Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | August 2017

Inviting a Second Bite at the Apple: Delaware Chancery Court Suggests New Approach to Evaluating Preclusive Effect of Prior Unsuccessful Derivative Litigation

In response to the Delaware Supreme Court's question in connection with remand, the Delaware Chancery Court has suggested reevaluation of its prior willingness to dismiss subsequent derivative litigation where an earlier derivative action has been dismissed due to demand futility. *In re Wal-Mart Stores, Inc. Delaware Derivative Litigation,* C.A. No. 7455-CB (consol.), supp. op. (Del. Ch. July 25, 2017). Where the court previously would dismiss subsequent efforts to re-litigate demand failure, the new approach suggested by the Chancery Court provides that an earlier action should not be given preclusive effect if it failed to survive a motion to dismiss pursuant to Delaware Chancery Court Rule 23.1, the Delaware analog to Federal Rule of Civil Procedure 23.1.

The case arose out of a series of derivative actions filed both in Arkansas and Delaware against a large

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Insurer Need Not Demonstrate Prejudice from Late Notice Under Claims Made and Reported Policy

The United States Court of Appeals for the Sixth Circuit, applying Ohio law, has held that an insurer does not need to show prejudice resulting from late notice under a claims made and reported policy in order to deny coverage. *McCarty v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa*, 2017 WL 2781561 (6th Cir. June 27, 2017). The court also held that an insurer does not have actual or constructive notice of a claim from a public court docket.

An attorney defending two clients in a breach of contract action failed to file an answer to the complaint, resulting in a default judgment being entered against the clients. The clients filed a malpractice claim against the attorney in January 2011. The attorney maintained a malpractice insurance policy for the claims made and reported policy period of February 2010 through February 2011. On December 8, 2011, ten months after the policy period had ended, the

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corporation. Multiple actions were consolidated in federal district court in Arkansas, and those actions were ultimately dismissed due to failure to allege demand futility. The actions filed in Delaware were likewise consolidated but proceeded more slowly, due in part to the fact that plaintiffs initially filed a books and records demand that had led to a Section 220 Delaware General Corporation Law proceeding alleging deficiencies in the defendant corporation's production. By the time that action was resolved and a consolidated derivative complaint was filed in Delaware, the Arkansas action had been dismissed. The defendants accordingly moved to dismiss the Delaware action based on collateral estoppel with respect to demand futility. The Chancery Court granted that motion.

On appeal, the Delaware Supreme Court ultimately issued a remand order, which asked the Chancery Court to address the following question:

> In a situation where dismissal by the federal court in Arkansas of a stockholder plaintiff's derivative action for failure to plead demand futility is held by the Delaware Court of Chancery to preclude subsequent stockholders from pursuing derivative litigation, have the subsequent stockholders' Due Process rights been violated? *See Smith v. Bayer Corp.,* 564 U.S. 299 (2011).

On remand, the Chancery Court began its analysis by noting that its prior decision was based in part on consideration of the Due Process issue, noting that case law nationally generally supported the notion that Due Process rights of the subsequent shareholders were deemed sufficiently protected, despite their status as non-parties to the first litigation, because courts were willing to conclude that the competing shareholders were in privity, at least where the initial shareholder's counsel provided adequate representation. However, the Chancery Court noted the peculiarities of derivative litigation in this context, in that Delaware courts have repeatedly admonished shareholders to "use the tools at hand," *i.e.,* to obtain corporate books and records under Section 220, before bringing a derivative action, which is in considerable tension with plaintiff counsel's financial incentive to be the first to file an action in a "race to the courthouse." As a result, the Chancery Court noted that the first filed actions were more prone to dismissal for demand failure, as they were less likely to have the benefit of "adequate due diligence." Thus, the subsequent shareholder would lose out on collateral estoppel grounds, despite a better prepared complaint, arguably giving rise to the Due Process concerns noted by the Delaware Supreme Court.

In response to this tension, the Chancery Court advocated adopting an approach suggested in dicta last year in *In re EZCORP Inc. Consulting Agreement Derivative Litigation*, 130 A.3d 934 (Del. Ch. 2016). That is, preclusive effect should only be given to prior derivative actions that have survived motions to dismiss pursuant to Rule 23.1. While acknowledging that this result could lead to "seriatim lawsuits litigating demand futility," the Chancery Court noted that such subsequent lawsuits would typically be based on "a more refined complaint with more particularized allegations or more tailored legal theories after doing additional homework, such as obtaining corporate books and records through a Section 220 proceeding." According to the court, this approach "should go a long way in addressing the 'fast-filer' problem and ensur[e] better protection of due process rights" for shareholder plaintiffs.

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Eleventh Circuit Affirms Dismissal Where Professional Services Exclusion Unambiguously Created Joint, Not Several, Obligations

The United States Court of Appeals for the Eleventh Circuit has affirmed the dismissal of a breach of contract and bad faith case against two insurers based on the policies' professional services exclusion, finding that the exclusion clearly created joint, not several, obligations. *Stettin v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 2017 WL 2858768 (11th Cir. July 5, 2017).

The coverage litigation stems from a Ponzi scheme orchestrated by a Florida attorney through his law firm, which resulted in the lawyer being sentenced to more than two years in prison. This particular case arises out of litigation based on the alleged conduct of certain executives of the bank and trust company that managed the law firm's accounts. The bank and certain of its executives were named as defendants in several suits seeking to recover for losses caused by the lawyer's scheme.

The bank and executives sought coverage from both its primary and excess professional liability insurance carriers. After both carriers denied coverage, the bank and the executives entered into a settlement that included the assignment of their policy rights to the bankruptcy trustees of the law firm and of other entities that lost money in the Ponzi scheme. Once the trustees were similarly denied coverage by the insurers, they brought a breach of contract and bad faith action against the carriers.

The insurers moved to dismiss the action, arguing that coverage was barred by the "professional services exclusion" in each policy. The exclusion provided that the insurer would not be liable for any Claim made against "any Insured alleging, arising out of, based upon, or attributable to the Organization's or any Insured's performance of or failure to perform professional services for others, or any act(s), error(s), or omission(s) relating thereto." The trial court agreed and dismissed the action.

On appeal, the trustees argued that the trial court erred by not reading the exclusion severally, and therefore barring coverage only as to the claims against those insured executives who directly provided professional services to the law firm. According to the trustees, claims against executives who were merely responsible for internal managerial banking functions should not be barred from coverage. Applying Florida law, the appellate court rejected this interpretation and found the trial court's observation that the phrase "any insured" unambiguously expresses a contractual intent to create joint obligations was correct.

In reaching its decision, the court rejected the trustee's reliance on *Premier Ins. Co. v. Adam*, 632 So. 2d 1054 (Fla. 5th DCA 1994), which involved a policy with a severability clause. Because the insurance policies issued by the appellees did not contain a severability clause, the court explained, an exclusion applying to the conduct of "any insured" created a joint obligation. ■

Computer Fraud Coverage Extends to Manipulation of External Email Server

The United States District Court for the Southern District of New York, applying New York law, has held that a cloud-based service provider's loss resulting from fraudulent wire instructions is covered under a computer fraud and funds transfer fraud policy because the fraudulent email changed data in the provider's computer system despite use of a third-party external email service. *Medidata Solutions, Inc. v. Federal Ins. Co.,* No. 15-CV-907 (S.D.N.Y. July 21, 2017). The court also held that the fraud precluded any finding that coverage was excluded based on the provider's knowledge or consent to the wire transfer.

The service provider purchased a policy that covered computer fraud and funds transfer fraud. The policy defined "computer fraud" as the "unlawful taking or the fraudulently induced transfer of Money" resulting from fraudulent "entry of Data into . . . or change to Data elements or program logic of a Computer System." Funds transfer fraud coverage protected the service provider from loss directly caused by fraudulent electronic instructions issued to a financial institution without the provider's knowledge or consent. Several of the service provider's employees received emails purportedly from the provider's president with instructions to wire funds to a bank account, causing an employee to issue a wire transfer of nearly $5 million. The service provider sought coverage for the loss, and the insurer denied on the grounds that there had been no fraudulent entry of data onto the provider's computer systems. The insurer further argued that funds transfer fraud coverage did not apply because the wire transfer was made with the service provider's knowledge and consent. The provider sued, and both parties moved for summary judgment.

The court granted summary judgment in favor of the service provider. The court held that the computer fraud coverage applied because the fraudster's email contained a code that tricked the provider's email server into identifying the email as coming from the president. The court rejected the insurer's argument that there was no coverage because the fraudulent emails did not require access to the service provider's computer system or input of fraudulent information to that system, because the external email server, rather than the provider's internal computer systems, populated the president's information in the email. The court held that manipulation of the email system via the code was sufficient to trigger coverage, and that actual hacking of the system was not required.

The court further ruled that the funds transfer fraud coverage grant also was triggered, rejecting the insurer's argument that the transfer was made with the provider's knowledge and consent. The court reasoned that "[t]he fact that the accounts payable employee willingly pressed the send button on the bank transfer does not transform the bank wire into a valid transaction. To the contrary, the validity of the wire transfer depended upon several high level employees' knowledge and consent which was only obtained by trick." ■

No Coverage Where Claim Reported After Extended Reporting Period

A Wisconsin intermediate appellate court has held that coverage was unavailable for a claim reported after the termination date of an extended reporting period purchased by the policyholder. *Sheffield v. Darwin Nat. Assur. Co.,* 2017 WL 3149792 (Wisc. Ct. App. July 25, 2017).

An insurer issued a claims-made-and-reported lawyers malpractice policy to a law firm for the period of January 11, 2012 to January 11, 2013. When the named partner of the firm departed for another firm, the firm cancelled the policy, effective September 4, 2012. At the same time, the firm purchased a two year extended reporting period ("ERP"). After the termination of the ERP on September 4, 2014, the law firm reported a claim made against it. The insurer denied coverage on the ground that the claim was not timely noticed.

In the ensuing coverage litigation, the court granted summary judgment to the insurer, holding that the claim was not timely noticed during the ERP. The policyholder had argued that the ERP did not commence until after a sixty-day "Automatic Extended Reporting" period in the policy. However, the court noted that the insurer added the ERP by endorsement, which clearly stated that the ERP "shall begin on September 4, 2012 and shall end on September 4, 2014." In addition, the court noted that the ERP was clearly an option offered in the alternative to the Automatic Extended Reporting period based upon the policy language. ■

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Corporate Coverage Analysis: Should the Chancery Court's approach ultimately be adopted by the Delaware Supreme Court, D&O insurers should expect a significant uptick in derivative actions and related defense costs, as a significant hurdle to subsequent derivative actions where an earlier action has failed due to demand futility will have been removed. Quick-filing plaintiffs' counsel without doubt will continue to race to the court house, but the decision also incentivizes a more considered action, grounded in a Section 220 books and records demand, to be filed as well, leading to litigation on multiple fronts and the "seriatim litigation" the Chancery Court predicted. While the Due Process issues here are complex and the Delaware Supreme Court's resolution of the issue remains to be seen, this is a potentially troubling development in terms of exposure faced by insurers. ■

Specific Litigation Exclusion Bars Coverage When Claim Arises "At Least in Part" From Excluded Litigation

An Illinois district court, applying Delaware law, has held that a specific litigation exclusion in a company's directors and officers insurance policy bars coverage for a claim arising "at least in part" from the litigation referenced in the exclusion. *RSUI Indem. Co. v. Worldwide Wagering, Inc,* 2017 WL 3023748 (N.D. Ill. Jul. 17, 2017).

The exclusion provided that, "[t]he Insurer shall not be liable to make any payment for Loss arising out of or in connection with any Claim made against any Insured alleging, arising out of, based upon or attributable to, directly or indirectly, in whole or in part, the following litigation [.]" The excluded litigation involved an allegation that an individual had agreed to bribe the governor of Illinois in exchange for his support of certain legislation. The excluded litigation resulted in a $78 million judgment.

In the underlying case, the company and its directors were alleged to have acted to conceal assets of the company from the creditors in the excluded litigation. The insureds argued that because the underlying litigation involved "some facts and allegations" relating to the excluded litigation, as well as allegations relating to funds not connected to the excluded matter, that the exclusion should not apply. The court rejected that argument, holding that the exclusion barred coverage and noting that the underlying matter need only arise out of the excluded matter "in part." The court explained that "[t]he exclusion provision . . . did not require that litigation be identical to the [excluded matter] to be excluded from coverage, litigation merely had to arise from or be based in part on the [excluded matter.]" ■

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clients notified the insurer's policy administrator of the claim.

The clients obtained a judgment against the attorney in January 2015. In June 2015, they filed suit against the insurer and its policy administrator to collect on the judgment from the insurance policy proceeds. The insurer and its administrator defended by asserting that the claim was not timely reported within the policy period. The clients argued that, while the notice was given outside of the reporting period, the insurer and its policy administrator had actual or constructive notice of the claim because a public court docket reflected the action against the attorney. The clients also argued that the insurer was not prejudiced by the late reporting. The district court granted judgment on the pleadings in favor of the insurer and its administrator. The clients appealed.

The Sixth Circuit affirmed. First, the court rejected the argument that the public court docket provided actual or constructive notice, reasoning that there is no provision in the policy that required the insurer or its administrator to monitor a public docket for claims. Second, the court held, based on its decision in *United States v. A.C. Strip*, 868 F.2d 181 (6th Cir. 1989), that under Ohio law an insurer need not demonstrate prejudice to deny a claim reported after expiration of the policy period of a claims made and reported policy. Because it was undisputed that notice was untimely, the court affirmed. ■

No E&O Coverage Where Insured Failed to Report Claim During Policy Period When It Was First Made

The Appellate Court of Illinois, applying Illinois law, has held that an insurer has no duty to defend or indemnify an insurance agent under an errors and omissions liability policy where the agent failed to provide notice of the claim during the policy period in which the claim was first made. *James River Ins. Co. v. Timcal, Inc.,* 2017 WL 2852812 (Ill. App. June 30, 2017).

The insurance agent received a letter from an insurer client in July 2012, alleging that the insurance agent had breached its duty as an insurance agent and that the insurer would seek to recover damages. The insurance agent failed to notify its E&O insurer until April 2013, after the policy had renewed. The E&O insurer filed a declaratory judgment action against the insurance agent, seeking a judgment that it had no duty to defend or indemnify the agent under either the policy in effect when the claim was first made or the renewal policy in effect when notice was ultimately given because the agent failed to provide timely notice of a claim. The trial court granted summary judgment for the insurer, and the agent appealed.

On appeal, the court held that the July 2012 letter unambiguously constituted a "written demand for monetary relief" and therefore a claim under the policy even though the letter did not specify a settlement amount or the total damages claimed. Further, the court held that the insurance agent unambiguously failed to timely report the claim to its insurer, rejecting the agent's argument that notice was not untimely if provided during the renewal policy period. The court instead concluded that renewals cannot affect the reporting period for claims-made-and-reported policies such as the one at issue. ■

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