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ANNUAL SURVEY OF DEVELOPMENTS IN INSURANCE COVERAGE LAW

BY EDWARD J. STEIN,* CORT T. MALONE,* AND ANNA M. PIAZZA**

This article reviews recent insurance coverage decisions. Most notably, the Connecticut Supreme Court shifted the burden of proof regarding the prejudice element of a liability insurance company's late notice defense and held that the insurance company, not the policyholder, now bears that burden. Connecticut state and federal courts issued several other decisions favorable to policyholders in the context of bad faith claims against insurance companies. In general, though, the cases continued the balanced jurisprudence noted in last year's survey of 2011 insurance coverage developments.[1] Connecticut courts also decided several cases concerning policy exclusions in homeowner's and professional liability insurance policies; strictly construed the terms "suit" and "other dispute resolution proceedings," as used in commercial general liability insurance policies; clarified a policyholder's ability to implead an insurance company via a third-party complaint; and addressed an insurance company's right to subrogation in specific contexts.

I. LATE NOTICE

In *Arrowood Indemnity Company v. King*,[2] the Supreme Court addressed an insurance company's late notice defense to coverage, noting that Connecticut requires two conditions to be met before an insurance company's duties can be avoided under a policy's notice provision: (1) an unexcused unreasonable delay in notification by the policyholder, and (2) resulting material prejudice to the insurance company.[3]

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1 Charles T. Lee and Mandiey Winalski, *Annual Survey of 2011 Developments in Insurance Coverage Law: Of Ponzi Schemes and Pot Cakes,* 86 CONN. B.J. 176 (2012).

2 304 Conn. 179, 39 A.3d 712 (2012).

3 *Id.* at 198.

With regard to the prejudice element, in 1988, in *Aetna Casualty & Surety Co. v. Murphy*,[4] the Supreme Court held that "[i]f it can be shown that the insurer suffered no material prejudice from the delay, the nonoccurrence of the condition of timely notice may be excused," provided the policyholder could prove the absence of material prejudice.[5] In its 2012 *Arrowood* decision, the Court overruled *Aetna v. Murphy* "to the extent that it allocated the burden to the insured to disprove prejudice" from late notice of a liability insurance claim. Under *Arrowood*, the insurance company now "bears the burden of proving, by a preponderance of the evidence, that it has been prejudiced by the insured's failure to comply with a notice provision."[6] In so holding, the Supreme Court reasoned:

> [T]he task of proving a negative is an inherently difficult one, and it may be further complicated by the opposing party's interest in concealment . . . Imposing this difficult task on the insured—the party least well equipped to know, let alone demonstrate, the effect of delayed disclosure on the investigatory and legal defense capabilities of the insurer—reduces the likelihood that the fact finder will possess sufficient information to determine whether prejudice has resulted from delayed disclosure.

(Internal citations omitted).[7]

With regard to the unexcused, unreasonable delay element, the facts of *Arrowood* raised the question whether social interactions between the insured and the claimant making no reference to an accident claim justified a delay in giving notice of a potential claim to the insurer, where the policy requires notice of "as soon as practical." *Arrowood* involved a serious head injury to a child who fell from a skateboard towed by an all-terrain-vehicle driven by the policyholders' son. The policyholders did not immediately notify their insurance company, and they continued to socialize with the injured boy's family after the accident with no men-

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[4] 206 Conn. 409, 538 A.2d 219 (1988), overruled in part by *Arrowood Indem.*, 304 Conn. at 179.

[5] *Id.* at 417-18, 420.

[6] 304 Conn. at 201.

[7] *Id.* at 203.

tion of a potential lawsuit. More than a year after the accident, however, an attorney for the injured boy alerted the policyholders that an action might be filed, at which time the policyholders gave notice to the insurance company. The Supreme Court found this delay unreasonable and unexcused, because the injury "was far from slight and was unmistakably apparent."[8] The policyholders' reliance on their social interactions with the family of the injured child failed because "the notice requirement turns not on an insured's subjective assessment of how likely a claim is to be brought, but rather on whether a reasonable person would recognize that 'liability may have been incurred.'"[9]

II. BAD FAITH

The cases addressing bad faith reflect continuing uncertainty as to the degree of specificity required when pleading a general business practice supporting a violation of the Connecticut Unfair Trade Practice Act ("CUTPA") based on the Connecticut Unfair Insurance Practices Act ("CUIPA") and other bad faith theories. In many cases, relatively bare allegations survived a motion to strike. For example, in *Savanella v. Kemper Independence Insurance Company*,[10] the Superior Court denied the insurance company's motion to strike: (1) a breach of the implied convent of good faith and fair dealing claim, where the policyholders alleged that the insurance company conspired to subvert Connecticut law; and (2) a CUTPA/CUIPA claim alleging that the insurance company committed unfair and deceptive acts "with such frequency as to constitute a general business practice of insurance misconduct." In connection with the CUTPA/CUIPA claim, the policyholders alleged the insurance company's conduct in the case at bar and multiple other cases—without providing specific examples—in which the insurance company and its related corporate entities

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[8] *Id.* at 200.

[9] *Id.* (quoting Plasticrete Corp. v. American Policyholders Ins. Co., 184 Conn. 231, 241, 439 A.2d 968, 972 (1981)).

[10] No. LLI CV 11 6003947S, 2011 WL 7049491 (Conn. Super Ct. Dec. 28, 2011) (Pickard, J.).

engaged in unfair insurance practices. The court held that the policyholders should be able to take discovery, and that a summary judgment motion "would be the appropriate vehicle to test" their allegations.[11]

A number of trial courts similarly denied motions to strike, holding essentially that so long as plaintiffs alleged that the insurer misconduct involved other insureds, detailing specific instances of the other misconduct is not required.[12] Others, however, required that plaintiffs plead the particulars of misconduct involving other policyholders simply to survive a motion to strike.[13] Past the pleadings stage, however, the decisions are sparse.

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[11] *Id.* at *2. In a simultaneous and similar ruling, the same court in *Furlong v. American Commerce Insurance Co.,* No. CV 11 6005516S, 2011 WL 7049494 (Conn. Super Ct. Dec. 28, 2011) (Pickard, J.), denied a motion to strike, where the plaintiff supplemented an underinsured motorist claim with a second count alleging bad faith in refusing to pay for damages, perform appropriate analysis, and communicate the basis for its actions. The court held that although "the plaintiff has not alleged much more than that the defendant had failed to pay the claim," this allegation, although thin, entitled the plaintiff to take discovery to try to establish his claims, and "[a]t the completion of discovery, a motion for summary judgment would be an appropriate method to raise the issue of insufficient proof of bad faith." *Id.*

[12] *See* Mamudi v. State Farm Fire & Cas. Co., CV126016785S, 2012 WL 6901141 (Conn. Super. Ct. Dec. 20, 2012) (Roche, J.) (denying insurance company's motion to strike common law bad faith claim, finding that policyholder adequately alleged improper purpose by pleading that insurance company had misrepresented claim status and sought to delay or reduce payment); Katz v. Hartford Fin. Servs. Grp., Inc., CV116020408S, 2012 WL 2149405 (Conn. Super. Ct. May 11, 2012) (Domnarski, J.) (denying insurance company's motion to strike common law bad faith claim and CUTPA claim, given allegations that defendant's failure to pay was for improper "nefarious" purposes and that it regularly delayed payments or made low offers, with such frequency as to indicate a general business practice); Traylor v. Awwa, 899 F. Supp. 2d 216 (D. Conn. 2012) (Thompson, J.) (denying motion to dismiss in a pro se wrongful death action against, *inter alia,* medical malpractice insurer for treating physician of the decedent, holding that plaintiff had stated a CUTPA claim by alleging that insurer had a practice of seeking out lawyers to defend cases in which the insurer planned to destroy evidence, and that it hired defense firm for physician because it had destroyed evidence in prior cases).

[13] *See* Chestnut Inv., LLC v. Nautilus Ins. Co., CV116020077S, 2012 WL 310761 (Conn. Super. Ct. Jan. 6, 2012) (Wilson, J.) (allowing motion to strike bad faith claims for failure to specifically plead acts performed with malice or dishonest purpose, and striking CUTPA claim for failure to allege CUIPA violation and general business practice); Presmarita v. CUNA Mut. Ins. Soc., HHDCV085018855S, 2012 WL 234273 (Conn. Super. Ct. Jan. 3, 2012) (Woods, J.) (allowing motion to strike based on failure to allege similar conduct with other insureds, despite the fact that policyholder's CUTPA claim premised on requiring confidential settlement agreement fell under the purview of CUIPA for not attempting to effectuate "fair and equitable settlements"); *see also* Perkins v. Hermitage Ins. Co., AANCV116006314S, 2012 WL 899065 (Conn. Super. Ct. Feb.

In one case that survived summary judgment on claims of breach of the covenant of good faith and fair dealing and CUTPA violations, *Glidepath, LLC v. Lawrence Brunoli, Inc.*,[14] the court found triable fact questions regarding a surety's failure to investigate. The evidence offered in opposition to summary judgment included that the insurance company did not discuss or review claims information with the claimant, and provided a conclusory denial letter without substantive analysis.

In theory, insurers may be liable for negligent claims handling as well as bad faith. That theory was tested, unsuccessfully for the policyholder, in *Carford v. Empire Fire & Marine Ins. Co.*[15] After a bench trial, the court held for the insurance company, concluding from the totality of evidence that it had acted with reasonable care in obtaining information and evaluating a claim of serious injury to support payment of policy limits, and tendering the balance of its limits seventeen months after the accident.[16] Plaintiff thus failed to establish its claim for excess liability based on negligent failure to settle the claim earlier, before a deadline unilaterally set by plaintiff's counsel; the court appeared unswayed by arguments that the earlier refusal to settle was unreasonable, and it gave "great weight" to a senior claims handler's contemporaneous reports to a reinsurer regarding uncertainty as to damages before the injured party's full medical recovery and to his suggestion that plaintiff file suit to allow time to "properly evaluate" the claim.[17]

In *Tucker v. American International Group Inc.,*[18] the United States District Court for the District of Connecticut

29, 2012) (Arnold, J.) (allowing bad faith claim based on allegation of improper purpose in denying claim where liability was clear and probable and plaintiff had alleged regular business practice of refusing to honor claims, but striking CUTPA claim which generally alleged similar misconduct involving other insureds, without pleading specific facts of defendant's action towards other insureds).

[14] HHDCV106014624S, 2012 WL 6924526 (Conn. Super. Ct. Dec. 21, 2012) (Peck, J.).

[15] CV065001946, 2012 WL 4040337 (Conn. Super. Ct. Aug. 21, 2012) (Tyma, J.).

[16] *Id.* at *6-7.

[17] *Id.* at *5-6.

[18] No. 3:09–CV–1499 (CSH), 2011 WL 6020851 at *5-8 (D. Conn. Dec. 2, 2011); reconsideration denied, 2012 WL 685461 (D. Conn. Mar. 2, 2012).

held that the Connecticut Supreme Court would recognize a "procedural bad faith claim"—i.e., a cause of action for bad faith in the insurance company's handling of a claim in the absence of a finding that the insurance company breached the policy. The court held that an insurance company has a duty to act in good faith while processing a policyholder's claim.

Finally, in a decision favorable to insurance companies, the Superior Court in *Ridgaway v. Mount Vernon Fire Insurance Co.*[19] held that an insurance company's claim file was not discoverable or even subject to *in camera* review in a lawsuit by the assignees of an excess liability insurance policy alleging breach of the duty of good faith and fair dealing and CUIPA and CUTPA violations. Applying a test set forth in *Hutchinson v. Farm Family Casualty Insurance Co.,*[20] the court held that although the plaintiffs had "alleged that the defendant acted in bad faith in various ways when denying coverage," satisfying the test's first prong, they had neglected "to allege that the defendant sought the advice of its attorney in order to conceal or facilitate its alleged bad faith conduct," thereby failing to satisfy the test's second prong.[21]

III. Duty To Defend

In *Ryan v. National Union Fire Ins. Co. of Pittsburgh PA*,[22] the United States Court of Appeals for the Second Circuit affirmed summary judgment on the duty to defend in circumstances that highlight the breadth of the defense obligation, and certified to the Connecticut Supreme Court an issue that highlights the costly potential consequences of breach. The coverage litigation arose from National Union's reliance on a prior wrongful acts exclusion to withdraw a

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[19] No. CV 116009339, 2012 WL 6901203 (Conn. Super. Ct. Dec. 24, 2012).

[20] 273 Conn. 33, 865 A.2d 1 (2005).

[21] While *Hutchinson* arose in the context of bad faith, CUIPA and CUTPA claims, and rejected the contention that such claims by their very nature require disclosure of privileged materials, courts may order production of claim files maintained by counsel who merely act as claims handlers for insurance companies. *See* First Aviation Services, Inc. v. Gulf, 205 F.R.D. 65 (D. Conn. 2001) (outsourcing claims "cannot become a mechanism for avoiding disclosure of documents through an assertion of privilege.").

[22] 692 F.3d 162 (2d Cir. 2012).

defense to executives of a broker-dealer firm under a professional liability insurance policy against claims that a broker at their firm had mismanaged and "churned" an investor account. While certain allegations of the underlying claim expressly pre-dated the August, 1999 retroactive date referenced in the exclusion, the claim was ambiguous, and other allegations were undated or occurred after that date.[23] Rejecting the insurance company's argument that all losses were interrelated and arose out of the excluded wrongs that occurred prior to the coverage period, the Second Circuit found a duty to defend under Connecticut law, reasoning that "[g]iven the ambiguity in the timing of the alleged wrongful acts within the four corners of the complaint, it is *possible* that these claims were based on conduct that occurred after August 1999."[24]

The Second Circuit next addressed whether an insurance company that breached its duty to defend could be liable for consequential damages, on National Union's appeal from the district court's imposition of reputational damages in favor of the policyholders, in addition to the cost of defending and settling the underlying claim, and without regard to policy limits. The dispute focused on competing interpretations of *Missionaries of the Company of Mary, Inc. v. Aetna Casualty & Surety Co.*,[25] the 1967 Connecticut Supreme Court decision establishing that breach of the duty to defend results in liability not only for the defense but also for the ensuing judgment, absent fraud or collusion, up to the policy limit, estopping the insurance company from asserting defenses or exclusions.[26] The Second Circuit found that neither *Missionaries* nor any subsequent case precludes the availability of traditional contract remedies, "which would ordinarily include consequential damages," and which would encourage insurers to defend the policyholder. The Second Circuit found a similar rationale for "what appears to be the estoppel rule adopted in *Missionaries*," *i.e.,* to "prompts insurers to err on

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[23] *Id.* at 167-68.
[24] *Id.* at 168 (emphasis in original).
[25] 155 Conn. 104, 230 A.2d 21 (1967).
[26] *Id.* at 111-13.

the side of providing a defense."[27] However, given that "Connecticut cases are silent on the availability of these [consequential] damages in duty to defend cases;" that public policy considerations failed to provide a clear answer; and that Connecticut courts also had not clearly decided whether reputational damages are available in a breach of contract action, the Second Circuit chose to certify these questions to the Supreme Court of Connecticut.[28]

After briefing, the parties withdrew the case from the Supreme Court, presumably as a result of settlement, so the bench and bar should not expect any guidance. However, the *Ryan* decision makes clear that insurance companies might prefer to err on the side of providing a defense, and that counsel for policyholders should consider broadly measured remedies for failure to do so.

Another decision of interest addressing the duty to defend in the context of excess insurance is *Cambridge Mutual Fire Insurance Company v. Ketchum*.[29] Cambridge sought a declaratory judgment that the umbrella liability insurance provided in its homeowners policy did not require it to defend or indemnify an action against the policyholder for personal injury arising from an automobile accident. The policyholder also had liability coverage through an auto policy, and the auto insurance company was defending the underlying personal injury claim, but that claim sought damages exceeding the auto policy limit, and the policyholder's motion for summary judgment asserted that the auto insurance company had offered to pay its policy limits in partial settlement of the underlying claim.

After rejecting the excess insurance company's attempt to avoid a defense based on facts outside the "four corners" of the underlying pleading, the *Cambridge Mutual* court addressed what appeared to be a question of first impression in Connecticut: whether the excess insurance company's duty to defend was triggered by liability exceeding primary limits.

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[27] *Ryan*, 692 F.3d at 169-70.
[28] *Id.* at 170-71.
[29] No. 3:11–cv–00743 (VLB), 2012 WL 3544885 (D. Conn. Aug. 16, 2012).

The court first surveyed the caselaw, finding that an apparent majority of states have held that the excess insurance company's duty to defend is not triggered until the policy limit of the primary carrier is exhausted by settlement or tender of payment, even if the claim for damages in the underlying action exceeded the primary limit and the excess policy would necessarily be implicated, with a minority of states holding that the excess insurance company's duty to defend is triggered once the excess insurance company becomes aware that the claim for damages in the underlying action will exceed the primary insurance company's policy limit.[30]

Finding no Connecticut cases on point, the *Cambridge Mutual* court agreed with the cases finding that an excess insurance company has a duty to defend where there is a reasonable possibility that a policyholder defendant's excess coverage may be reached despite the fact that a primary insurance company has also undertaken the defense. This conclusion did not run contrary to the terms of the excess policy under review, which promised coverage for an occurrence "if covered by a primary policy which ... has been exhausted" and also promised coverage for an occurrence if "not covered by any primary insurance." Because the underlying claim exceeded the limits of the primary policy, the court found that the majority of the claim was no longer "covered by any primary insurance" and therefore held that the excess insurance company had an obligation to defend. The court did not address whether the primary insurance company's offer of policy limits constituted an exhaustion of the policy, but rather grounded its decision on finding the primary policy "in effect exhausted" because the claim was in excess of primary policy limits, so that the excess coverage necessarily was implicated.[31]

Two noteworthy duty to defend decisions also were issued in *Pacific Employers Insurance Co. v. Travelers Casualty & Surety Co.*,[32] which concerned scores of under-

[30] *Id.* at *5.
[31] *Id.* at *6.
[32] 888 F.Supp. 2d 271 (D. Conn. 2012).

lying claims brought against St. Francis Hospital by victims of a doctor at the hospital, George Reardon, who was alleged to have sexually abused a large number of underage patients. The underlying complaints were consolidated into a uniform complaint that alleged corporate negligence, breach of fiduciary or confidential relationship, vicarious liability, and other claims.

The hospital was insured by primary policies that contained two coverage parts with separate limits: one for hospital professional liability ("HPL"), covering liability arising out of professional services, and one for general liability ("GL"), covering damages because of bodily injury or property damage caused by an occurrence. To address overlapping coverage in one set of underlying policies issued by Travelers, the HPL part included a "non-concurrency" provision, stating that except as stated in the HPL part, the policy did not apply to injury arising out of professional services; in another policy issued by Evanston, the HPL part excluded liability within the GL part, and the GL part excluded liability within the HPL part.[33] The hospital's excess insurance company, PEIC, had a duty to defend upon exhaustion of underlying limits.[34]

PEIC sought declaratory judgment that the underlying claims of sexual misconduct triggered only GL coverage, not HPL, because they involved sexual misconduct, not medical treatment. Therefore, both the primary insurance companies had a duty to defend under their GL coverage.[35] Having exhausted its HPL coverage, Travelers argued that the underlying claims implicated HPL coverage and therefore, under its "non-concurrency" provision, could not also trigger GL coverage; Evanston argued that it had not undertaken a duty to defend, only to indemnify, and concurred with Travelers that the claims triggered only HPL coverage, not GL.[36]

Applying Connecticut law, the United States District Court for the District of Connecticut reasoned that to pre-

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[33] *Id.* at 273-75.
[34] *Id.* at 273.
[35] *Id.* at 276.
[36] *Id.* at 277.

vail, PEIC would have to show that one or more of the underlying claims potentially implicated only GL coverage, not HPL. PEIC argued that many theories of causation in the underlying uniform complaint did not involve professional services (e.g., failure of nonmedical employees such as security guards to report suspicious behavior). Because these allegations potentially fell within the GL coverage and it remained unknown what the remaining plaintiffs might prove at trial, the court found a duty to defend under Travelers' GL coverage part.[37]

On a motion for reconsideration, the court reiterated its original holding that Travelers had a duty to defend under its GL coverage part and reached the additional conclusion that Travelers had to defend under its HPL coverage part as well. Travelers' argument for reconsideration was premised on an endorsement that had not been considered in the original decision. This endorsement appears to have been manuscript language, the details of which would not be of general interest, but the court's response to Travelers' argument may be of interest to underwriters and their counsel:

> The Court remains unconvinced. For one thing, Travelers' reading runs up against the fact that Special Endorsement No. 1, specifically Section B.2, is written in gibberish. … Suffice it to say that the Connecticut Supreme Court must not have encountered Special Endorsement No. 1 when it observed, in reference to insurance contracts, that 'parties ordinarily do not insert meaningless provisions in their agreements.[38]

The Court read the non-concurrency provision and special endorsement to dictate that a claim ultimately must fall on one side or the other of the HPL/GL divide. However, the claims continued to potentially trigger either coverage, and the policies did not state where the defense obligation fell when an underlying action contains claims that still might possibly fall on either side. The court concluded that "the dual possibilities of coverage trigger dual duties to defend,"

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[37] *Id.* at 282.

[38] Pacific Employers Insurance Co. v. Travelers Casualty & Surety Co., No. 3:11CV924(MRK), 2012 WL 3202934, at *4 (D. Conn. Aug. 3, 2012) (quoting R.T. Vanderbilt Co. v. Cont'l Cas. Co., 273 Conn. 448, 468, 870 A.2d 1048 (2005)).

i.e., a defense under both coverage parts, and requested further briefing on allocation of defense costs in such mixed cases.[39]

IV. The "Known Loss" Doctrine and Continuous Trigger

In *Travelers Casualty v. Netherlands Insurance Co.,*[40] the Superior Court addressed two issues that frequently arise in insurance litigation in the context of a dispute between two insurance companies over their respective defense obligations to a common policyholder who had been sued by the State of Connecticut for faulty construction of the University of Connecticut School of Law library. The court noted that Connecticut appellate courts have not addressed the "known loss" or "loss in progress" doctrine, which Netherlands raised as a defense based on the policyholder's purported knowledge of the damage resulting from its allegedly faulty construction prior to the inception of the Netherlands policies. However, the United States District Court for the District of Connecticut and several Superior Courts previously had interpreted the doctrine narrowly, holding that insurance coverage was precluded only for knowledge of "actual losses" as opposed to "potential losses."[41] Because the circumstances of the case included multiple parties with potential liability, a loss that occurred over many years, dispute as to the extent and timing of the policyholder's knowledge, and the fact that the State itself was not aware of actual losses until after the inception of the Netherlands policies, the court held that the known loss provision of the Netherlands' policy did not preclude its duty to defend.

The court then turned to the issue of determining whether and when an "occurrence" took place, and found that it need not take place at the same time as the subsequent injury. The court applied the "continuous trigger" approach, under which "an occurrence has happened when-

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39 *Id.* at *6

40 No. CV 09 4045937 S, 2012 WL 2548867 (Conn. Super. Ct. June 1, 2012).

41 *Id.* at *4-5.

ever the claimant was exposed to the cause of the injury, was injured in fact, or the injury became manifest."[42] Because the State's complaint alleged continuous injury via water leaking through the masonry and causing physical injury to the property, including after the year 2000 when the Netherlands policies incepted, coverage was triggered by an injury resulting from an occurrence during the policy period.

V. Policy Exclusions And Related Definitions

In *New London County Mutual Insurance Co. v. Nantes,*[43] the Supreme Court examined a homeowner's insurance policy exclusion for injuries arising out of the use of a motor vehicle. Defendants, assignees of their landlord's policy, suffered carbon monoxide poisoning when the landlord left a motor vehicle running in the garage. The Supreme Court affirmed the trial court's grant of the insurance company's summary judgment motion based on the motor vehicle exclusion, finding that "use" of a motor vehicle did not require its "operation" and did include parking. The court rejected the defendants' argument that because the policy did not exclude coverage for a contributing cause of their injuries—the closing of the garage door—the motor vehicle exclusion did not apply. Rather, the exclusion applied because the motor vehicle's use "was connected to or created a condition that caused … [the defendants'] injuries."[44]

In *New London County Mutual Insurance Company v. Zachem*,[45] the Superior Court held that a vandalism exclusion in a homeowner's policy barred coverage where the home sustained a fire and an explosion as a result of an intruder's

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[42] *Id.* at *5-7, citing Security Ins. Co. of Hartford v. Lumbermens Mutual Casualty Co., 264 Conn. 688, 697 n. 12, 826 A.2d 107 (2003).

[43] 303 Conn. 737, 36 A.3d 224 (2012).

[44] *Id.* at 758. *See also* New London County Mut. Ins. Co. v. Bialobrodec, 137 Conn. App. 474, 482, 48 A.3d 742 (2012) (affirming summary judgment that motor vehicle exclusion in homeowner policy precluded coverage of claim arising from fatal motorcycle injury, where homeowners' son allowed decedent to use his motorcycle and claimants alleged negligent supervision; "[i]f the decedent had not used and operated the motorcycle, crashed and suffered injuries, any alleged failure of the parents to supervise their son with respect to the motorcycle could not be the basis of a cause of action against them …."); Allstate Ins. Co. v. Martinez, No. 3:11CV574 (VLB), 2012 WL 6115094 (D. Conn. Dec. 10, 2012).

[45] No. KNL CV 09 4009267, 2012 WL 1292662 (Conn. Super. Ct. Mar. 29, 2012).

intentional breaking of a propane copper pipe. The exclusion precluded coverage for loss "caused by … vandalism … if the dwelling has been vacant for more than 30 consecutive days immediately before the loss." The court held that the property was "vacant" because the owner only made periodic visits to the property, no one had lived on the premises for several years, and "the dwelling did not contain any items suitable for habitation."[46] It further held that an alleged water heater spark that started the explosion did not constitute an "ensuing loss" such that there was coverage. The court relied on *Sansone v. Nationwide Mutual Fire Insurance Co.*[47] a property insurance case which held that "where there is a concurrence of two causes, the efficient cause—the one that sets the other in motion—is the cause to which the loss is to be attributed, though the other cause may follow it and operate more immediately in producing the disaster."

In *Truck Insurance Exchange v. Buinauskas,*[48] the Superior Court examined two exclusions in a homeowner's insurance policy, where the policyholder sought a defense and indemnity against a claim that he injured a state trooper while he resisted being arrested in his home. First, the court held that a physical abuse exclusion might preclude coverage for injuries that the policyholder inflicted on a police officer while resisting arrest, where the underlying complaint alleged that the policyholder "used his … body as a projectile" with "physical injury []as the likely outcome of his conduct." Second, the court determined that a professional services exclusion applied only to professional services provided by the policyholder, and not those provided by a third party at the time of his injury, so it did not apply to the services provided by the injured police officer. The court noted that a policyholder would expect a homeowner's insurance policy to cover "injuries to professionals who come to the home to provide services."[49]

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[46] *Id.* at *1-2.

[47] 47 Conn. Supp. 35, 39, 770 A.2d 500, 503 (Super. Ct. 1999) *aff'd*, 62 Conn. App. 526, 771 A.2d 243 (2001).

[48] No. LLI CV 11 6004847S, 2012 WL 234095 (Conn. Super. Ct. Jan. 6, 2012).

[49] *Id.* at *2.

The Appellate Court in *Shaw v. Freeman*[50] held that the property damage exclusion in a professional liability insurance policy did not bar coverage for the plaintiff's losses after she retained the defendant, an attorney, to represent her in the purchase of property. The exclusion precluded coverage of claims "arising from the injury to or destruction of tangible property." The plaintiff claimed that the defendant attorney failed to notify her that the property was encumbered, and the property ultimately had to be demolished. The court reasoned that the plaintiff's claims "emanate, not from the destruction of property by the defendant, but rather from the defendant's failure to adequately review the title policy and search the land records in preparation for the transfer of the property."[51] The court concluded that the plaintiff's damages, which included the cost of razing the building, engineering services and asbestos sampling, "are more properly characterized as claims of damages arising from the defendant's alleged malpractice."

In another decision involving a lawyer's professional liability insurance policy, the Appellate Court in *Lancia v. State National Insurance Co.*[52] held that an insurance company had no duty to defend several actions against an attorney alleging he was involved in fraudulent real estate transactions, because the allegations arose from his ownership of a mortgage brokerage company, rather than his practice of law. After the insurance company refused to defend and indemnify the underlying suits, the lawyer brought an action for breach of contract. The trial court entered summary judgment for the insurance company, based on the lawyer's affidavit swearing that he had only provided legal advice and services in connection with the insured law firm, and not with any other entity; the court found no dispute that the lawyer was working for the named insured when he committed the alleged wrongful acts. The Appellate Court concurred that the underlying actions potentially alleged

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[50] 134 Conn. App. 76, 38 A.3d 1231 (2012).

[51] *Id.* at 85.

[52] 134 Conn. App. 682, 41 A.3d 308, *cert. denied,* 305 Conn. 904, 44 A.3d 181 (2012).

covered conduct in the insured's capacity as an attorney, but nevertheless reversed, finding no potential coverage of the underlying complaint based on an exclusion of any claim arising out of any insured's activities as an officer, director, or in other capacities, of any company or organization other than the named insured or a prior law firm. Here, the Appellate Court found that each underlying claim alleged that the lawyer was involved in real estate transactions in his capacity as a mortgage broker and the owner of a mortgage brokerage firm, and found no allegations against the insured that were predicated solely on his role as an attorney, not a mortgage broker.

In a decision involving medical professional liability insurance, the Appellate Court in *Connecticut Insurance Guaranty Association v. Drown*[53] held that the state guaranty fund (as successor to an insolvent insurance company) had no obligation to defend or indemnify a professional corporation, based on an exclusion of coverage for the insured corporation with "with respect to injury arising solely out of acts or omissions in the rendering or failure to render professional services by individual physicians or nurse anesthetists, or by any paramedical for whom a premium charge is shown on the declarations page." The trial court had granted summary judgment for the insured, finding this exclusion ambiguous and concluding that the purpose of the policy was to provide coverage to the corporate entity, in light of an insuring agreement which promised to pay "all sums that the [professional corporation] shall become legally obligated to pay as damages because of ... [i]njury arising out of the rendering of or failure to render ... professional services by any person for whose acts or omissions the corporation/partnership insured is legally responsible." The Appellate Court reversed, rejecting the policyholder's argument that applying the exclusion would render its coverage illusory. The court reasoned that the exclusion applied only where an injury arises "solely" out of acts or omissions by individual physicians, nurses, or scheduled paramedicals, and noted that the insurance com-

[53] 134 Conn. App. 140, 37 A.3d 820, *cert. granted, in part, on other grounds,* 305 Conn. 908, 44 A.3d 183 (2012).

pany had identified a number of hypothetical scenarios where the exclusion would not apply, such as an injury arising partially out of the acts or omissions of a physician and partially out of the acts or omissions of a non-scheduled paramedical. The court also found support in recent cases from other jurisdictions,[54] and it found no conflict with the Connecticut Supreme Court's 2011 decision in *Johnson v. Connecticut Insurance Guaranty Association*,[55] because it involved "distinct legal issues."[56]

Finally, *Recall Total Information Management, Inc. v. Federal Insurance Co.*[57] held that consequential damages to prevent dissemination of data following the theft or loss of computer data tapes containing personal employee information did not constitute damages because of "property damage" under the terms of commercial general liability policies. The policies at issue defined property damage, in pertinent part, as "physical injury to tangible property, including resulting loss of use of that property" and expressly excluding "any software, data or other information that is in electronic form." The court held that there was no damage to tangible property where "there are no claims for actual damage to the tapes, the cost of the lost tapes or the car" and "the claims arise from the preventative measures taken by [the claimant] because of the theft, or loss of use, of the data on the tapes—not the tapes themselves."[58]

The *Recall* decision also addressed whether the phrase "other dispute resolution proceeding" in a policy's "suit" definition encompassed a settlement between an additional insured and a third party claimant, where the claimant did not commence litigation, arbitration, or any other formal process. The court found no evidence that the settlement

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[54] *Id.* at 154, citing Valentin–Rivera v. New Jersey Property–Liability Ins. Guaranty Assn., No. A–1925–09T1, 2011 WL 1085559 (N.J. Super. App. Div. March 25, 2011), *cert. denied,* 27 A.3d 949 (N.J. 2011); Massachusetts Insurers Insolvency Fund v. Mountzuris, No. 08–1962–B, 2009 WL 1663932 (Mass. Super. April 21, 2009).

[55] 302 Conn. 639, 31 A.3d 1004 (2011).

[56] *Drown*, 134 Conn. App. at 154-56.

[57] No. X07 HHD CV 09 5031734 S, 2012 WL 469988 (Conn. Super. Ct. Jan. 17, 2012).

[58] *Id.* at *5.

process could be characterized as an "other dispute resolution proceeding," reasoning that if it were, "every discussion, however informal, between an insured and a third party would be deemed a dispute resolution proceeding." The court also noted that because the insurance company had not consented to the settlement, it could not constitute a "suit" under a provision defining "suit" to include "an arbitration proceeding or other dispute resolution proceeding in which such damages are sought and to which the insured must submit or does submit *with our consent*."[59]

VI. Impleading An Insurance Company Via Third-Party Complaint

In *Turano v. Pellaton*,[60] the plaintiff sued a contractor (Quality Dry Basements, Inc.) who had performed basement waterproofing services at the plaintiff's property when the plaintiff was injured during a visit to inspect the completed work. The contractor was permitted to implead the subcontractor (Oak Services, LLC) allegedly responsible for the work leading to plaintiff's injury. The third-party defendant was then permitted to implead its insurance company (Atlantic Casualty Insurance Company). Atlantic Casualty, which previously had denied coverage, moved to strike Oak Services' third-party complaint on three grounds. The court denied Atlantic Casualty's motion and refuted each of its arguments.

Atlantic Casualty first argued that Oak Services was precluded from bringing its third-party complaint under either General Statutes Section 52-102a or Practice Book Section 10-11 because Oak Services was not named as a defendant by the plaintiff. The court noted that the purpose of Section 52-102a, like that of Federal Rule 14(a), is to obviate the multiplicity of actions and, as noted by the Connecticut Supreme Court: "The object of the impleader rule is to facilitate litigation, to save costs, to bring all of the litigants into one proceeding, and to dispose of an entire

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[59] *Id.* at *3 (emphasis added).

[60] No. FST CV 10 6005723 S, 2012 WL 4122908 (Conn. Super. Ct. Aug. 20, 2012).

matter without the expense of many suits and many trials."[61] Ultimately, despite a "dearth of caselaw on the scope of Section 52-102a(d)," the court held that the statute's plain language—"A third-party defendant [Oak Services] may proceed under this section against any person not a party to the action [Atlantic Casualty] who is or may be liable to him for all or any part of the third-party plaintiff's [Quality Dry's] claim against him"—suggested that it would apply to the case at bar.[62] Thus, the court held that the case fit the parameters of Section 52-102a(d) and rejected Atlantic Casualty's first ground in support of its motion to strike.

The court then relied on applicable Supreme Court precedent of *Schurgast v. Schumann*,[63] which supported the propriety of a third-party defendant's motion to implead its insurance company, to reject Atlantic Casualty's second argument that "Connecticut law precludes insurance coverage issues from being litigated in the underlying tort action for which coverage is sought."[64] The court found no support for Atlantic Casualty's argument on this issue. Finally, the court refuted Atlantic Casualty's third ground for its motion to strike, in holding that the insurance company would not be prejudiced in a sufficient manner such that it would necessitate granting a motion to strike.

VII. SUBROGATION

In *Hanover Insurance Group, Inc. v. Transportation General, Inc.,*[65] the court held that an insurance company was entitled to equitable or legal subrogation after it defended and paid a settlement on behalf of the policyholder, a transportation broker, arising from the negligence of its transportation providers. The transportation broker had transportation agreements with two transportation providers, both of which contained indemnification provi-

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[61] *Id.* at *3, citing Beaudoin v. Town Oil Co., 207 Conn. 575, 588, 542 A.2d 1124 (1988).

[62] *Turano*, 2012 WL 4122908, at *4.

[63] 156 Conn. 471, 485, 242 A.2d 695 (1968).

[64] *Turano*, 2012 WL 4122908, at *4.

[65] No. HHD CV 11-6019949, 2012 WL 753768 (Conn. Super. Ct. Feb. 16, 2012).

sions in the transportation broker's favor. The court held that "the issue of whether privity exists between the … [insurance company] and … [the transportation providers] is irrelevant because equitable subrogation does not arise from any contractual relationship between the parties but takes place as a matter of equity even without an agreement to that effect." Furthermore, as its policyholder's subrogee, the insurance company had "standing to bring contractual and common-law indemnification claims" against the transportation providers.[66]

In *Amica Mutual Insurance Co. v. Andresky*,[67] an insurance company's breach of contract claim against lessees survived summary judgment where the lessees were required by their lease with the homeowners to pay all costs of repair caused by the neglect and to obtain insurance, they failed to do so, a fire resulted, and the insurance company paid $500,000 to the homeowners under a home insurance policy.

VIII. Additional Insureds

In *Northeast Utilities Service Co. v. St. Paul Fire and Marine Ins. Co.,*[68] the District Court for the District of Connecticut (Haight, J.), applying Connecticut law, entered summary judgment for insurance companies against a claim by Northeast Utilities and Connecticut Light & Power for coverage as "additional insureds" on a contractor's CGL policy. The underlying claim arose from an explosion at an electrical vault owned by an additional insured at which the contractor was providing maintenance service, which killed one of the contractor's employees and injured another. In the ensuing lawsuit, plaintiffs alleged that the additional insureds were entirely at fault, with no negligence or wrongful act attributed to the contractor. An endorsement to the contractor's policy provided coverage to the additional insureds "[t]o the extent that such additional insured is held liable for your acts or omissions arising out of and in the

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66 *Id.* at *6.
67 No. FST CV 11-6008143, 2012 WL 527678 (Conn. Super. Ct. Jan. 31, 2012).
68 No. 3:08-CV-01773 (CSH), 2012 WL 2872810 (D. Conn. July 12, 2012).

course of ongoing operations performed by you or your subcontractors for such additional insured." In other words, the coverage applied to liability for the contractor's acts or omissions in connection with its work for the additional insureds.

The court entered summary judgment for the insurance companies, finding on undisputed facts that the underlying claims alleged that the additional insureds were liable for their own acts and omissions as the sole cause of the explosion, not any misconduct by the contractor, and that the underlying settlements did not include any information to the contrary. The court rejected the additional insureds' arguments that their liability "necessarily" would be for the contractor's acts or omissions, given clear allegations to the contrary that NU's negligence, not the contractor's, caused the incident. The court also rejected the additional insureds' reliance on their own affirmative defenses against the contractor as a basis for coverage, reasoning that they could not create vicarious liability that did not otherwise exist, and noting that the underlying settlements were not attributable to the affirmative defenses. Concluding that this result reflected the business realities, the court explained: "The restriction of coverage to [the contractor's] acts or omissions simply fits the fact that the [CGL] Policy was [the contractor's] policy, not [the additional insured's] policy. [The contractor] included additional-insured coverage in the [CGL] Policy to meet its undertaking in the Contract to protect [the additional insureds], but [the contractor] was not obliged to purchase insurance to protect [the additional insureds] against their own conduct."

IX. Conclusion

In the 2012 decisions discussed above, Connecticut state and federal courts rendered holdings generally in the policyholder's favor in the context of bad faith claims against insurance companies. The mixed results in other decisions reflect a balanced jurisprudence and signal that our courts give careful attention to the particular facts, procedural contexts, and policy provisions of the cases before them.

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