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Ninth Circuit Holds That Vizio's Failure to Obtain Excess Insurer's Consent Before Settling Dooms Its Bid for Coverage

Vizio was embroiled in a well-publicized class action suit over its Smart TVs. It allegedly secretly collected viewer information and sold that information to other companies without the viewers' consent. Vizio notified its primary insurer, Navigators, and its excess insurer, Arch, of the lawsuit in February 2016. Arch's policy followed form to the Navigators policy and attached at $5 million.

Navigators denied coverage based on an exclusion. Arch requested more information. Vizio never updated Arch about the Smart TV litigation but sent Navigator's denial letter to Arch. Arch internally decided to deny coverage but had not communicated its coverage position to Vizio. About two years after giving notice, Vizio settled the Smart TV litigation for $17 million. It did not seek Arch's consent.

A coverage action ensued. The district court found that Vizio was not entitled to coverage because Vizio didn't notify Arch of its claim after the underlying Navigator's policy limit was exhausted. On appeal, the Ninth Circuit found that the district court had erred but ruled for Arch for another reason: lack of consent.

The Ninth Circuit explained that Arch had no obligation to indemnify Vizio when notice was given because the underlying policy limits had not yet been exhausted. But that did not mean

Vizio's earlier notice to Arch was insufficient. Arch's policy did not require the insured to provide notice of claim once Navigator's policy exhausted. The earlier notice was enough.

Vizio breached a policy condition, however, in not obtaining Arch's consent before settling the Smart TV litigation. Vizio raised three arguments on why it did not have to get Arch's consent, but the court rejected them all.

First, Vizio argued that the Arch policy did not expressly call for consent. The court rejected this argument in short order because the Arch policy, which followed form to the Navigators policy, incorporated the consent provision from the Navigators policy.

Second, Vizio argued that the Arch policy had its own provision regarding "Duties in the Event of a Claim," and that provision did not require Vizio to obtain Arch's consent before settling. Vizio contended that Arch's policy conflicted with Navigator's. The court disagreed. The provision only addressed notice of claims, not consent. There was no conflict.

Third, Vizio argued that even if the consent provision applied, it was not enforceable because Arch itself breached the contract by not responding to Vizio's February 2016 notice.

Vizio tried to support its argument by citing California regulations that require an insurer to accept or deny a claim within 40 days of tender. But as the court explained, that regulation applied only to "proof of claim," not "notice of claim." Arch responded to Vizio's notice of claim in less than a week and had requested updates from Vizio, which it never received.

Vizio next argued that Arch breached the policy because it internally denied coverage but never informed Vizio of its decision. It cited case law for the proposition that an insurer's breach of its policy renders a prior written consent provision unenforceable. The court found that principle applied only where the insurer has actually denied coverage. Arch never told Vizio that it was

denying coverage. It asked for substantive updates about the litigation, which Vizio never provided. Vizio thus denied Arch the opportunity to participate in the settlement negotiations.

In short, the court found that Vizio failed to allege facts that plausibly showed that Arch breached the policy. And even if it did, that would not excuse Vizio from seeking Arch's consent before settling.

Another point worth noting concerns equitable contribution. One of Vizio's other primary insurers had contributed to the defense and settlement of the claim and assigned Vizio its right of equitable contribution against other insurers. The Ninth Circuit quickly shot down this claim because there is no right of contribution where the insurers do not share the same level of coverage. Arch's policy is excess of primary policies. The court rejected Vizio's contention that the Arch policy became a primary policy once the Navigators policy exhausted.

The case is *Vizio v. Arch*, No. 22-55755 (9th Cir. Oct. 30, 2023). It's unpublished, and not citable, but addresses important insurance issues.

Illinois Federal Court Finds That Loss Due to the Incorporation of Tainted Oral Rinse into Hygiene Packets Was Not Caused by an Occurrence

Sage Products supplies hospitals and nursing homes with oral hygiene kits. The kits contain a toothbrush, a swab, and an oral rinse. The packaging included detachable sleeves, which were integral to the product's usefulness.

Sage contracted with ChemRite to supply the oral rinse. But ChemRite made the rinse using the same equipment that it used to make toxic car wash. The Food and Drug Administration warned ChemRite that its manufacturing process for the oral rinse did not meet proper standards. FDA sent a similar letter to Sage.

Sage recalled all kits that used ChemRite's oral rinse. It then sued ChemRite for its lost profits. The parties later resolved the dispute through a consent order that transferred ChemRite's insurance rights to Sage. Sage next sued ChemRite's insurer.

The coverage litigation came down to a single issue: was there an "occurrence"? The policy used the standard definition: "an accident, including the continuous or repeated exposure to substantially the same general harmful conditions." The word "accident" was undefined, but the court looked to its ordinary meaning. It concluded that it must determine whether the conduct was an unintentional act in the sense that it was not volitional.

Sage argued that two events caused "property damage": (1) the incorporation of the tainted rinse into the kits; and (2) the physical removal of the rinse packets from the kits.

Applying Wisconsin law, the court began with the principle that faulty workmanship is not an "occurrence" but can lead to an "occurrence" that causes "property damage." Sage conceded that ChemRite's production process may have been faulty, but argued there was an "occurrence" when Sage incorporated the tainted oral rinse into its kits. The court disagreed because Wisconsin law treats installation as part of workmanship. And even if it didn't, there still would not be an "occurrence" because the oral rinse solutions were not put into the packets by chance; Sage intended to add them. True, Sage did not know the rinse was tainted. But under Wisconsin law, an unexpected result alone is not necessarily an accident; the means or cause must be accidental.

The court next considered if there was an "occurrence" when Sage removed the oral rinse from its kits. The facts were not in dispute. Sage recalled the product, opened up the kits, and disposed of the tainted rinse as it was required to do. These acts, the court said, were volitional, not accidents. And the damage to the kits was expected once Sage opened the packages to remove the rinse.

Thus, the court held that any damage or loss of use that resulted from Sage's recall of the oral hygiene kits and its removal of the oral rinse were not caused by an "occurrence" as defined by the policy. It awarded the insurer summary judgment.

The case is *Sage Prods. LLC v. Federal Ins. Co.*, No. 19-cv-5308 (N.D. Ill. Oct. 25, 2023).

Indiana Federal Court Rules That Clearing of Wetlands Was Not an Occurrence

The insured cleared an area of property for farm use. The Indiana Department of Environmental Management (IDEM) cited the insured for unpermitted wetland clearing and requested that the wetlands be restored. IDEM later imposed civil penalties.

The insured submitted a claim under its farm policy, but the insurer disclaimed any duty to defend or indemnify. The insurer filed a declaratory judgment action and moved for summary judgment.

The insurer argued that the claim was not covered because it did not involve "property damage" caused by an "occurrence." The term "occurrence" was defined as an "accident," which the court found under Indiana law meant "an unexpected happening without an intention or design." Implicit in the meaning of "accident," the court noted, is intentionality.

Applying this concept, the court concluded there was no "occurrence" because the land clearing did not happen unexpectedly. IDEM accused the insured of clearing and grading a state forested wetland without a permit. The court said that no reasonable interpretation of the word "accident" would cover the insured's actions. The policy did not cover the penalty imposed by IDEM. And because the policy did not cover the insured's intentional acts, the insurer had no duty to defend. The insurer was awarded summary judgment.

The case is *Celina Ins. Grp. v. Larry and Carol Yeley Fam. Ltd. Partnership*, No. 1:22-cv-00865-JPH-TAB (S.D. Ind. Oct. 24, 2023).

Wrongful Prosecution Claim Does Not Trigger Occurrence Policy in Effect in Year After Initial Prosecution, Kentucky Court of Appeals Holds

In 1987, William Virgil was charged in Kentucky with murder. Virgil was convicted and spent the next twenty-eight years in prison. DNA testing later showed that no physical evidence on the murder victim's body tied the crime to Virgil.

Once free, Virgil filed a federal lawsuit under 42 U.S.C. § 1983 against the Newport insureds, which were the city, its police department, and various individual officers. Virgil claimed that his constitutional rights were violated because the local authorities arrested and charged him without probable cause. Virgil also offered proof that police officers fabricated evidence against him.

Newport tendered the suit for defense and indemnification to Westport Insurance Co. The Westport policy periods were between July 1, 1997, and July 1, 2000. Westport denied coverage on the basis that no offense or occurrence causing "personal injury" occurred during its policy periods. Still, Westport agreed to defend the insureds subject to a reservation of rights and filed a declaratory judgment action. The Kentucky trial court ruled for Westport. The insureds appealed.

The Court of Appeals of Kentucky affirmed. The court held that there was no coverage under the Westport policies. The court reasoned that the policies were triggered only by an injury-causing event during the policy period. Virgil was wrongfully incarcerated during the Westport's policy period, but this was not a new injury, just a continuation of an initial harm. This conclusion, the court added, aligned with what a reasonable insured would understand about insurance coverage.

The court distinguished a decision involving the same wrongful conviction under policies issued by Travelers Indemnity Company. In that decision, *St. Paul Guardian Ins. Co. v. City of Newport*, 804 F. App'x 379, 384 (6th Cir. 2020), the Sixth Circuit had found Travelers was obligated to defend and indemnify the Section § 1983 suit. (We covered the *St. Paul* case in our April 2020 update).

But the Kentucky court found that the policy in the earlier Sixth Circuit case differed because it was triggered by injury or damages sustained during the policy period, whereas the Newport policy was only triggered by an injury-causing event. Because the injury-causing event – the wrongful prosecution – did not occur during the Newport policy periods, the policies were not triggered.

The court acknowledged that a malicious prosecution action does not accrue until after the case is successfully prosecuted. But that did not matter for insurance purposes. Malicious prosecution results in a cause of action for damages. The insurance coverage analysis concerns the separate question of who pays for those damages: the wrongdoer or the insurer.

The court held that the trial court did not err when it determined that Westport had no contractual obligation to defend the insureds in the underlying suit.

The case is *City of Newport v. Westport Ins.,* 2022-CA-0384-MR (Ky. Ct. App. Oct. 6, 2023).

Arizona Federal Court Strictly Enforces Reporting Provision of Claims-Made Policy, Finding that Renewal Does Not Extend Reporting Period

The insured operated a restaurant in Tempe, Arizona. In August 2021, several former employees filed a Fair Labor Standards Act wage and hour action against the restaurant.

Between 2016 and 2023, the insured had employment practices liability insurance policies with United States Liability Insurance Co. The EPL policies were claims-made policies that limited

coverage to certain employment-related claims first made against an insured during the respective policy periods and reported to the insurer.

The EPL policy at issue was in effect from January 8, 2021, through January 8, 2022. The notice of claim provision required the insured, as a condition precedent to coverage, to give notice of a claim no later than 60 days after the expiration date of the 21-22 policy or the effective date of any cancellation or non-renewal of the policy.

The insured first reported the FSLA action on March 30, 2022. The insurer denied coverage for the claim on the grounds it was not reported within 60 days after the policy expired. The insured filed a breach of contract action in federal court.

The court granted summary judgment for the insurer. Applying Arizona law, the court noted that it was undisputed that the policy expired on January 8, 2022. Thus, under its plain terms, the insured failed to give notice within 60 days of the policy expiration date.

The court rejected the insured's argument that the successive renewals of the EPL policies created seamless coverage for all claims made between 2016 and 2023. The court emphasized that the main purpose of a claims-made policy is to limit coverage to certain claims made against the insured during a policy period or reporting period, thus allowing insurers to more accurately price risk. To negate these claims reporting requirements simply because the insured bought successive claims-made policies would be to convert the policy into an occurrence policy for any claim which arises during the span of consecutive policy periods. Claims-made policies were instituted to avoid precisely that scenario.

Because there was no coverage as a matter of law under the policy language, the insurer did not breach the policy.

The case is *Green Fili, LLC v. United States Liab. Ins.,* No. CV-23-00655-PHX-DGC (D. Ariz. Oct. 12, 2023).

California Federal Court Finds Insurer Has No Duty to Defend Patently False Battery Claim

On June 1, 2019, the insured and another individual, Michael Hannegan, were at a party in Newport Beach, California. They got into an altercation. There was a dispute over exactly what happened, but the insured alleged that Hannegan slapped the insured, ran from the party uninjured, and then slipped and fell, causing his own injury.

Hannegan sued the insured in California state court for battery. The insured tendered the suit to Nationwide Mutual Insurance Company. The insured had a tenant's policy with Nationwide with liability coverage. Nationwide denied coverage on the basis that there was no covered "Occurrence," and alternatively, that that the claim was otherwise excluded because the insured's actions were intentional or criminal.

No monetary judgment was awarded against the insured, but the insured had incurred defense costs. The insured sued Nationwide in federal court for breach of contract and extra-contractual claims. Nationwide moved to dismiss.

The court granted Nationwide's motion. Accepting the insured's allegations as true for purposes of the motion, the insured failed to plead facts potentially showing that the bodily injuries claimed by Hannegan were due to an accident caused by the insured's negligent acts. Rather, the complaint as drafted alleged that Hannegan's injury was self-inflicted.

The court rejected the insured's argument that Nationwide had a duty to defend the underlying suit because Hannegan's battery claim was "false." The insured pointed to a police report that suggested the insured, and not Hannegan, was the actual victim of the battery. The

court said that even if the battery claim were false on its face, it did not follow that Nationwide had a duty to defend it. Rather, Nationwide's obligations under the policy depended on whether the complaint alleged a covered or non-covered claim, not whether the complaint raised a "true or false" claim. The facts as alleged, whether true or not, did not implicate the policy's coverage.

The court also dismissed the insured's extra-contractual claim for breach of the covenant of good faith and fair dealing. An element of this claim was the withholding of benefits due under the policy. Because Nationwide did not withhold any benefits due under the policy, there could be no claim for breach of the covenant of good faith and fair dealing.

The case is *Tautenhahn v. Nationwide Mut. Ins.,* 23-CV-00795 (C.D. Cal. Oct. 10, 2023).