applying Maryland law, has held that the policyholder's failure to cooperate does not bar coverage where the insurer is not prejudiced as a result of the failure to cooperate. *Ball v. NCRIC, Inc.*, 2002 U.S. App. LEXIS 13932 (4th Cir. July 10, 2002). It also held that a demand letter can constitute a "claim."

The insured, a doctor, was sued by a patient for medical malpractice. The patient alleged that the doctor would prescribe certain drugs to her that would put her into a stupor and then have sex with her. Around the same period, in November 1987, the insured was arrested on separate charges of illegally selling narcotics. While free on bond, the doctor fled the country and did not return for his criminal court proceedings. The doctor was apprehended in May 1991.

The patient's attorney notified the doctor's legal malpractice insurer of her claim on December 14, 1987 by telephone and a hand delivered letter. The insurer had issued a claims-made policy and reported medical malpractice policy in force at that time. The insurer indicated that it would investigate the claim. After receiving these communications, the insurer attempted to contact the doctor telephonically at his home and at his office. The insurer also sent letters to several addresses soliciting the insured's cooperation, but was unable to contact him because of his fugitive status.

Approximately four years later, the patient filed a formal arbitration claim against the doctor before the Maryland Health Claims Arbitration Office. About one year later, the patient's attorney notified the insurer that the insured had been served and provided a claim statement and affidavit listing the insured's address in a federal prison. The insurer subsequently denied coverage for the claim on the ground that the claim was made outside the policy period. The insurer did not attempt to contact the doctor in prison.

In 1995, the patient obtained a default judgment against the doctor. She then brought an action against the insurer to collect the judgment. The carrier argued that there was no coverage under the policy for several reasons. First, it asserted that the insured breached his obligation to cooperate, and the insurer was prejudiced as a result. Second, it contended that it was prejudiced by the doctor's failure to notify it of the claim in a timely manner. Finally, the insurer argued that the operative claim was the filing of the Maryland Health Claims Arbitration matter, and it occurred after the expiration of the doctor's claims-made medical malpractice policy on January 1, 1988.

The Fourth Circuit rejected each of the insurer's arguments. With respect to the asserted lack of cooperation, the court reasoned that there was no evidence that the doctor's failure to cooperate while a fugitive hindered the insurer's ability to defend against the suit that ultimately was filed. Further, no evidence indicated that the doctor refused to cooperate after he was apprehended, particularly since the insurer never contacted him at that juncture. The court also concluded that the doctor's failure to give notice did not prejudice the insurer because the patient herself notified the insurer of the claim in 1987. Finally, the court rejected the argument that no claim was made during the policy period. According to the court, the terms "claim" and "suit" are not synonymous, and the letter in 1987 amounted to a demand that could constitute a "claim" for purposes of the policy. ✦

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D&O Policy Proceeds Are Property of Bankruptcy Estate, But Directors Obtain Reimbursement of Defense Fees

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were not permitted to exercise their contractual right to payment of defense costs. The court also acknowledged that any prejudice to the debtor was speculative because the debtor had made no claim for indemnification or entity coverage. Moreover, the court rejected the trustee's argument that there may be indemnification claims in the future, opining that the claims for which the insurer would be paying defense costs would be the same claims for which the directors would seek indemnification from the debtor. Thus, the insurer's payment of defense costs would minimize the potential exposure of the debtor. Lastly, the court rejected the trustee's argument that the personal profit and dishonesty exclusions would ultimately bar coverage under the D&O policy for defense fees and losses. The court refused to decide the coverage issues raised by the trustee, indicating that the insurer's payment of defense fees would be at its own peril. ✦

Failure To Report Claims Arising During Policy Period Bars Coverage

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The court rejected plaintiffs' argument that AISLIC had to demonstrate prejudice arising from Shellington's failure to give notice, holding that under Pennsylvania law, the notice-prejudice rule does not apply to claims-made policies. Likewise, the court refused to consult the text of one of AISLIC's insurance brochures which allegedly obfuscated the reporting requirement, holding that such a reference to extrinsic evidence was impermissible where the contract unambiguously precluded coverage. Finally, the court rejected the plaintiffs' estoppel and waiver arguments, concluding that although AISLIC had initially stated that coverage was available for the claims, AISLIC had reserved the right to deny coverage. According to the court, AISLIC could not waive a requirement directly addressing the policies' scope of coverage, and AISLIC's statements had not prejudiced Shellington, as he could not have remedied his failure to provide timely notice. ✦

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