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This newsletter is intended to summarize significant cases impacting the insurance practice since the Spring 2011 newsletter. It is not a comprehensive digest of every case involving insurance issues during this period or of every holding in the cases discussed. This newsletter was not compiled for the purpose of offering legal advice. Any opinions expressed herein are those of the authors and do not necessarily reflect the views of Beirne, Maynard & Parsons, L.L.P.

FURTHER LIMITATIONS ON *MID-CONTINENT V. LIBERTY MUTUAL*

Evanston Ins. Co. v. National Union Fire Ins. Co. of Pittsburgh, PA., 2010 WL 2854289 (E.D. Tex. July 19, 2010)

Mid-Continent v. Liberty Mutual does not preclude a claim for contribution between two excess co-insurers whose policies both contained "excess" other insurance clauses.

This is another case arising out of the settlement of a wrongful death claim by Atofina Petrochemicals, Inc. ("Atofina"). The deceased worker was an employee of Triple S, a contractor of Atofina. Triple S was insured by a $1 million primary policy issued by Admiral and a $9 million umbrella policy issued by Evantson. Atofina was an additional insured on both the Admiral and Evanston policies. Atofina was insured under a $1 million primary policy issued by Liberty Mutual and a $25 million excess policy issued by National Union.

After the filing of the wrongful death suit, Admiral and Liberty Mutual both tendered their policy limits to Atofina. Evanston denied coverage. Atofina brought a declaratory judgment action against both Evanston and National Union seeking a determination of coverage under the excess policies. National Union and Atofina then reached an agreement that National Union would fund any judgment or settlement paid by Atofina provided Atofina was unsuccessful in pursuing its claims against Evanston.

The wrongful death case settled for $6.75 million and Atofina sought to recover $5.75 million from Evanston (after allowing for the $1 million funded by Admiral. Ultimately, the Texas Supreme Court held that Evanston was liable and it paid Atofina $5.75 million. In this lawsuit, Evanston sought to recover from National Union, its pro-rata share of $4.75 million (the 6.75 million settlement less the $1 million funded by the primary carriers) under theories of contribution, contractual and equitable subrogation, breach of contract and unjust enrichment.

On cross-motions for summary judgment, the court held that Evanston was entitled to recover from National Union its proportionate share of the $4.75 million 25/34ths) allocable to the excess carriers. The court first rejected National Union's contention that Evantson's $5.75 million payment to Atofina revived the Liberty Mutual primary policy such that National Union's excess policy was never triggered. Turning to Evanston's contribution claim, the court rejected the contention that *Mid-Continent v. Liberty Mutual* barred Evanston's claim, noting that *Mid-Continent v. Liberty Mutual* was expressly limited to the "context presented." Both the Evanston and National Union policies contained "excess" other insurance clauses rather than pro-rata clauses at issue in *Mid-Continent v. Liberty Mutual*. Thus, the court reasoned, neither policy suggested that either Evanston or National Union was agreeing to pay only its proportionate share of the loss.

The court also distinguished *Mid-Continent v. Liberty Mutual* on the grounds that, unlike the carriers in that case, Evanston denied coverage and only paid after being ordered to do so by the Texas Supreme Court. Accordingly, Evanston could not be regarded as a volunteer.

The court then turned to Texas law dealing with the interpretation of other insurance clauses, and in particular, *Hardware Dealers*. Finding that the two "excess" other insurance clauses conflicted, the court disregarding both other insurance clauses and assessed liability for the settlement on a proportionate basis.

Maryland Casualty Co. v. Acceptance Indemnity Ins. Co., 639 F.3d 701 (5th Cir. 2011)

Mid-Continent v. Liberty Mutual does not preclude a contractual subrogation claim by one insurer that defended and settled a claim against another insurer that denied coverage and refused to defend or indemnify the insurers' common insured.

Guidry was insured under a series of four consecutive CGL policies. The first policy was issued by Maryland, while the subsequent three policies were issued by Acceptance.

Guidry constructed a swimming pool during the policy period of the Maryland policy. Over the next few years, four leaks and a crack developed in the pool. Guidry repaired the first leak, but additional leaks developed and were repaired a different contractor. The pool owner brought suit against Guidry and Guidry tendered the claim to both Maryland and Acceptance.

Maryland agreed to defend Guidry, but Acceptance denied any obligation to defend or indemnify. Maryland settled the case and obtained a full release of its insured. Maryland then brought suit against Acceptance seeking a declaration that Acceptance owed a duty to defend and indemnify Guidry and seeking Acceptance's pro rata share of the costs it incurred to defend and settle the claim under theories of contribution and contractual and equitable subrogation.

The district court held that Acceptance had a duty to defend and that Maryland was entitled to recover a pro rata portion of the defense costs. The district court granted Acceptances motion for summary judgment as to Maryland's contribution claim, but denied the motion as to the subrogation claim. The district court distinguished *Mid-Continent v. Liberty Mutual* on two grounds: 1) Acceptance had denied any duty to defend or indemnify; and 2) Maryland and Acceptance were not co-insurers because they insured Guidry under separate, consecutive policies that did not provide overlapping coverage for the same claim.

The Fifth Circuit affirmed, holding that *Mid-Continent v. Liberty Mutual* does not bar a contractual subrogation claim when one of the insurers has denied coverage. The Fifth Circuit did not reach the issue of whether insurers under consecutive, rather than overlapping, policies were co-insurers. The Fifth Circuit also affirmed the award of a pro rata portion of the defense costs, relying on *Trinity Universal v. Employers.*

This case also raised the issue of the interaction between *Mid-Continent v. Liberty Mutual* and *Don's Building v. OneBeacon* and the potential impediments to settlement when multiple policies are implicated by property damage that occurs over a period of years. The Fifth Circuit's determination that *Mid-Continent* did not apply because Acceptance had denied coverage made it unnecessary for the court to consider that issue. However, the district court solved the potential problems associated with coverage afforded to an insured by consecutive, non-overlapping policies issued by different carriers by holding that in such a situation, the insurers are not co-insurers and that since there was no overlapping coverage, *Mid-Continent* did not apply.

Colony Ins. Co. v. Peachtree Construction, Ltd., 647 F.3d 248 (5th Cir. 2011)

The Fifth Circuit reversed and remanded: (1) the district court's summary judgment finding no duty defend or indemnify based upon the underlying plaintiff's allegations of negligence only on the part of an additional insured in light of the Texas Supreme Court's holding in *D.R. Horton v. Markel*; and (2) the district court's dismissal of an excess carrier's subrogation claim based on *Mid-Continent v. Liberty Mutual*, in light of the Fifth Circuit's recent decision in *Amerisure v. Navigators*.

Peachtree was hired by TXDOT as the general contractor on repaving project. Peachtree subcontracted with Cross Roads to provide signs, barricades and warning devices on the project. Cross Roads obtained primary and excess liability insurance naming Peachtree as an additional insured. Pursuant to the contract between Cross Roads and Peachtree, Cross Road's insurance would be primary to any other coverage carried by Peachtree. Colony was the primary carrier for Cross Roads.

Peachtree also carried primary coverage with Travelers and excess coverage with Great American. Peachtree was named in a wrongful death lawsuit alleging negligence in the use of signage, barricades and warnings. Peachtree joined the Cross Roads as a third-party defendant and demanded a defense from Colony as an additional insured. Colony agreed to defend, subject to a reservation of rights. Colony filed a declaratory judgment action against Peachtree and Travelers asserting that it had no duty to defend or indemnify Peachtree because the underlying petition only alleged negligence against Peachtree,

not Cross Roads. After a settlement of the underlying lawsuit funded by Travelers, Great American and Colony, Great American intervened in the declaratory judgment action seeking reimbursement of its contribution to the settlement from Colony.

The district court dismissed Great American's complaint, holding that Great American's reimbursement claims were precluded by *Mid-Continent v. Liberty Mutual*. The district court also granted Colony's motion for summary judgment, finding that because Colony owed no duty to defend Peachtree, it could have no duty to indemnify. The Fifth Circuit reversed the summary judgment in favor of Colony, noting that after the district court's ruling, the Texas Supreme Court had decided *D.R. Horton – Texas, Ltd. v. Markel Int'l,* holding that an insurer could have a duty to indemnify even absent a duty to defend. Thus, the Fifth Circuit determined that the district court's ruling on the motion for summary judgment was both premature and incorrect, in that the district court refused to consider extensive evidence offered by Peachtree and Great American with respect to Cross Roads' involvement in the project.

The Fifth Circuit also concluded that *Mid-Continent* does not preclude Great American's contractual subrogation claim as a matter of law. Noting that after the district court granted Colony's 12(b)(6) motion, the Fifth Circuit rejected an overly broad reading of *Mid-Continent* in *Amerisure Ins. Co. v. Navigators Ins. Co.*, 611 F.3d 299 (5th Cir. 2010). In *Amerisure*, the Fifth Circuit observed that the majority of district courts to have considered *Mid-Continent* have "cabined it to its facts."

The Fifth Circuit then applied the criteria utilized by Judge Rosenthal in *Employers Ins. Co. of Wausau v. Penn-America Ins. Co.*, 705 F.Supp.2d 696 (S.D. Tex. 2010), limiting *Mid-Continent* to situations where the insurers: (1) were co-primary insurers; (2) did not dispute that both covered the loss; and (3) were subject to "pro-rata" other insurance clauses. Noting that in this case, Colony has denied coverage and that, like *Amerisure*, this was a dispute between a primary and an excess carrier, the Fifth Circuit vacated the dismissal of Great American's subrogation claim and remanded the case to the district courts.

EXTRINSIC EVIDENCE

Weingarten Realty Management Co. v. Liberty Mut. Fire Ins. Co., 343 S.W.3d 859 (Tex. App. – Houston [14th Dist.] 2011, pet. denied)

While the duty to defend is ordinarily determined based upon the eight corners rule, that rule applies only for the protection of parties to the insurance contract. Extrinsic evidence, even evidence contradicting the plaintiff's allegations in the underlying lawsuit, was admissible to establish that the defendant was not an additional insured.

In the underlying liability lawsuit, Johnson sued her employer, Norstan Apparel Ships and Weingarten Realty Management Company ("Weingarten Management") arising out of an assault at her place of employment. Johnson alleged that Weingarten Management was the entity that leased the retail space to her employer. However, the actual lessor was a different entity, Weingarten Realty Investors ("Weingarten Investors"), Weingarten Management only managed the property.

The lease between Johnson's employer and Weingarten Investors required Norstan to obtain a liability policy naming "all lessors of the premises" as additional insureds. Norstan acquired such a policy from Liberty Mutual.

Weingarten Management initially defended the Johnson lawsuit pursuant to a self-insured retention and it was subsequently defended by its own carrier, Scottsdale. Weingarten Management subsequently demanded a defense from Liberty Mutual, but Liberty Mutual denied coverage. The case was tried and a jury found no liability on the part of Weingarten Management.

Weingarten Management and Scottsdale brought suit against Liberty Mutual seeking to recover the defense costs they expended in the Johnson lawsuit, contending that Liberty Mutual owed a defense to Weingarten Management due to Johnson's allegations that Weingarten Management was the lessor of the premises. Weingarten Management and Scottsdale conceded that Weingarten Management was not the lessor of the property.

The court held that extrinsic evidence could be considered to determine whether there was a duty to defend Weingarten Management. The court reasoned that the eight corners rule applies to protect parties to the insurance contract. As a stranger to the contract, Weingarten Management was not entitled to that protection. Therefore, extrinsic evidence showing that Weingarten Management was not the lessor of the property was admissible to establish that Weingarten Management was not an additional insured under the policy despite the fact that this

evidence contradicted the allegations in the plaintiff's petition.

POLICY BUY-BACK NOT AGAINST PUBLIC POLICY

General Agents Ins. Co. of America, Inc. v. El Naggar, 340 S.W.3d 552 (Tex. App. — Houston [14th Dist.] 2011, no pet. h.)

Policy buy-back agreement between insurer and insured is not void as against public policy in absence of strong public policy reasons against enforcement.

El Naggar brought suit against Traxel Construction, and others, in connection with a dispute over the construction of a building. Traxel was insured under a CGL policy issued by Gainsco. After the first trial between El nagger and Traxel ended in a mistrial, Gainsco and Traxel entered into a policy buy-back agreement whereby in exchange for $50,000, Traxel released Gainsco from any liability under the policy. El Naggar contended that the policy buy-back agreement was void as against public policy because both Gainsco and Traxel were aware of El Naggar's claims at the time of the agreement, that the agreement leaved El Naggar without a remedy and that the insurance was a prerequisite to the construction contract (disputed).

The Court of Appeals declared that the policy buy-back agreement was not void as against public policy under these circumstances. In so doing, the court distinguished *Ranger v. Ward*, the principal case relied upon by El Naggar, on the grounds that in *Ranger*, there was a statute requiring the insurance in question.

PROPER *STOWERS* DEMAND

McDonald v. Home State County Mutual Insurance Co., 2011 WL 1103116 (Tex. App. – Houston [1st Dist.] 2011, pet. denied)

In order to trigger insurer's under the common law *Stowers* duty or the insurer's statutory duty to settle a third-party claim, settlement demand from plaintiff must offer to release any hospital liens. The failure of plaintiff's demand to specifically offer to release a hospital lien negated any duty to settle and the potential invalidity of the hospital lien is irrelevant.

McDonald was seriously injured when he was struck by a vehicle operated by Rangel, who was insured by Home State. McDonald was treated at Memorial Hermann Hospital, which filed a hospital lien. McDonald's counsel sent a time sensitive demand offering to settle McDonald's claims in exchange for the payment to McDonald of the total amount of liability insurance available. The demand did not reference Memorial Hermann's lien.

Prior to the time to accept the demand, the adjuster handling the claim learned of the Memorial Hermann lien. On the day the demand was to expire, the adjuster called McDonald's attorney and left a message offering to settle the claim for the full amount of Rangel's policy limits and asking that the attorney return the call. The call was not returned. Shortly thereafter, the insurer again offered to settle the claim for full policy limits provided McDonald sign a document expressly releasing the hospital lien. This offer was rejected.

McDonald's case against Rangel was tried to the court and McDonald obtained a sizeable judgment. He then obtained a turnover of any rights Rangel had against his insurer. McDonald asserted that Home State breached its *Stowers* and statutory duties to settle.

The Court of Appeals rejected McDonald's contention that release of the hospital lien was "implicit" in his demand, noting that there was no mention of the hospital lien in the demand letter. The court also noted that the demand required payment of full policy limits to McDonald, which could have left Home State liable to Memorial Hermann under the lien. Accordingly, a reasonably prudent insurer would not have accepted the demand.

McDonald next argued that the lien was invalid because it listed an incorrect date of accident, had the wrong address for McDonald and did not specifically identify Rangel as the responsible third-party. The court stated that "the validity of the lien itself is irrelevant to whether the demand letter triggered the *Stowers* duty."

ALLOCATION/CONCURRENT CAUSES

Markel American Insurance Co. v. Lennar Corp., 342 S.W.3d 704 (Tex. App. – Houston [14th Dist.] 2011, pet. filed)

This appeal follows a jury trial after Lennar I was remanded to the trial court after an appeal from competing summary judgments. After a jury trial, the district court rendered judgment in favor of Lennar. On appeal, in Lennar II, the Court of Appeals reversed and rendered judgment in favor of Markel.

This opinion is well worth reading considering its analysis of the insured's burden to apportion damages between covered and uncovered claims and whether a unilateral settlement by the insured falls within the definition of "ultimate net loss" for purposes of coverage. The facts of the case are well-known to most practitioners in the insurance field. Accordingly, they will not be recounted here. However, a brief description of the key holdings might prove useful.

The insured must prove that damages are covered under a policy in order to recover. Under the doctrine of concurrent causes, when covered and non-covered perils combine to create a loss, the insured is only entitled to recover the portion of damage caused by the covered peril. In Lennar I, the court found that the costs to remove the EFIS system in order to repair other property damage was a covered loss, but that the cost to remove the EFIS system because it was defective in order to prevent property damage was not covered. The jury issues requested by Lennar failed to apportion between these two elements of damages. Thus, in Lennar II, the Court of Appeals reversed and rendered judgment in favor of Markel.

The Markel policy contained the standard definition of "ultimate net loss" that, in the case of a settlement, requires the written consent of the insurer. It was undisputed that Markel did not consent to the settlements in writing.

Lennar contended that the lack of consent was immaterial, pointing to the Court of Appeals' holding in Lennar I that an insurer cannot rely on a settlement without consent condition to avoid coverage unless the insurer suffers prejudice. Lennar relied upon a jury finding that Markel was not prejudiced by Lennar's settlement.

The Court of Appeals rejected Lennar's argument pointing out that Markel was not relying on the voluntary payment condition in the policy. Rather, it was relying on the definition of "ultimate net loss" itself, which provided that a settlement must be with the insurer's consent to fall within the definition. The Court of Appeals noted that a condition was not at issue and since waiver cannot operate to rewrite an insurance policy and create coverage where none exists, Markel's lack of consent to Lennar's settlements precluded Lennar from establishing that it incurred "ultimate net loss" within the meaning of the policy. The Court of Appeals reversed and rendered.

CONTRACTING DISEASE NOT AN AUTO ACCIDENT

Lancer Ins. Co. v. Garcia Holiday Tours, 345 S.W.3d 50 (Tex. 2011)

The Texas Supreme Court held that the transmission of a communicable disease from a bus driver to his passengers is not a risk covered by Lancer's business auto policy, affording coverage for accidental bodily injuries resulting from the vehicle's use. The Court concluded that the passengers' injuries did not result from the vehicle's use but rather from the bus company's use of an unhealthy driver.

Several Alice High School band members contracted tuberculosis ("TB") from a bus driver who took them on a field trip to Six Flags Fiesta Texas. The infected band members sued the driver and the operator of the bus company, Garcia Holiday Tours, asserting that they were negligently exposed to the disease as a result of being confined on the bus with the infected driver, who was coughing throughout the trip. The bus company notified its insurance carrier, Lancer Insurance Company, of the suit, but Lancer refused to defend. The bus company proceeded to trial, where a jury found it and the driver liable and awarded over $5 million in damages to the infected passengers. After judgment was entered, the bus company and driver sued Lancer, asserting contractual and extra-contractual claims and seeking a declaratory judgment under the business auto policy. The passengers-judgment creditors intervened, and also sought a declaration under the policy. Competing summary judgments were filed. The trial court granted the passengers' motion and denied Lancers'.

Lancer's business auto policy afforded coverage for damages the insured was legally obligated to pay "because of 'bodily injury' . . . caused by an 'accident' and resulting from the ownership, maintenance, or use of a covered 'auto.'" Lancer conceded the bus was a covered "auto," that the passengers' claims involved an accident, and that tuberculosis is a "bodily injury" under the policy, but denied that the accident and injuries resulted from the use of the bus, as the policy requires. While agreeing that the policy might provide coverage for communicable diseases transmitted during the bus trip, the Court of Appeals nevertheless reversed the passengers' summary judgment because there was no conclusive proof that the infections had occurred on the bus and remanded the case to resolve this factual dispute. Lancer appealed to the Texas Supreme Court.

In reversing the Court of Appeals' decision, the Texas Supreme Court examined the issue of whether the bus's use caused the injuries under *Mid-Century Ins. Co. of Texas v. Lindsey*, 997 SW.2d 153 (Tex. 1999), which requires some causal connection "between the accident or injury and the use of the motor vehicle." *Id*. at 156. In analyzing that connection, the Supreme Court indicated "that to invoke coverage the vehicle's use must be a producing cause or a cause in fact of the accidental injury." *Lancer Ins. Co. v. Garcia Holiday Tours*, 345 S.W.3rd 50, 57 (Tex. 2011). The Court emphasized that to be a producing cause the use must have been a substantial factor in bringing about the injury, which would not otherwise have occurred. *Id*. The Court held that when the vehicle merely furnishes a place or situs for the accident or injury to occur, as the bus did here, it is not a substantial factor, and the causal link is insufficient to invoke coverage. The Court also noted that the exposure to the infected person could have occurred anywhere and that the bus did not generate the TB bacteria or make it more virulent. Accordingly, the Court of Appeals' judgment was reversed and judgment was rendered that the passengers, bus company and driver take nothing on their indemnity claim against Lancer.

CERTIFIED QUESTIONS PENDING

Evanston Insurance Co. v. Legacy of Life, Inc., 645 F.3d 739 (5th Cir. 2011)

1. Does policy coverage for "personal injury" provide coverage for mental anguish without physical manifestation?

2. Does policy coverage for "property damage" provide coverage for alleged loss of use of the plaintiff's deceased mother's organs and tissues?

This case involves the interpretation of a combined professional and general liability insurance policy issued by Evanston Insurance Co. to Legacy of Life, Inc. Evanston denied Legacy's request for a defense of the underlying lawsuit seeking, among other things, mental anguish damages and property damage, including consequential loss of use, relating to the harvesting and donation of a deceased's organs and tissues. Neither the alleged mental anguish or alleged injury to or destruction of property involved physical injury. The plaintiff alleged that her deceased mother consented to Legacy harvesting of her mother's organs and tissues based upon the representation that the harvested organs and tissues would be distributed on an non-profit basis, and that, contrary to these representations, Legacy transferred the tissues to a for-profit company, which sold the tissues to hospitals at a profit.

After denying the request for a defense Evanston filed this suit, seeking a declaratory judgment that it had no duty to defend Legacy. The policy provides professional liability coverage for "personal injury" arising out of an act, error or omission in professional services rendered. "Personal injury" is defined to mean "bodily injury, sickness, or disease including death. . . ." The policy also provides general liability coverage for "Personal Injury or Property Damage." The policy defines "Property Damage," as "Physical Injury to or destruction of tangible property, including consequential loss of use thereof, or loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an Occurrence."

Evanston and Legacy filed competing motions for summary judgment on the duty to defend issue. The District Court granted Legacy's motion and denied Evanston's motion. The Court determined that the policy's definition of "Personal Injury" was broad enough to cover mental anguish and emotional distress. It further determined that the policy covered the alleged loss of use of the tissues and organs because it believed that a Texas court could potentially find the deceased's tissues and organs were "property," which falls within the "property damage" coverage.

Despite the Texas Supreme Court's opinion in *Trinity Universal Insurance, Co. v. Cowen*, 945 S.W.2d 819, 823-24 (Tex. 1997), holding that "an insurance contract defining 'bodily injury' as 'bodily harm, sickness, or disease,' did *not* include 'purely emotional injuries'…and 'unambiguously requires an injury to the physical structure of the human body,'" the Fifth Circuit found that the proper interpretation of "personal injury" under Legacy's policy is not clear under existing Texas law. While the definitions at issue in this case, and in *Trinity*, are nearly identical, the Court emphasized that the term being defined is not, and "personal injury" could be read to encompass more than simple physical harm because "personal injury," as opposed to "bodily injury," could include claims for emotional distress. Since the term "personal injury" has not been addressed by Texas appellate courts in the liability insurance coverage context, the Fifth Circuit certified the question of whether the policy's definition of "personal injury" includes coverage for mental anguish unrelated to physical damage.

Additionally, the Court certified the question of whether the policy's definition of "property damage" provided coverage for alleged loss of use of the plaintiff's deceased mother's organs and tissues, noting that Texas law is unclear as to whether the existence of quasi-property rights, rather than full property rights, that exist in body parts, would be sufficient to trigger coverage under the policy's definition of "property damage." Citing, *Burnette v. Surratt*, 67 S.W.2d 1041, 1041 (Tex. Civ. App.—Dallas 1934, writ ref'd)(even though "there is no property in dead man's body," a dead man's body "may be considered as a sort of 'quasi-property,' in which certain persons have rights therein…."). The Court noted that it is unclear whether *Burnette's* holding that full property rights do not exist in the body of the decedent extends to the direct question presented here – "whether alleged loss of use of human tissues, organs, bones, and body parts fall within an insurance policy's definition of loss of use of "tangible property," given *Burnette's* acknowledgment of certain "quasi-property" rights in a decedent's body.

PARTIES' "STRIKE–THROUGHS" IN FORM INSURING AGREEMENT MUST BE CONSIDERED

The Houston Exploration Co. & Offshore Specialty Fabricators, Inc. v. Wellington Underwriting Agencies, Ltd., 2011 WL 379631 (Tex. August 26, 2011)

The Texas Supreme Court held that the parties' strike-throughs of certain provisions in a builder's "all risk" property damage insurance policy reflected the party's intention that certain expenses incurred in connection with a covered loss would not be reimbursed under the policy's indemnity provision. While recognizing that deletions from a draft insuring agreement do not always indicate the party's intent, the Court found that they do when, as here, they are part of the customary negotiation process.

Offshore Specialty Fabricators, Inc. agreed to construct a drilling platform for the Houston Exploration Company. The contract required Offshore to obtain builders risk insurance naming Houston Exploration as an additional insured. Offshore Specialty's local broker, negotiated coverage in the London market, and as is customary there, the parties reached an agreement by lining through provisions in a form insurance policy. The policy terms provided that the insurer, Wellington, would indemnify the insureds for "cost necessarily incurred and duly justified in repair or replacement" of lost or damaged property. However, several provisions calling for reimbursement of other expenses associated with covered losses were struck through, including a provision related to "stand-by charges," which provided payment for the cost of keeping equipment used for the repairs available through delays for bad weather.

A few weeks after the policy issued, the drilling platform Offshore constructed became unstable, requiring immediate repairs. However, work was delayed by severe storms in the Gulf of Mexico during which Offshore kept repair vessels standing by so that they could resume repairs as soon as the weather improved. The insureds submitted a claim for over $3 million, which included about $1 million for weather stand-by charges. The underwriters paid over $2 million, acknowledging that the platform damage was a covered occurrence, but refused to pay the weather stand-by charges. The insureds sued the underwriters on the policy, and the underwriters counterclaimed, alleging a false claim. The trial court granted partial summary judgment for the insureds, construing the policy to require payment of the weather stand-by charges. In its Order, the trial court explained that it disregarded the stricken policy language as parol evidence, finding the policy to be unambiguous in favor of coverage. The Order further explained that "whereas parol evidence may be used to interpret an ambiguous contract, it cannot be used to create an ambiguity."

On interlocutory appeal, the Court of Appeals held that the stand-by charges were not covered under the policy, noting that by striking out the provision, the parties must have intended that the charges were not reimbursable. The Court specifically held that "deletions remaining within an insurance policy can be considered in construing an unambiguous insurance policy."

In affirming the Court of Appeals' decision, the Texas Supreme Court held that deletions in a printed form agreement must be considered when construing the policy, and are indicative of the parties' intent. The Court explained that a written contract must be construed to give effect to the parties' intent expressed in the text as understood in light of the facts and circumstances surrounding the contract's execution subject to the parol evidence rule. Although the parol evidence rule applies when parties have a valid, integrated written agreement and precludes enforcement of prior or contemporaneous agreements, the rule does not prohibit consideration of surrounding circumstances that inform, rather than vary from or contradict the contract text. The Court

further explained that the manner in which the insurance policy in this case was negotiated in the London market is crucial to understanding its terms. The parties did not create the policy text; rather they began with a form policy that covered "all risk" of property damage, subject to a laundry list of terms that provided for reimbursement of different expenses incurred in connection with the covered loss. They did not edit the policy language, but they did strike-through several provisions requiring reimbursement of expenses, which clearly evidenced the parties' intent in the contract.

CLAIM ACCRUES FOR LIMITATIONS PURPOSES WHEN COVERAGE DENIED – NO "MAGIC WORDS" REQUIRED

Citigroup, Inc. v. Federal Ins. Co., Twin City Fire Ins. Co., 649 F.3d 367 (5th Cir. 2011)

The Fifth Circuit held that the insured's breach of contract claims accrued when the insurer communicated that it would not provide coverage to the insured and were, therefore, barred by limitations because they were not filed within 4 years of such accrual date.

The Court noted that a claim for a breach of an insurance contract accrues and limitations begin to run on the date coverage is denied. The Court explained, however, that denial letters need not contain any "magic words. . . used to deny a claim," but merely must communicate that the insurer or policy will not provide coverage for the claim. Citing *Provident Life & Accident Insurance Co. v. Knott*, 128 S.W.3d 211 (Tex. 2003) (explaining that in order for a letter to constitute a denial, the letter need not use the term "denial," but only state that there is not coverage for the claim and give reasons why). Here, coverage was sufficiently denied for accrual purposes when the excess carrier sent the insured a letter advising that "Twin City cannot extend coverage under its policy," and that "no coverage is afforded." Accordingly, the insured's breach of contract claim was barred by limitation since it was filed more than four years after the carrier communicated the denial.

EXCLUSION REQUIRES ONLY "CAUSAL CONNECTION OR RELATION" OR "INCIDENTAL RELATIONSHIP"

National Fire Ins. Co. of Hartford v. Radiology Associates, 2011 WL 3444213 (5th Cir. August 8, 2011)

In this duty to defend case, the Fifth Circuit held that a patient's sexual assault claims against the insured were excluded from coverage because the claims arose out of specifically excluded conduct, *i.e.*, claims arising out of (or having a causal connection or relation to) any sexual act, violation of the penal code or an intentional tort.

The insured, Radiology Associates and its former employee, Brian K. Riley were sued by Marie and Daniel Pecore, who alleged Riley sexually assaulted Marie when he performed an unauthorized vaginal examination. The Pecores specifically alleged that Radiology Associates negligently failed to provide a chaperone during the examination, failed to post notices informing patients of the right to a chaperone and failed to monitor its employees properly. Upon receipt of the complaint, Radiology Associates requested a defense from its professional liability insurer, American Physicians, as well as its standard umbrella insurers. All three insurers refused to defend.

Radiology Associates subsequently filed a third-party complaint against American Physicians, seeking a declaratory judgment and alleging breach of contract for refusing to defend.

The policy at issue provided coverage for claims resulting from "professional services," but contained three exclusion which excluded coverage for any claims "arising out of" any sexual act, an act or omission in violation of the penal code, or an intentional tort. The district court granted summary judgment in favor of Radiology Associates holding that it was unclear whether any of these exclusions applied to Riley's actions as described in the complaint.

In reversing the district court's summary judgment, the Fifth Circuit held that the claims were excluded because they all "arise out of" Riley's unauthorized sexual conduct and, but for the improper conduct, the plaintiffs would have no claims against Radiology Associates.

The Fifth Circuit noted that the district court concluded that American Physicians had a duty to defend because it was unclear whether the alleged facts fit into an exclusion and that alleged facts "potentially stated a claim for negligence" because Riley may have negligently thought he was entitled to administer a vaginal exam, or that in the course of performing the authorized ultrasound he negligently and inappropriately touched Pecore. The Fifth Circuit emphasized, however, that the complaint

made no allegations that Riley "may have negligently believed his actions were authorized" and cautioned that courts should not "imagine factual scenarios which might trigger coverage." Applying the "eight corners rule" and focusing on the actual facts alleged in the complaint which described Riley's conduct as "a sexual assault," the Court concluded that Riley's conduct constituted unauthorized sexual conduct.

Even though the complaint specifically alleged that Radiology Associates negligently failed to provide a chaperone, failed to post notice informing patients of their right to a chaperone, and failed to monitor its employees properly, the Fifth Circuit held that these claims fell outside of the policy coverage because they "arise out of" Riley's unauthorized sexual conduct, and but for Riley's improper conduct, Pecore would have no claims against Radiology Associates. Therefore, these claims fall within the policy exclusions and outside of the policy coverage, relieving American Physicians of its duty to defend.

In determining whether the claims arose of out Riley's excluded actions, the Court relied upon *Utica National Insurance Co. of Texas v. American Indemnity Co.*, 141 S.W.3d 198-203 (Tex. 2004), which "held that 'arises out of' means that there is simply a 'causal connection or relation,' which is interpreted to mean that there is but for causation, though not necessarily direct or proximate causation." The Court also noted that it had previously held, applying Texas law, that "when an exclusion prevents coverage for injuries arising out of particular conduct," a claim need only bear an *incidental relationship* to the described conduct for the exclusion to apply."

Finally, the court rejected the insured's argument that, in analyzing the duty to defend, the court must interpret the allegations in the complaint from the "standpoint of the insured," and stated that "the Texas Supreme Court has made clear that the use of the insured's perspective is limited to defining occurrences." Citing, *King v. Dallas Fire Ins. Co.*, 85 S.W.3d 185, 191-192 (Tex. 2002).

NO ABATEMENT WHILE APPRAISAL GOES FORWARD

In Re Liberty Mutual Group, Inc., 2011 WL 2149482. (Tex. App.—Houston [14th Dist.] May 26, 2011, no pet.)

The Fourteenth Court of Appeals confirmed that mandamus will not lie regarding the grant or denial of a motion to abate pending the completion of an appraisal. The court relied upon the Texas Supreme Court's recent holding that "the trial court's failure to grant the motion to abate is not subject to mandamus, and the proceedings need not be abated while the appraisal goes forward." Citing, *In re Universal Underwriters of Texas Ins. Co*., 2011 WL 1713278, *7 n.5 (Tex. May 6, 2011).

This proceeding arose from a dispute over the amount of a covered loss under a homeowner's insurance policy. The real parties in interest, the Mitchells, filed a claim with Liberty Mutual under their homeowner's policy after Hurricane Ike. When a dispute arose over the amount of the covered loss, Liberty Mutual invoked the appraisal process under the terms of the policy. The Appraisal was underway when the Mitchells filed suit. Liberty Mutual answered and filed a motion to abate the case until the appraisal was completed. In its petition, Liberty Mutual sought an order compelling the trial court to abate the underlying proceeding until the appraisal was completed.

While noting that the mandamus relief is appropriate to enforce an appraisal clause, the court of appeals confirmed that mandamus is not available regarding the trial court's failure to grant a motion to abate pending the appraisal.

MANDAMUS APPROPRIATE TO ENFORCE APPRAISAL, BUT NOT TO ABATE DURING APPRAISAL

In re Universal Underwriters of Texas Ins. Co., 2011 WL 1713278 (Tex. May 6, 2011)

The Texas Supreme Court conditionally granted mandamus compelling the trial court to grant Universal's motion to compel appraisal, but held that the trial court's failure to grant a motion to abate the underlying proceeding during the appraisal was not subject to mandamus (Citing, *In re Allstate Cnty. Mut. Ins. Co*., 85 S.W.3d 193, 196 (Tex. 2002).

Grubbs Infinity, a car dealership, suffered hail damage to buildings on its property. Grubbs filed a claim with its insurer, Universal Underwriters, which subsequently paid over $4 million for the damage. Grubbs asked Universal to re-inspect, contending the claim had not been investigated or fully paid. Universal re-inspected and made a supplemental payment. Several months later, Grubbs sued Universal for underpayment, alleging breach of contract and bad faith, as well as violations of the DTPA and the Texas Insurance Code. Universal answered and invoked the policy's appraisal clause

by filing a motion to compel appraisal and to abate all other proceedings in the interim. When the trial court denied the motion, Universal unsuccessfully sought mandamus relief from the court of appeals. Universal petitioned the Texas Supreme Court, which, after hearing oral argument, conditionally granted relief.

Grubbs alleged that Universal waived its right to invoke appraisal by waiting eight months, from the date that Grubbs asked for re-inspection to the date that Grubbs sued, before demanding appraisal. Grubbs argued that this was an unreasonable delay as a matter of law. The Texas Supreme Court, noting that appraisal clauses are generally enforceable absent illegality or waiver, held that Universal had not waived its right to appraisal. The Court stated that, "while an unreasonable delay is a factor in finding waiver, reasonableness must be measured from the point of impasse." *Id.* at *3. Noting that "an impasse is not the same as a disagreement about the amount of loss" and that ongoing negotiations … do not trigger a party's obligation to demand appraisal," the Court found that Universal invoked appraisal within a reasonable time after the parties had reached an impasse. *Id.* at *3-5. Additionally, the Supreme Court noted that"[M]ere delay is not enough to find waiver; a party must show that it has been prejudiced." *Id.* "Prejudice to a party may arise in any number of ways that demonstrate harm to a party's legal rights or financial position." *Id.* The Court observed, however, that "it is difficult to see how prejudice could ever be shown when the policy, like the one here, gives both sides the same opportunity to demand appraisal. If a party senses that impasse has been reached, it can avoid prejudice by demanding appraisal itself." *Id*. Grubbs, however, failed to demonstrate prejudice.

EDM Office Services, Inc. v. Hartford Lloyds Ins. Co., 2011 WL 2619069 (S.D. Tex. July 1, 2011)

The district court issued an order granting the insurer's motion to compel appraisal finding that compliance with the alleged "claims handling" provisions of the contract and the Texas Insurance Code is not a condition precedent to compelling appraisal. The court further found that the insurer had not waived its right to invoke appraisal, nor had the insured proved that it had been prejudiced.

Following Hurricane Ike, the insured, EDM., filed a claim under its insurance policy with Hartford alleging roof damage and water intrusion damage throughout the building. Hartford's insurance adjuster inspected the property and estimated that the property damage was in an amount lower than the policy's deductible.

EDM filed suit alleging claims for breach of contract, common law bad faith and violations of the Texas Insurance Code. The case was originally filed in state court on September 2, 2010, but was subsequently removed by Hartford to federal court. Hartford moved to compel appraisal on May 25, 2011. EDM argued that Hartford was not entitled to appraisal because it failed to conduct a reasonable investigation of the claim, which it asserted was a condition precedent to invoking appraisal. Additionally, EDM argued that Hartford failed to comply with various contractual and statutory provisions related to the handling and payment of the claim, including alleged violations of §§542.056 and 541.060.

The district court held that contractual and statutory compliance were not a condition precedent to exercising appraisal rights under the policy. The court looked to the contract to determine whether it contained any conditional language to support EDM's claim of condition precedent. The court found no such language. Moreover, the court found that Hartford did not waive its right to appraisal under the policy, emphasizing that a mere delay in seeking appraisal is not enough to find waiver without a showing of prejudice. The court held that EDM had failed to prove that it had been prejudiced, citing, *In re Universal Underwriters of Texas Ins. Co*., 2011 WL 171 3278, *7 n.5 (Tex. May 6, 2011).

Finally, the district court looked at the issue of whether the case should be stayed during the appraisal process. The court noted that "while a trial court has no discretion to deny the appraisal, the court does have some discretion as to the timing of the appraisal." Noting that there is authority for both staying the entire case and continuing the litigation as relates to the coverage issues, the district court found that this case involved both coverage and loss valuation issues so it stayed only the part of the litigation involving loss valuation issues and continued the remainder of the case involving coverage issues pending the appraisal.

CONTRACT CLAIMS SEVERED FROM PROMPT PAYMENT AND EXTRA-CONTRACTUAL CLAIMS – BUT NO ABATEMENT

In re Loya Insurance Co., 2011 WL 3505434 (Tex.App.—Houston [1st Dist.] August 11, 2011, no pet.)

In this mandamus proceeding, Loya Insurance Company seeks mandamus relief from a trial court's order partially severing its insureds' breach of insurance contract claim from the insureds' extra-contractual claims, but refusing to sever the insureds' prompt payment claim or to abate any of the claims. The First Court of Appeals conditionally granted mandamus relief, directing the trial court to order a severance of the insureds' breach of contract claim from both the extra-contractual and prompt payment claims, but denying Loya's request for abatement.

The insureds sued Loya for breach of their homeowners' insurance policy, violation of the prompt payment provisions of Chapter 542 Texas Insurance Code, violation of the common law duty of good faith and fair dealing, and fraud. After the insureds rejected Loya's offer to settle all claims, Loya moved to sever and abate the contract claims from the extra-contractual claims. The trial court denied the motion and Loya sought a writ of mandamus, prompting the insureds to request that the trial court modify its order. The insureds agreed to sever the breach of contract claim from the extra-contractual claims, except for their statutory claim for prompt payment. Pursuant to the insureds' request, the trial court 1) vacated its earlier order, 2) severed the breach of contract and Ch. 542 prompt payment claims from the remainder of their claims, and 3) denied Loya's request for abatement.

The First Court of Appeals held that the insured's breach of contract and prompt payment claims presented distinct claims and directed the trial court to order that they be severed. The court noted that a trial court must sever the insureds' extra-contractual claims from its contractual claims to avoid prejudice when an insurer has made an offer to settle, noting that the insurer would be prejudice because evidence of the settlement offer is ordinarily inadmissible to prove the merit of the coverage claim but may be admissible as relates to the extra-contractual claims. Citing, *F.A. Richard and Assocs. v. Millard*, 856 S.W.2d 765, 766-67 (Tex. App. – Houston [1st Dist.] 1993, orig. proceeding); *U.S. Fire Ins. Co. v. Millard*, 847 S.W.2d 668, 671-72 (Tex. App. – Houston [1st Dist.] 1993, orig. proceeding). The Court declined to follow *Lusk v. Puryear*, 896 S.W.2d 377, 379 (Tex. App.—Amarillo 1995, orig. proceeding), which held that the trial court abused its discretion in severing an insured's breach of contract claims from its prompt payment claims, finding that *Lusk* was distinguishable because no settlement offer had been made by the insurer and there were no other underlying coverage disputes distinct from the contract claims as there were here.

Noting that both Houston Courts of Appeals have long concluded that where an insured has filed a breach of contract claim as well as extra-contractual claims, and the carrier has made a settlement offer, the trial court should abate the latter claims to prevent undue prejudice (*State Farm Mut. Auto. Ins. Co. v. Willborn*, 835 S.W.2d 260, 262 (Tex. App. – Houston [14th Dist.] 1992, orig. proceeding); *U.S. Fire Ins. Co. v. Millard*, 847 S.W.2d 668, 673 (Tex. App. – Houston [1st Dist.] 1993, orig. proceeding),), the Court held that the insurer was not entitled to abatement here because it failed to support an argument for complete abatement and failed to show prejudice or burden relating to continuing parallel discovery related to both claims. The Court did, however, hold that the insurer was entitled to a separate trial on the insured's extra-contractual claims.

DUTY TO DEFEND: REIMBURSEMENT FOR USE OF INDEPENDENT COUNSEL

Downhole Navigator, L.L.C. v. Nautilus Ins. Co., 2011 WL 4889125 (S.D. Tex. May 9, 2011)

In this declaratory judgment coverage action, the federal district court applied the principles of *Davalos* in ruling upon cross-motions for summary judgment, holding that the insured improperly rejected the carrier's counsel selection and was thus not entitled to reimbursement of defense costs related to its use of independent counsel because the insured failed to show that the facts to be adjudicated in the underlying suit were the same facts upon which coverage hinged.

Sedona Oil & Gas hired Downhole to provide directional drilling services to help redirect the drilling of a well to a better location in the reservoir. Downhole allegedly damaged the well during the process, and Sedona thereafter sued Downhole in state court under a negligence theory to recover its alleged damages. Downhole notified Nautilus of the claim and sought a defense and indemnity.

Nautilus issued a reservation of rights letter citing, *inter alia*, an exclusion for "Testing or Consulting Errors and Omissions," an "Engineers, Architects or Surveyors Professional Liability" exclusion, and a "Professional Liability Exclusion – Electronic Data Processing Services and Computer Consulting or Programming Services." Nautilus further advised that it would select counsel to provide a defense for

Downhole subject to the reservation of rights. Downhole rejected the offer of a defense and hired its own counsel, contending that Nautilus' failure to offer an unqualified defense created a "material" conflict. Nautilus disagreed, stating that it was simply reserving its rights pending investigation of the matter and arguing that Downhole was not entitled to separate counsel unless and until a coverage issue developed.

Downhole then filed this declaratory judgment action against Nautilus in federal court. Downhole subsequently filed a motion for summary judgment seeking both a determination that it was entitled to recover the defense costs incurred in the underlying action and a determination that it was entitled to indemnity for any judgment that might be rendered against it in that action. Nautilus filed cross-motions for summary judgment.

The district court denied Downhole's motion and granted a partial summary judgment in favor of Nautilus, holding that Downhole improperly rejected the carrier's chosen counsel and was not entitled to reimbursement of defense costs, but ruling that it was premature to rule on the indemnification issue.

The court noted in its analysis that the issue in the underlying suit brought by Sedona was whether Downhole was negligent, not whether Downhole was providing a service of the type excluded under the policy, and though Downhole expressed concern that the insurer retained counsel might direct the facts to indicate that Downhole was providing such services, the court pointed out that the state court fact finder would make no such determination. Accordingly, because Downhole failed to establish that the facts to be adjudicated in the underlying suit were the same facts upon which coverage hinged, Nautilus obtained summary judgment.

In holding that it was premature to rule on the indemnification issues, the court noted that it is well-settled Texas law that the duty to indemnify is established by the actual facts determining liability in the underlying case, and thus the duty to indemnify cannot determined until the underlying action is resolved.

ADVERTISING INJURY:
PUBLICATION REQUIRED

Continental Cas. Co. v. Consolidated Graphics, Inc., et al, 646 F.3d 210 (5th Cir. 2011)

In this coverage action brought in the wake of a substantial verdict in a trade secrets case, the 5th Circuit applied Texas law and held that there was no duty to defend and no coverage for advertising injury under the insurers' policies because there was no announcement or dissemination of a message designed to induce the general public to use the insured's services.

When Daniel Chambers left his employment at Rudamac, a California based printing company, and began working for Thousand Oaks Printing & Specialties, a subsidiary of Consolidated Graphics, he allegedly misappropriated trade secrets, including information relating to product pricing, profit margins and promotions. As a result, Rudamac sued Chambers, Thousand Oaks and Consolidated in California state court asserting causes of action for misappropriation of trade secrets, unfair business practices, intentional interference with prospective economic advantage, breach of fiduciary duty, unjust enrichment, intentional interference with employment relations, as well as seeking an accounting. The case was tried and the jury rendered a large verdict against all of the defendants, including a substantial punitive damages award.

Consolidated and its subsidiaries were insured under two primary liability policies issued by Sentry Insurance and an excess policy issued by Continental. All of the policies provided coverage for advertising injury. During the pendency of the underlying case, the insurers sought declaratory judgment in federal court in Texas seeking a judgment that there was no duty to defend or indemnify. The parties agreed that Texas law applied.

The Sentry policy required that an advertising injury be "committed in the course of advertising [the insured's] goods, products or services" in order for there to be coverage. In that regard, the court's analysis turned on whether the insured's conduct at issue in the underlying case constituted advertising. Though several other jurisdictions apply a broad meaning to the term "advertising," the court concluded that Texas' view is more restrictive – requiring that there be public dissemination of information aimed at inducing the public to purchase goods or services from the publishing party. Since the contacts that Chambers had with Rudamac's customers were one-on-one and there was no public dissemination of any kind, the court held that there was no advertising, no advertising injury, and no coverage.

Continental's excess policy contained clear language defining "advertisement" to require a broadcast or publication to the general public about goods or services for the purpose of attracting customers or supporters. Apparently recognizing the significance of that definition, the Consolidated insureds did not contend that there was an advertising injury within the meaning of the Continental policy. Instead, they argued that Continental had a duty to defend if Sentry had a defense obligation and its policy limits were exhausted. The court disposed of this argument by noting its holding that Sentry had no duty to defend.

The Consolidated insureds also argued that the duty to indemnify could not be determined from the summary judgment record. Given that Sentry was relying on the insuring clauses of the policies – not exclusions, the court held that the Consolidated insureds had the burden of establishing that the claims for which they sought defense costs and indemnification fell within coverage and that the Consolidated insureds failed to meet that burden.

DUTY TO DEFEND/INDEMNIFY: "YOUR WORK" EXCLUSION

Cook v. Admiral Insurance Co., 2011 WL 3652590 (5th Cir. August 19, 2011)

Cook was retained to deliver and oversee installation of casing in a well being drilled by Brogdin. Additionally, Cook was required to haul away any excess casing. Unfortunately, Cook miscounted the pipe joints and hauled away too much resulting in the well being completed at a depth shallower than Brogdin required. Brogdin was required to rework the well to correct the problem. Subsequently, Brogdin sued Cook for the cost of reworking the well in state court.

Cook had a CGL policy with Admiral, and he placed the carrier on notice of the pre-suit claim. Admiral responded with notice that an endorsement relating to underground work restricted the available policy limits to $100,000 even though it was a $1,000,000 policy. Subsequently, Cook filed a declaratory judgment seeking a declaration that the full limits were available to address the claim. Admiral removed the case to federal court. Admiral countersued seeking a declaration that it had no duty to defend because Brogdin's claims were not covered and alternatively that the available limits were $100,000. Cook and Admiral filed cross-motions for summary judgment.

In granting Admiral's summary judgment and finding that there was no duty to defend or indemnify, the federal district court held that there was no property damage and no "loss of use of tangible property that is not physically injured." The 5th Cir. affirmed, but on other grounds. It held that two exclusions defeated both the duty to defend and the duty to indemnify. The first excluded coverage of property damage to "That particular part of real property on which . . . are performing operations if the "property damage" arises out of those operations." The second excluded coverage of property damage to "That particular part of any property that must be restored, repaired or replaced because "your work" was incorrectly performed on it." The court noted that the improper well completion arose directly out of Cook's operations and that the reworking was required on that same well because of Cook's negligence.

The court rejected Cook's argument that the first exclusion was inapposite because there was a gap in time between the occurrence and the loss of use, thus negating the "arising out of" requirement. Cook argued that the occurrence was the negligent removal of too many pipe joints and that the loss of use was the running of an insufficient string of casing. The court distinguished the events from a situation presented in *Mid-Continent Cas. Co. v. JHP Development, Inc.* where there was a lengthy suspension of construction activities. Cook also sought to argue that the second exclusion was inapplicable because the defective work was the removal of too much casing, while the loss of use was to the well itself – a separate property. In holding that this interpretation was strained, the court reiterated that the plain meaning of the exclusion is that "property damage only to parts of the property that were themselves the subjects of the defective work is excluded." In that regard, it was significant that Cook not only created the situation where there was not enough casing on the well site, but also oversaw the completion of the well – causing the defects in the well as a whole. Cook's negligent work was not on a discrete subsystem that had a "domino effect of damage to the entire well." Instead, Cook's work was on the well itself.

The court also held that Admiral had no duty to indemnify Cook because the same reasons negating the duty to defend also precluded any possibility that Admiral would ever have to indemnify.

INSURANCE BROKER OWES NO DUTY TO ADDITIONAL INSURED TO OBTAIN ADEQUATE INSURANCE

West Houston Airport, Inc. v Millennium Insurance Agency, Inc., 2011 WL 3715975 (Tex. App.—Houston [14th Dist.], Aug. 25, 2011, no pet.)

In a case of first impression, the Houston Court of Appeals held that a retail insurance broker *did not* owe a duty to an additional insured to provide adequate insurance coverage. In *Millennium*, the plaintiff – a landlord claiming status as an additional insured under its tenant's general liability policy – asserted claims against the named insured's retail broker for negligent placement and procurement of insurance. The named insured/tenant, VMI, was contractually required to obtain $1,000,000 per occurrence in general-liability insurance coverage and name the plaintiff/landlord as an additional insured pursuant to a lease contract between VMI and the plaintiff. VMI obtained an insurance policy from its broker, Millennium, which contained $50,000 limit in coverage for damage caused by fire.

While VMI was occupying the leased property as a holdover tenant, the leased property was damaged by a fire allegedly caused by a large oven used by VMI. The plaintiff/landlord claimed Millennium was liable for all damages caused by the fire that exceeded the policy's $50,000 limit on the basis that Millennium was negligent in procuring inadequate coverage. The plaintiff presented evidence that: 1) VMI specifically requested adequate coverage per the contract between plaintiff and VMI; 2) Millennium informed VMI that the policy complied with the contract; and 3) the policy failed to provide the requested coverage. Plaintiff acknowledged that its entire case was premised on instruction given by VMI to Millennium, and that it had never discussed insurance coverage with Millennium.

The Court rejected the plaintiff's theory of liability, holding Millennium did not owe a duty of professional care to WHA relative to the amount of liability insurance available to indemnify VMI. In so holding, the court noted the lack of any precedent in which the general duties a broker owes to its client (i.e. to use reasonable diligence to obtain requested insurance, and inform client promptly if unable to do so) were extended to a non-client, such as an additional insured. With this backdrop, the court recognized that generally, one who sustained damage because of professional negligence must show privity of contract with the professional. Finding no privity of contract between the plaintiff and Millennium, the court refused to recognize a duty from which liability could be imposed. The court then recognized that any duty to provide proper coverage for the additional insured was one based on the contract between VMI and the plaintiff, and owed by *VMI*, not Millennium. The Court refused to "shift VMI's responsibilities to Millennium."

The court also noted it was not reasonably foreseeable to Millennium that a limitation of coverage under the general liability policy for one specific type of causation (*i.e.*, fire) would harm the plaintiff. Further, the court noted that the plaintiff was acting as a third-party claimant, as opposed to a traditional additional insured, as it alleged that VMI, the named insured, was at fault for the fire.