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Insurance Update

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Third Circuit: Product Liability Claims Alleging Faulty Workmanship Do Not Amount To An "Occurrence" Under Certain Policies

The Third Circuit held that where the manufacturer of aluminum profiles installed in windows and doors was sued for breach of warranty, it could not recover its defense costs because faulty workmanship did not constitute an "accident" as defined by certain commercial general liability policies.

The Case

Marvin Windows, a manufacturer of windows and doors, claimed Sapa Extrusions' frames (which were incorporated in Marvin's products) prematurely failed in coastal installations. According to Marvin, the frames, called profiles, oxidized, cracked, and peeled.

Marvin sued Sapa claiming more than $100 million in damages for, among other things, incurring the cost of investigating and responding to consumer complaints and repairing and replacing the failed frames. Sapa settled Marvin's suit. Sapa then filed an action against its insurers for coverage. The policies defined the term "occurrence" in varying ways.

The district court awarded summary judgment to all of the insurers. Sapa appealed.

The Third Circuit's Decision

The Third Circuit affirmed in part, reversed in part, and remanded for further proceedings.

The court observed that all of the policies afforded coverage only if property damage was caused by an "occurrence," but how the policies defined "occurrence" differed. It divided the policies into three groups: (1) the "accident" definition; (2) the "expected or intended" definition; and (3) the "injurious exposure" definition.

Most of the policies defined "occurrence" by using the "accident" definition: "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." The court determined that this required an unforeseeable, fortuitous event.

The court found that the faulty workmanship alleged in Marvin's complaint did not amount to an "occurrence" under this group of policies because fortuity was lacking. Sapa controlled the product supplied. Thus, any liability flowing from Sapa's failure to deliver a product that met the agreed specifications was "too foreseeable to be considered an accident." The court affirmed this part of the district court's ruling.

But for the two remaining groups of policies, the court predicted that the Pennsylvania Supreme Court would find these definitions "ambiguous" and remanded for further proceedings in the district court.

The "expected or intended" group of policies defined "occurrence" as "an accident, including continuous or repeated exposure to conditions, which results in Bodily Injury or Property Damage neither expected nor intended from the standpoint of the Insured." The court found that this definition narrowed "accident" by including only conditions that the insured subjectively intended.

The "injurious exposure definition" defined "occurrence" as "injurious exposure, including continuous or repeated exposure, to conditions, which results, during the policy period, in personal injury or property damage . . . neither expected nor intended from the standpoint of the insured." The circuit court found that the district court did not separately analyze this group of policies, despite their unique wording. Because they also contained subjective intent language, the court remanded this group back to the district court for further consideration. The case is *Sapa Extrusions, Inc. v. Liberty Mut. Ins. Co.*, No. 18-2206 (3d Cir. Sept. 13, 2019).

Liability Policy Did Not Cover Sewer System Repair Costs Because They Were Not 'Damages,' Fifth Circuit Rules

The U.S. Court of Appeals for the Fifth Circuit, affirming a district court's decision, has ruled that an owner's costs to repair a sewer system were not covered by its liability insurance policy because those costs were not "damages."

The Case

The owner of a sewer system servicing the Kingston Plantation neighborhood in Bossier City, Louisiana, spent more than $600,000 to repair the system following a localized collapse that produced a sewage backup in one home.

The owner submitted a claim to its liability insurer seeking reimbursement for the cost of repairing the sewer system.

The insurer denied the claim, and the owner sued.

The U.S. District Court for the Western District of Louisiana granted summary judgment in favor of the insurer, and the owner appealed to the Fifth Circuit.

The Fifth Circuit's Decision

The Fifth Circuit affirmed.

In its decision, the court explained that the insurance policy covered "sums" that the owner was "legally obligated to pay as damages." It then observed that when the owner paid to repair its sewer system, it was not compensating anyone for loss or injury.

Therefore, the court held, the repair costs were not damages and were not covered by the owner's insurance policy.

The court rejected the owner's argument that its repair costs were covered under the policy because they were incurred to prevent additional backups and potential sewage spills and did not fall within the policy's "owned property" exclusion.

The court concluded that whether or not the owned property exclusion applied, the owner's repair costs were not covered by the policy because those costs were not damages.

The case is *Eagle Water, L.L.C. v. Ash*, No. 19- 30056 (5th Cir. Sept. 26, 2019).

Seventh Circuit Finds Breach of Contract Exclusion Broader Than E&O Coverage Grant, Rendering Coverage Illusory

The U.S. Court of Appeals for the Seventh Circuit, reversing a district court's decision, has ruled that a breach of contract exclusion was broader than the errors and omissions ("E&O") coverage grant in the insureds' policies, thus rendering that coverage illusory and the exclusion subject to being reformed.

The Case

DVO Inc. and WTE-S&S AG Enterprise, LLC, entered into a standard form agreement created by the Engineers Joint Contract Documents Committee under which DVO was to design and build an anaerobic digester for WTE. The digester was to be used to generate electricity from cow manure, which then would be sold to the electric power utility.

WTE subsequently sued DVO for breach of contract. A trial court found in favor of WTE and ordered DVO to pay over $65,000 in damages and $198,000 in attorneys' fees.

DVO asserted that the award was covered under the E&O professional liability provisions of its insurance policies, which required the insurer to pay "those sums the insured becomes legally obligated to pay as 'damages' or 'cleanup costs' because of a 'wrongful act' to which this insurance applies."

The insurer countered that coverage was precluded by a breach of contract exclusion that excluded coverage for claims or damages based upon or arising out of a breach of contract.

In response, DVO argued that the breach of contract exclusion was so broad as to render the E&O professional liability coverage illusory and, therefore, that it could not be enforced to preclude the insurer's duty to defend.

The U.S. District Court for the Eastern District of Wisconsin held that the professional liability coverage was not illusory because it would still apply to third party claims against DVO, and that even if it was illusory, the remedy would be to reform the contract to allow coverage to third party claims, not to allow coverage for all professional liability claims.

DVO appealed to the Seventh Circuit.

The Seventh Circuit's Decision

The Seventh Circuit reversed.

After noting that the parties did not disagree that WTE's claim against DVO fell within the E&O coverage provisions, the circuit court turned to the breach of contract exclusion.

The Seventh Circuit pointed out that the state court complaint against DVO alleged that DVO had contracted to design and construct the anaerobic digester and that because of its faulty design, damages were incurred. The circuit court explained that the complaint against DVO alleged a claim that arose out of the contract and, therefore, fell within the exclusion.

The Seventh Circuit did not stop there, however. It decided that the breach of contract exclusion was "broader than the grant of coverage" and, therefore, that it rendered coverage "illusory."

The court said that the language in the exclusion was "extremely broad" in that it included claims based upon "or arising out of" the contract, "thus including a class of claims more expansive than those based upon the contract."

The court pointed out that, under applicable Wisconsin law, the term "arising out of" had been interpreted to reach any conduct that had "at least some causal relationship between the injury and the event not covered." The court said that the "quite expansive" exclusion applied to all contracts, whether express or oral, and even including contracts implied in law or fact. Given that broad language, it added, the exclusion "would include even the claims of third parties."

Because third party claims of professional negligence fell within the exclusion, the Seventh Circuit held, the exclusion rendered the professional liability coverage "illusory."

The Seventh Circuit remanded to the district court to reform the exclusion to meet DVO's "reasonable expectations" of coverage.

The case is *Crum & Forster Specialty Ins. Co. v. DVO, Inc.*, No. 18-2571 (7th Cir. Sept. 2019).

Texas Appellate Court Finds Issue of Fact As to Whether a Golf Cart Is a Covered 'Auto'

In a suit arising from an accident involving a golf cart, the court held that the insured failed to establish its right to summary judgment on the duty to defend because there was a genuine issue of fact as to whether the golf cart involved in the accident was a covered "auto," despite the possibility that some golf carts might qualify.

The Case

The insured, Pharr-San Juan-Alamo ISD ("PSJA"), was sued for damages sustained by a minor who was allegedly injured after being thrown from a golf cart driven by a PSJA employee. PSJA

demanded that its automobile liability insurer, Texas Political Subdivisions Property/Casualty Joint Self Insurance Fund (TPS) defend and indemnify it in the underlying suit. TPS denied coverage.

TPS filed a declaratory judgment action against PSJA. Both parties moved for summary judgment.

The policy at issue provided liability coverage for damages caused by an accident and resulting from the ownership, maintenance, or use of a covered "auto." The policy defined an "auto" as "a land motor vehicle, trailer or semitrailer designed for travel on public roads but does not include mobile equipment." "Mobile equipment" was defined, in part, as "vehicles designed for use principally off public roads."

TPS argued that golf carts are necessarily "mobile equipment" under Texas law because the Texas Transportation Code defined "golf cart" as "a motor vehicle designed by the manufacturer primarily for use on a golf course." In other words, TPS argued, a golf cart could not be designed for use principally on public roads. Therefore, TPS asserted, based on the allegations in the underlying complaint, it had no duty to defend or indemnify PSJA.

In response, PSJA argued that although golf carts were traditionally designed primarily for use on a golf course, the term has a broader meaning today because manufacturers now design and advertise some golf carts primarily for use on public roads. PSJA submitted advertisements from a golf cart manufacturer that depicted people using several models of golf carts to perform everyday errands on public roads. PSJA argued that because the underlying complaint failed to describe the "golf cart" in question, a reasonable interpretation of the complaint included a golf cart designed for use on a public road like those in advertisements.

The trial court entered judgment for PSJA. The trial court found that TPS breached its duties to defend and indemnify.

The Appellate Court Decision

The Texas Court of Appeals reversed, finding that neither party carried its burden on summary judgment.

The court agreed that TPS was not entitled to summary judgment on its legal argument that all golf carts – without exception – are designed for use primarily off public roads. The court agreed with PSJA that the term "golf cart" has an expanded meaning in today's lexicon.

Relying on extrinsic evidence submitted by PSJA, the court noted that the design of some golf carts go beyond the normal golf-course use. For example, the court noted that many of the design features, such as a speedometer, three-point seat belts, and turn signals, would be superfluous to a golfer. The court noted that one manufacturer described these features as designed for "on-roading." The court further noted that Texas law allows certain "on-roading" in golf carts.

Although the court agreed that not all golf carts are designed for use primarily off public roads, it held that TPS had established an issue of fact as to whether the particular golf cart at issue in the underlying case was designed for use primarily off public roads. The court cited extensive evidence that PSJA's athletic director described the golf cart in question as a "normal golf cart you

would see at a golf course." The court also cited to a prior representation by PSJA's counsel that the golf cart in question was "not street legal" and was an "older model, electric type commonly seen on golf courses."

However, the court declined to decide whether this extrinsic evidence conclusively precluded coverage. The court noted that, in the trial court, TPS had limited itself to an eight-corners argument based on the policy and underlying complaint. Therefore, the court reversed the trial court's judgment and remanded the case back to the trial court for further proceedings.

The case is *Tex. Political Subdivisions Property/Casualty Joint Self Ins. Fund v. Pharr-San Juan-Alamo ISD* (Tex. App. Ct. Sept. 26, 2019).

California Courts Enforce Homeowner's Insurance Policy's One-Year Suit Limitation Provision

An appellate court in California has affirmed a trial court's decision finding that a homeowner's lawsuit against her insurance company was untimely because it was filed more than one year after the insurer had closed her claim.

The Case

On July 30, 2015, a California homeowner discovered that the wood flooring in the kitchen of her home was damaged. The next day, she submitted a claim to her insurer.

The insurer's representative inspected the home four days later.

Then, on August 6, 2015, the insurer sent the homeowner a letter explaining that the damage was caused by an intermittent leak in a water supply line to her refrigerator and was excluded under the homeowner's insurance policy. The letter stated: "We have completed our evaluation and determined there is no coverage for your loss."

The letter also reminded the homeowner that the policy provided a one-year period in which she could sue that began when it closed her claim. The letter noted that it closed her claim on August 6.

About two weeks later, on August 18, the homeowner sent the insurer an email disagreeing with its "denial" and requesting all of the insurer's file on her claim.

The insurer sent a letter the next day enclosing all claim-related documents, and also said it would "be more than happy to reconsider its position based on any new or additional information or documentation that you have or may acquire in the future." The insurer's letter, however, was clear that the homeowner's claim remained closed: "Please refer to our letter of August 6, 2015 wherein we advised you that we have closed your claim. Your claim remains closed."

In late October 2015, the homeowner's lawyers sent the insurer a letter disputing its coverage position, demanding that it "re-open this claim," and arguing that it should not have closed its claim file as indicated in its letter of August 6, 2015.

The insurer responded on November 12, 2015, acknowledging receipt of the October letter and indicating it wanted to "review" it. The insurer also said, "Once we complete our review of your correspondence we will advise you." It added, "[p]lease be advised at this time the file remains closed."

On December 21, 2015, the insurer sent a letter to the homeowner's lawyers stating that their letter did "not provide a valid basis for a change in the coverage determination."

There was additional correspondence between the parties in 2016 and then, on September 28, 2016, the homeowner sued the insurer, asserting that its denial of her claim was improper.

The trial court granted the insurer's motion for summary judgment, and the homeowner appealed.

The Appellate Court's Decision

The appellate court affirmed.

In its decision, the appellate court explained that the insurer sent an unequivocal formal written denial of the homeowner's claim on August 6, 2015 that specifically quoted the one-year suit limitation provision in her policy. The appellate court then ruled that because the insurer never said that it reopened her file, and indicated that the claim had been closed in August 2015, the homeowner's September 28, 2016 lawsuit was "clearly untimely."

The appellate court was not persuaded by the homeowner's argument that the insurer had to tell the insured (or her attorneys) about the one-year suit limitation period every time it considered and rejected new or additional information or documentation or the period began to run anew.

In the appellate court's opinion, that theory would put insurers in an untenable position of either losing the benefit of the one-year suit limitation provision or acting in bad faith by announcing an early denial and then refusing to consider *any* new information. Moreover, the appellate court concluded, the insured's theory would allow insureds to extend the one-year period at will by "the simple expedient of making many requests for reconsideration."

The case is *Hufstedler v. Mercury Ins. Co.*, No. G056113 (Cal. Ct. App. Sept. 9, 2019).

Late Notice Doomed Insureds' Coverage Bid

A federal district court in Illinois has ruled that an insurer had no duty to defend its insureds against trademark and counterfeiting claims where they did not provide timely notice of the claims against them.

The Case

After the National Hockey League ("NHL") sued A&R Collectibles, Inc., and an executive officer, they sought coverage under a businessowners insurance policy.

The insurer, which participated in the defense, asked the U.S. District Court for the Northern District of Illinois to declare that it had no duty to defend because the insureds failed to give it timely notice of the NHL's claims.

The insurer argued that A&R knew of the NHL's trademark claims from a cease-and-desist letter the NHL sent in July 2016 and that A&R knew of the NHL's counterfeiting claims from email the NHL sent to A&R's attorneys in March 2017. A&R, however, did not notify its insurer of these claims until August 6, 2018, when it tendered defense of the NHL's lawsuit.

The insureds responded that their notice was not untimely because they had no knowledge of the NHL's claims against them until July 27, 2018, when the NHL's complaint was served. They also argued that even if notice was untimely, the insurer could not deny coverage on that basis because it had not shown prejudice from the delay and because it abandoned reliance on the alleged late notice by defending the suit and failing to assert late notice as a coverage defense at any time before it filed its declaratory judgment action.

The insurer moved for summary judgment.

The District Court's Decision

The district court, applying New York law, granted the motion.

In its decision, the court first said that there was "no question" that receipt of a cease-and-desist letter could trigger an insured's duty to provide notice of a potential claim.

The court added that even if the NHL's July 2016 cease-and-desist letter did not reasonably inform A&R of a potential claim against it or against its executive officer, the March 30, 2017 email "unquestionably did."

The court noted that the March 2017 email asserted that A&R's executive was "selling counterfeit NHL merchandise through the A&R Collectibles website, including but not necessarily limited to a counterfeit Chicago Blackhawks jersey," and demanded that A&R "(1) cease all sales of the Chicago Blackhawks jersey; (2) advise NHL of the vendor from which it purchased those products; (3) provide an accounting of its sales of that product; and (4) deliver any remaining inventory of the Chicago Blackhawks jersey to NHL for destruction."

In the court's opinion, although the March 2017 email stopped short of threatening legal action, it left "no doubt" that the NHL intended to enforce its trademark rights against A&R. In addition, the court continued, the "accounting" the email demanded echoed a demand in the July 2016 letter that specified that the reason for the accounting was "so we may determine if a payment of monetary damages is appropriate." According to the court, this language belied the argument that prior to being served with the NHL's complaint, A&R was unaware of any demand that could be defended, settled, and paid by the insurer.

Therefore, the court ruled, the March 2017 email made A&R and its executive officer aware of the "possibility" of a claim, triggering their notice obligations under the policy.

The court next decided that the 16 months that elapsed between A&R's receipt of that email and its tender of the NHL's lawsuit to the insurer was an unreasonable delay and, therefore, that the tender did not comply with the policy's notice requirements.

The court rejected A&R's argument that, under New York Insurance Law § 3420(a)(5), the insurer had to demonstrate that it was prejudiced by the delay. The court pointed out that Section 3420(a)(5) did not apply to A&R's insurance policy, because the policy was not "issued or delivered" in New York.

Finally, the court ruled that the insurer had not abandoned its late notice defense by failing to assert it in its original disclaimer letter. The court explained that the insurer expressly reserved, throughout its claim correspondence with A&R and its executive officer, "all of its rights, remedies, and defenses under the law and under the [p]olicy, including its right to raise other and further coverage defenses as they become apparent" and that A&R and its executive officer failed to show that, despite this language, the insurer intended to waive reliance on its late notice defense.

The case is *Frankenmuth Mutual Ins. Co. v. Hockey Cup, LLC*, No. 18 C 8142 (N.D. Ill. Sept. 20, 2019).

Insured Said Raccoons Engaged in 'Vandalism and Malicious Mischief' When They Damaged Its Property. Court Dismissed Because Scienter Was Lacking

A federal district court in Pennsylvania has dismissed an insured's claim seeking coverage for "vandalism and malicious mischief" damage allegedly caused by raccoons, reasoning that "vandalism" and "malicious mischief" presupposed conscious, willful misconduct by a human being, not raccoons.

The Case

The owner of a home in the Pittsburgh area asserted that raccoons had somehow entered the dwelling and caused a substantial amount of damage to the interior.

The owner made a claim on its insurance policy, contending that the damage was a result of "vandalism or malicious mischief" by the raccoon.

The insurer denied the claim, explaining that there was no coverage because the loss "was the result of an animal or animals damaging the dwelling."

The owner sued for breach of contract and insurance bad faith, and the insurer moved to dismiss.

The insurer contended that raccoons cannot commit vandalism or engage in malicious mischief and, therefore, that there was no coverage upon which to premise a claim for breach of contract or for insurance bad faith.

The owner countered that the policy was ambiguous because it did not specifically define "vandalism" or "malicious mischief." It contended that, because those terms were undefined, they might include damage caused by raccoons. At the very least, the owner argued, the question

of whether an animal could engage in "vandalism" or "malicious mischief" was one of first impression in Pennsylvania and, therefore, did not lend itself to disposition on a motion to dismiss.

The Court's Decision

The court granted the motion.

In its decision, the court explained that the only way that the owner was entitled to coverage would be if the raccoons' acts constituted "vandalism or malicious mischief."

The court ruled that they did not.

The court found that the terms "vandalism" and "malicious mischief' were not ambiguous, especially not with respect to whether they could be construed to encompass the conduct of animals.

The court decided that there was "no merit" to the owner's contention that the terms "vandalism" and "malicious mischief' were ambiguous because they were not defined in the insurance policy. Indeed, the court found that their common dictionary definition and their specific legal usage showed that they were inapplicable to animal behavior.

According to the court, damage caused by animals – in this case, raccoons – could not be deemed to have arisen from "vandalism" or "malicious mischief" because those terms presupposed conscious, willful misconduct by a human being.

The court concluded by quoting the following from a New Mexico court of appeals decision rejecting a similar claim for damage allegedly caused to the plaintiff's property by a bobcat:

> Alas, it is written in the law
> That an animal with the paw
> Does not have the mind
> To do the damage of this kind.
> And so, I'm sorry, the Plaintiff won't get paid.
> That's how the contract was made.
> This policy does not apply
> When the bobcat runs awry.

The case is *Capital Flip, LLC v. American Modern Select Ins. Co.*, No. 2:19-cv-180 (W.D. Pa. Sept. 19, 2019).

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