THE STATE OF NEW HAMPSHIRE

MERRIMACK, SS. **SUPERIOR COURT**

BEFORE THE COURT-APPOINTED REFEREE
IN RE THE LIQUIDATION OF THE HOME INSURANCE COMPANY
DISPUTED CLAIMS DOCKET

In Re Liquidator Number: **2008-HICIL-38**
Proof of Claim Number: **INSU275827-01**
Policy or Contract Number: ______
Claimant Name: **James F. Scherr**
Insured or Reinsured Name: ______
Date of Loss: ______

COMPENDIUM OF NON-NEW HAMPSHIRE CASES CITED
IN LIQUIDATOR'S SECTION 15 SUBMISSION

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ADMIRAL INSURANCE CO., INC., Plaintiff, v. CHRISTIAN BRIGGS, et al, Defendant.

Civil Action No. 3:02-CV-0310-N

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS, DALLAS DIVISION

264 F. Supp. 2d 460; 2003 U.S. Dist. LEXIS 14433

March 31, 2003, Decided
March 31, 2003, Filed

PRIOR HISTORY: Admiral Ins. Co. v. Briggs, 2002 U.S. Dist. LEXIS 12030 (N.D. Tex., July 2, 2002)

DISPOSITION: [**1] Plaintiff's Motion for Partial Summary Judgment denied.

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff insurer filed a declaratory action against defendants, an insured and current and former officers and directors, seeking a declaration that the insurance policy issued to the insured did not require the insurer to defend or indemnify the insured or its officers or directors in connection with various state lawsuits. The insurer moved for partial summary judgment.

OVERVIEW: The insurer first argued that a case that arose out of a lease contract fell under the policy's contract exclusion provision. The court found that the insurer's interpretation of the contract exclusion provision was overly broad. The insurer's interpretation would have excluded coverage under the policy for all stock fraud claims because they all involved a contract for the sale of stock. Next, the insurer's interpretation of the contract provision failed under the doctrine of ejusdem generis because the case was not based upon nor did it arise out of the lease contract. The alleged harm in the case occurred at the time the agreement to accept stock instead of cash was made. The insurer argued that summary judgment was appropriate on its claim that three actions, which were brought by the insured's investors, should have been treated as one claim under the policy. The court found that the summary judgment record did not establish that all the claims involved in the three cases arose out of the same related wrongful acts. The lawsuits contained different alleged misstatements, omissions, and promises that occurred on different days to different individuals.

OUTCOME: The insurer's motion for partial summary judgment was denied.

CORE TERMS: stock, summary judgment, coverage, exclusion provision, lease, matter of law, lawsuit, duty to defend, single claim, corners, exclusion clause, entitled to judgment, misrepresentations, misstatements, doctrine of ejusdem generis, insurance policies, duty to indemnify, general words, indemnify, insured, Wrongful Acts, insurance application, case arises, security deposit, fraud claims, written contract, overly broad, declaratory, indirectly, indemnity

LexisNexis(R) Headnotes

Insurance Law > Claims & Contracts > Declaratory Relief > General Overview
Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Duty to Defend
Insurance Law > Claims & Contracts > Policy Interpretation > General Overview
[HN1]When interpreting the language of insurance policies, Texas courts apply what is referred to as the "eight corners" rule. The court must look only to the four corners of the most recent underlying petition and the four corners of the insurance policy when determining an insurer's duty to defend the insured in the underlying case.

Insurance Law > Claims & Contracts > Declaratory Relief > General Overview
Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Duty to Defend
[HN2]An insurance company's duty to defend is broader than the duty to indemnify; so if no duty to defend exists, no duty to indemnify exists.

Contracts Law > Contract Interpretation > General Overview

[HN3]The doctrine of ejusdem generis is a rule of contract construction that provides that, if words of a specific meaning are followed by general words, the general words are interpreted to mean only the class or category framed by the specific words.

COUNSEL: For Admiral Insurance Company Inc, Plaintiff: Guy Michael Hohmann, LEAD ATTORNEY, Sarah Starnes, Hohmann Taube & Summers, Austin, TX.

For Admiral Insurance Company Inc, Plaintiff: D Ronald Reneker, Bush Craddock & Reneker, Dallas, TX.

For Selwyn Jossett, Consol Plaintiff: Werner Anthony Powers, LEAD ATTORNEY, Haynes & Boone, Joseph J Mastrogiovanni, Jr, Mastrogiovanni Schorsch & Mersky, Dallas, TX.

For Leo Hindrey, Richard Millman, Defendants: Li Chen, LEAD ATTORNEY, Sidley Austin Brown & Wood, Dallas, TX.

For Leo Hindrey, Richard Millman, Tim Robertson, Defendants: Steven T Cottreau, Tanya Bartucz, Sidley Austin Brown & Wood, Washington, DC.

For Selwyn Josset, Ian Bonner, Defendants: Joseph J Mastrogiovanni, Jr, LEAD ATTORNEY, Mastrogiovanni Schorsch & Mersky, Dallas, TX.

For Richard Millman, Defendant: Kelly J Kubasta, Sidley Austin Brown & Wood, Dallas, TX.

For Christian Briggs, Defendant: Ben L Krage, LEAD ATTORNEY, Krage & Janvey, Dallas, TX.

For Bill Carroll, Grant Wynn, Defendants: Lloyd E Ward, LEAD ATTORNEY, Lloyd Ward & Associates, P.C., Dallas, TX.

For James W Lincoln, II, [**2] Defendant: Donald E Hill, LEAD ATTORNEY, Michael S Forshey, Patton Boggs, Dallas, TX.

For Admiral Insurance Company, Consol Defendant: Sarah Starnes, LEAD ATTORNEY, Hohmann Taube & Summers, Austin, TX.

For Admiral Insurance Company, Consol Defendant: D Ronald Reneker, Bush Craddock & Reneker, Dallas, TX.

For Munsch, Hardt, Kopf & Harr, P.C., Movant: Thomas A Culpepper, LEAD ATTORNEY, Thompson Coe Cousins & Irons - Dallas, Dallas, TX.

For Robert Yaquinto, Jr, Intervenor: Geoffrey S Harper, LEAD ATTORNEY, Fish & Richardson, Dallas, TX.

For Bill Carroll, Grant Wynn, Counter Claimants: Lloyd E Ward, LEAD ATTORNEY, Lloyd Ward & Associates, P.C., Dallas, TX.

For Richard Millman, Counter Claimant: Li Chen, LEAD ATTORNEY, Kelly J Kubasta, Sidley Austin Brown & Wood, Dallas, TX.

For Admiral Insurance Company Inc, Counter Defendant: Guy Michael Hohmann, LEAD ATTORNEY, Sarah Starnes, Hohmann Taube & Summers, Austin, TX.

For Admiral Insurance Company Inc, Counter Defendant: D Ronald Reneker, Bush Craddock & Reneker, Dallas, TX.

JUDGES: David C. Godbey, United States District Judge.

OPINION BY: David C. Godbey

OPINION

[*461] **ORDER**

Before the Court is Plaintiff Admiral [**3] Insurance Company's Motion for Partial Summary Judgment. For the reasons stated below, that motion is DENIED.

I. FACTUAL BACKGROUND

The Defendant, Admiral Insurance Company, Inc. ("Admiral"), filed this declaratory action against several defendants seeking a declaration that the Management Liability Insurance Policy Number 6251421 (the "Policy") issued to Cool Partners, Inc. ("CPI") does not require Admiral to defend or indemnify CPI or its officers or directors in connection with various state lawsuits. [1] It seeks a Court determination regarding its defense and indemnity obligations under the Policy to Cool Partners, Inc. ("CPI") as well as a number of CPI current and former officers and directors in four underlying lawsuits. [2]

1 Admiral seeks declaratory relief on several grounds. It alleges:(1) that various CPI officers made misrepresentations in portions of CPI's insurance application; (2) that CPI breached its obligation to cooperate with Admiral in connection with a lawsuit; (3) that certain CPI officers made

additional misrepresentations on an insurance application to increase CPI's coverage; (4) that the allegations in the *Rosenthal* case are similar to allegations in two other cases for which CPI has sought indemnity, so the three suits should be treated as a single claim under the Policy for purposes of the policy limits; and (5) that the *CB Parkway* case should be excluded from coverage because its subject matter falls within a Policy exclusion.

[**4]

2 Three of the lawsuits, *Barnidge, Fiorentino,* and *Rosenthal,* were brought by CPI investors alleging CPI and its officers and directors mismanaged the company and/or defrauded investors. The fourth lawsuit, *CB Parkway,* was brought by CPI's former landlord for various claims including breach of contract and securities fraud. The landlord took CPI stock instead of cash for the first year's rent on the lease as well as the security deposit, and when the company filed bankruptcy, the stock became virtually worthless.

In its Motion for Partial Summary Judgment, Admiral is seeking judgment as a matter of law on two claims based on contract interpretation. First, Admiral argues that the *CB Parkway* case arises out of a lease contract and, therefore, falls under the Policy's contract exclusion provision. [*462] Admiral claims it owes no duty to defend or indemnify CPI or its directors or officers in the case because the Policy contains an explicit coverage exclusion for cases that arise out of contracts. *See* Admiral App. pp. 18, 21-23. In addition, Admiral argues summary judgment is [**5] appropriate on its claim that the *Barnidge, Fiorentino,* and *Rosenthal* actions should be treated as one "claim" under the Policy. Admiral urges that the three actions are "Related Wrongful Acts" under the Policy because they allege very similar claims that arise out of the same series of facts, and they should, therefore, be treated as a single claim. *See* Admiral App. 20, 24. Because the Court finds that Admiral has not shown it is entitled to judgment as a matter of law that the *CB Parkway* case falls within the Policy's contract exclusion provision and that the three other cases should be treated as one "claim" under the policy, Admiral's Motion for Partial Summary Judgment is DENIED.

II. DISCUSSION

A. CB Parkway Issue

[HN1]When interpreting the language of insurance policies, Texas courts apply what is referred to as the "eight corners" rule. The court must look only to the four corners of the most recent underlying petition and the four corners of the insurance policy when determining an insurer's duty to defend the insured in the underlying case. *Harken Expl. Co. v. Sphere Drake Ins. P.L.C.,* 261 F.3d 466, 472 (5th Cir. 2001); *Nat'l Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc.,* 939 S.W.2d 139, 141, 40 Tex. Sup. Ct. J. 353 (Tex. 1997). [**6] [HN2]An insurance company's duty to defend is broader than the duty to indemnify; so if no duty to defend exists, no duty to indemnify exists. *Am. Nat'l Ins. Co. v. Ryan,* 274 F.3d 319, 324 (5th Cir. 2001).

In this case, Admiral urges that it has no duty to defend CPI and its officers and directors in the *CB Parkway* case because of the Policy's contract exclusion clause. The clause states that no coverage exists for claims "based upon, arising out of, directly or indirectly resulting from or in consequence of, or *in any way involving* any oral or written contract or agreement" unless "such liability would have attached to the Insured in the absence of the oral or written contract or agreement." *See* Admiral App. p. 23 (emphasis added). Admiral argues that the *CB Parkway* case *involves* a written contract, namely the lease for which CB Parkway agreed to take stock as payment, and therefore the case should be exempt from coverage under the contract exclusion provision. This argument fails for two reasons. First, Admiral's interpretation of this contract exclusion provision is overly broad. Its interpretation would exclude coverage under the Policy for all [**7] stock fraud claims because they all involve a contract for the sale of stock. Admiral itself does not contest coverage for the *Barnidge, Fiorentino,* and *Rosenthal* cases, all of which allege stock fraud. Admiral's interpretation of the contract exclusion provision would prevent coverage for misstatements by CPI's directors and officers, which are clearly covered under another provision the Policy. [3] Admiral's interpretation of the contract exclusion clause contradicts its own admissions and other provisions of the Policy. Because Admiral's interpretation of the contract exclusion provision of the Policy is overly broad, it fails.

3 *See* Admiral App. p. 18.

Second, Admiral's interpretation of the contract provision fails under the doctrine [*463] of *ejusdem generis* [4] because the phrase upon which Admiral is relying "in any way involving" must be interpreted to be part of the class or category that preceded it; therefore, the phrase "in any way involving" must be read in a manner consistent with the [**8] terms "based upon, arising out of, directly or indirectly resulting from or in consequence of" a contract - all terms indicating a causal relationship between the contract and the claim. The *CB Parkway* case is not based upon nor does it arise out of the lease contract. Rather, the *CB Parkway* complaint alleges that CP Parkway suffered harm when CPI and its officers and directors made alleged misstatements and misrepresenta-

tions regarding the future success of CPI in order to convince CP Parkway to accept CPI stock instead of cash for payment on the lease and security deposit. *See* Jossett's Response App. 69-70. The breach of CPI's lease is immaterial to the securities fraud claim because the alleged harm in the *CB Parkway* case occurred at the time the agreement to accept stock instead of cash was made. The lease contract did not cause the stock fraud claim, it simply provided the context in which the stock fraud took place. Accordingly, Admiral is not entitled to judgment as a matter of law that the Policy's contract exclusion clause applies to the *CB Parkway* case, and summary judgment on this claim is DENIED.

4 [HN3]The doctrine of *ejusdem generis* is "a rule of contract construction that provides that, if words of a specific meaning are followed by general words, the general words are interpreted to mean only the class or category framed by the specific words." *Hussong v. Schwan 's Sales Enters., Inc.*, 896 S.W.2d 320, 325 (Tex. App. - Houston [1st Dist.] 1995, no writ).

[**9] ***B. Barnidge, Fiorentino, and Rosenthal Issue***

The Court finds that Admiral cannot show as a matter of law the *Barnidge, Fiorentino,* and *Rosenthal* cases should be treated as a single "claim" under the Policy. The summary judgment record does not establish that all the claims involved in the three cases arise out of the same "Related Wrongful Acts", which the Policy defines as acts "logically or causally connected by reason of any common fact, circumstance, situation, transaction, casualty, event or decision." *See* Admiral App. p. 20. The lawsuits contain different alleged misstatements, omissions and promises that occurred on different days to different individuals. *See* Admiral App. p. 81, 99, 112. Because Admiral cannot show it is entitled to judgment as a matter of law that the *Barnidge, Fiorentino,* and *Rosenthal* cases should be treated as one single "claim" under the Policy, summary judgment is not appropriate for this claim.

III. CONCLUSION

Ultimately, Admiral fails to show that its claims that the *CB Parkway* falls within the Policy's contract exclusion provision and that the *Barnidge, Fiorentino,* and *Rosenthal* cases should treated [**10] as one "claim" are appropriate for judgment as a matter of law. Accordingly, Admiral's Motion for Partial Summary Judgment is DENIED.

SIGNED this 31 day of March, 2003.

David C. Godbey

United States District Judge

The ARIZONA PROPERTY AND CASUALTY INSURANCE GUARANTY FUND, a subdivision of the Department of Insurance of the State of Arizona, Plaintiff-Appellant, v. William B. HELME, M.D. and Jane Doe Helme, husband and wife; Neurological Surgeons, P.C., an Arizona corporation; Glenda Worsham, surviving spouse of Linward A. Worsham, and Chanita Lin Engelke and Choya Lynn Worsham, surviving children of Linward A. Worsham, Defendants-Appellees

No. CV-86-0368-PR

Supreme Court of Arizona

153 Ariz. 129; 735 P.2d 451; 1987 Ariz. LEXIS 152; 64 A.L.R.4th 651

March 26, 1987

SUBSEQUENT HISTORY: [***1] Reconsideration Denied May 5, 1987.

PRIOR HISTORY: Appeal from the Superior Court of Maricopa County, Court of Appeals No. 1 CA-CIV 7644, Maricopa County Superior Court No. C-437261, The Honorable Howard V. Peterson, Judge.

Opinion of the Court of Appeals, Division One, Ariz. , P.2d (1986).

DISPOSITION: Vacated in Part.

CASE SUMMARY:

PROCEDURAL POSTURE: Defendants, a doctor and a medical facility, appealed from an order of the Superior Court of Maricopa County, Court of Appeals (Arizona), in which the court held that defendants' acts of negligence constituted one occurrence and that defendants breached their duty to cooperate.

OVERVIEW: Defendants entered into a settlement agreement with decedent's survivors after the survivors brought suit for medical malpractice. Plaintiff insurer brought suit seeking a declaration that its liability was limited to $ 99,000.00 under Ariz. Rev. Stat. § 20-664(A)(1). The lower court held that defendants' negligence constituted one occurrence and that defendants breached their duty to cooperate by entering into a settlement agreement after plaintiff declined to settle. Defendants appealed. The supreme court reversed. The supreme court held that the number of acts producing the injuries rather than the number of injuries caused defined the term occurrence as used in the policy. Because two doctors committed separate acts of negligence producing one injury, there were two occurrences in which plaintiff was liable. Defendants were not bound by the cooperation clause where plaintiff failed to settle the claim.

OUTCOME: The court vacated in part the order of the court of appeals. The court affirmed the grant of partial summary judgment in favor of the survivors and the case was remanded for further proceedings.

CORE TERMS: occurrence, survivors, insured, doctor, omission, cooperation, covered claim, insurer, settlement, x-rays, summary judgment, coverage, breached, causal, surgery, settlement agreement, cooperate, obligated, causative, causally, insurance policy, insolvent insurers, per occurrence, duty to indemnify, anticipatory, shareholder, contractual, discovery, connected, patient

LexisNexis(R) Headnotes

Civil Procedure > Jurisdiction > Jurisdictional Sources > Constitutional Sources
Civil Procedure > Jurisdiction > Subject Matter Jurisdiction > Jurisdiction Over Actions > General Overview
[HN1]The court has jurisdiction pursuant to Ariz. Const. art. 6, § 5(3), and Ariz. Rev. Stat. § 12-120.24.

Civil Procedure > Summary Judgment > Standards > General Overview
[HN2]The court reviews the record in the light most favorable to the nonmoving party.

Insurance Law > Industry Regulation > Insurance Guaranty Associations > Coverage
Insurance Law > Industry Regulation > Insurance Guaranty Associations > Limits on Claims
Insurance Law > Malpractice Insurance > Number of Claims

[HN3]The Arizona Property and Casualty Insurance Guaranty Fund is liable for a maximum of $ 99,900 per "covered claim." Ariz. Rev. Stat. § 20-664(A)(1).

Insurance Law > Industry Regulation > Insurer Insolvency > General Overview
Insurance Law > Malpractice Insurance > Number of Claims
[HN4]A "covered claim" is a claim that would have been covered by the insolvent insurer's policy. Ariz. Rev. Stat. § 20-661(3).

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview
Insurance Law > Malpractice Insurance > Number of Claims
[HN5]If an insurance policy uses "occurrence" without defining the term, the courts inquire whether there was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damages.

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview
[HN6]To determine the meaning of a clause which is subject to different interpretations or constructions the court must examine the purpose of the clause, public policy considerations, and the transaction as a whole.

Insurance Law > Malpractice Insurance > Number of Claims
[HN7]The number of acts producing injury or damage, rather than the number of injuries caused, is the key on which the definition of "occurrence" turns.

Insurance Law > Malpractice Insurance > Number of Claims
[HN8]Multiple acts causing a single injury will constitute multiple occurrences, while a single act will constitute a single occurrence even though it causes multiple injuries or multiple episodes of injury.

Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Payments
Insurance Law > General Liability Insurance > Obligations > Cooperation
Torts > Negligence > Duty > Affirmative Duty to Act > Voluntary Assumption of Duty
[HN9]The guaranty law requires the insured to cooperate with the Fund to the same extent they would have been required to cooperate with the insurer. Ariz. Rev. Stat. § 20-667(A).

Insurance Law > General Liability Insurance > Obligations > Cooperation
[HN10]Ordinarily, an insured's breach of the cooperation clause relieves a prejudiced insurer of liability under the policy.

Insurance Law > General Liability Insurance > Obligations > Cooperation
Insurance Law > Malpractice Insurance > Settlements
[HN11]Insurance policies are governed by the basic contract law principle that if one party to a contract breaches the agreement, the other party is no longer obligated to perform his or her contractual obligations.

Contracts Law > Types of Contracts > Express Contracts
Insurance Law > General Liability Insurance > Obligations > Cooperation
Insurance Law > Malpractice Insurance > Settlements
[HN12]In purchasing an insurance company's express agreement to pay covered claims, the insured is buying security from financial loss which he may sustain from claims against him.

Commercial Law (UCC) > Sales (Article 2) > Form, Formation & Readjustment > General Overview
Contracts Law > Breach > Anticipatory Repudiation > General Overview
Contracts Law > Contract Interpretation > General Overview
[HN13]A party which repudiates its contract obligations on the basis of an incorrect interpretation of a contract has committed an anticipatory breach.

Contracts Law > Breach > Anticipatory Repudiation > General Overview
Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Duty to Defend
Torts > Transportation Torts > General Overview
[HN14]As a general matter, insurance carriers owe their insureds three duties, two express and one implied. These are the duties to indemnify, the duty to defend, and the duty to treat settlement proposals with equal consideration. Any breach, actual or anticipatory, of these duties deprives the insured of the security that he has purchased because the breach leaves him exposed to per-

sonal judgment and damage which may not be covered or may exceed the policy limits.

Insurance Law > Bad Faith & Extracontractual Liability > Refusals to Defend
Insurance Law > General Liability Insurance > Obligations > Cooperation
Insurance Law > Malpractice Insurance > Settlements
[HN15]Once an insurer breaches any duty to its insured, the insured is no longer fully bound by the cooperation clause.

Contracts Law > Breach > Anticipatory Repudiation > General Overview
Contracts Law > Types of Contracts > General Overview
Insurance Law > General Liability Insurance > Obligations > Cooperation
[HN16]An insurer's anticipatory repudiation eliminates the insured's duty of cooperation so that the insured may enter into any type of agreement or take any type of action that may protect him from financial ruin.

Civil Procedure > Settlements > General Overview
Insurance Law > General Liability Insurance > Obligations > Cooperation
Insurance Law > Malpractice Insurance > Settlements
[HN17]The insurer's breach narrows the insured's obligations under the cooperation clause and permits him to take reasonable steps to save himself.

Civil Procedure > Settlements > General Overview
Insurance Law > Malpractice Insurance > Settlements
[HN18]A settlement agreement containing a covenant not to execute against the tortfeasor is not inherently collusive or fraudulent.

COUNSEL: Holloway & Thomas, P.C. by Benjamin C. Thomas, Grant H. Goodman, Phoenix, for plaintiff-appellant.

Leonard & Clancy, P.C. by Kenneth P. Clancy, Phoenix, for defendants-appellees.

JUDGES: En Banc. Feldman, Vice Chief Justice. Gordon, C.J., and Cameron and Holohan, JJ., concur. Jack D.H. Hays, J., participated in the determination of this matter but retired before the opinion was filed. James Moeller, J., did not participate in the determination of this matter.

OPINION BY: FELDMAN

OPINION

[*131] [**453] Arizona Property and Casualty Insurance Guaranty Fund (Fund) brought a declaratory judgment action to limit its obligation to pay claims against doctors whose professional liability insurance carrier became insolvent. The court of appeals reversed the trial court's grant of summary judgment in favor of the doctors, limiting [***2] the Fund's liability to the one claim it had already paid. *Arizona Property & Casualty Insurance Guaranty Fund v. Helme*, 153 Ariz. 123, 735 P.2d 445 (Ct.App.1986). Defendants have asked us to review that opinion pursuant to Rule 23, Ariz.R.Civ.App.P., 17A A.R.S. (Supp.1986). Because the issue is a matter of first impression, we granted the petition to correct an error of law regarding the Fund's obligations.

[HN1]We have jurisdiction pursuant to Ariz. Const. art. 6, § 5(3) and A.R.S. § 12-120.24.

FACTS

The trial court granted summary judgment in favor of defendants. Therefore, [HN2]we view the record in the light most favorable to the Fund. *Farmers Insurance Co. v. Vagnozzi*, 138 Ariz. 443, 448, 675 P.2d 703, 708 (1983).

Linward A. Worsham became paralyzed and eventually died following an April 29, 1975 automobile accident. Alleging medical malpractice, his wife and children (survivors) brought a wrongful death action against numerous doctors and medical personnel. The complaint did not specify the acts of alleged negligence, but during discovery it became clear that the predominant theory of recovery was based on the failure of those treating Worsham to either [*132] [***3] [**454] examine his spinal x-rays or react to his worsening condition. According to survivors, the x-rays showed a fracture dislocation of Worsham's cervical vertebra, a condition which, unrecognized, was left untreated and allegedly caused Worsham's subsequent quadriplegia and resulting death.

Dr. John A. Eisenbeiss and Neurological Surgeons, P.C. (NSPC), the professional corporation of which Eisenbeiss was a shareholder and employee, were among the named defendants. Survivors' complaint alleged that the negligence of Eisenbeiss *and* other unspecified NSPC employees contributed to Worsham's death.

NSPC and its shareholders had purchased professional liability insurance coverage with Imperial Insurance Company of California (Imperial). Under the Imperial policies, NSPC and *each* of NSPC's employed doctors were insured for up to $ 3 million coverage *per* "oc-

currence." Imperial, however, became insolvent in May 1975 and was unable to honor the claims. As a consequence, the Fund, created by the state of Arizona in 1970 to pay claims of insolvent insurers, assumed Imperial's claim obligations. *See* A.R.S. §§ 20-661 *et seq.* The Fund, however, may pay no more than [***4] $ 99,900 on each "covered claim." A.R.S. § 20-664(A)(1). [1] A "covered claim" is "an unpaid claim . . . which arises out of and is within the coverage of an insurance policy" issued by an insolvent insurer. A.R.S. § 20-661(3).

1 Renumbered A.R.S. § 20-667(B) (Supp.1986). We use the former statutory designations throughout this opinion.

When the Fund becomes involved, it assumes all the "rights, duties and obligations" of the insolvent insurer. A.R.S. § 20-664(A)(2). [2] Accordingly, when the Fund received notice of survivors' lawsuit, it retained counsel to defend Eisenbeiss and NSPC, thus fulfilling its obligation under the policy provision which required Imperial to defend any suit against the insured. Discovery ensued. During February 1980, survivors offered to discharge Eisenbeiss, NSPC, and any other NSPC shareholders for $ 99,900, the Fund's per claim liability limit. The Fund declined this settlement offer.

2 Renumbered A.R.S. § 20-667(C) (Supp.1986).

[***5] As discovery continued, survivors learned that Dr. William B. Helme, another NSPC employee and shareholder, might also have been negligent in failing to examine Worsham's x-rays. [3] Survivors' attorneys believed that their failure to name Helme as a defendant presented no obstacle to recovery because they believed that survivors could recover from NSPC for Helme's negligence under respondeat superior principles.

3 The parties argue over when survivors learned of Helme's negligence and when they first notified the Fund. We do not believe the timing material to the legal issues involved in this appeal.

Shortly before trial, survivors' attorneys notified the Fund that they now were seeking to recover $ 199,800 for separate claims based on the separate acts of negligence of the two doctors, Eisenbeiss and Helme. The Fund took the position that its liability was limited to $ 99,900 because (1) neither Helme *nor* NSPC could be liable for Helme's negligence as he was not a named defendant and the statute of limitations [***6] had run against him, and, (2) even if NSPC could be held liable for Helme's negligence, there had been only one "occurrence" under the Imperial policy and, therefore, survivors could recover for only one "covered claim" under A.R.S. § 20-664(A)(1).

In a March 18, 1981 letter, survivors' attorneys told the Fund that they were willing to settle the suit against Eisenbeiss, Helme, and NSPC for $ 137,500. The letter also mentioned that the doctors had retained private counsel and were discussing settlement possibilities with survivors. The letter continued:

> [The doctors] are concerned about personal exposure for sums in excess of the $ 100,000 coverage you [the Fund] claim[s] to have. They believe, and we believe, that there is $ 200,000 in coverage. There is some discussion (preliminary only) that a stipulated judgment be [*133] [**455] entered in the amount of $ 350,000 in exchange for a release of any personal liability of Dr. Eisenbeiss or his group.

Once the Fund declined this settlement offer, Eisenbeiss, Helme, and NSPC, on the advice of their personal attorney, entered into a settlement agreement with survivors. The doctors and the corporation [***7] allowed survivors to obtain a judgment against them and NSPC for $ 350,000 in exchange for the survivors' covenant not to execute against the doctors or NSPC. This type of agreement is commonly referred to as a "Damron" [4] agreement. In addition, each doctor made certain stipulations as to his own negligence, the number of individual negligent acts, and the number of separate occurrences under the Imperial policy.

4 *See post* 153 Ariz. at 137-38, 735 P.2d at 459-60.

The Fund had declined an invitation to participate in the settlement negotiations. In an affidavit, Robert H. Renaud, the attorney hired by the Fund to defend Eisenbeiss and NSPC, said that he was aware of the settlement discussions, but did not desire to attend or to participate.

The Fund then paid $ 99,900 for the Eisenbeiss claim and filed this action requesting a declaration that its liability does not exceed that amount. The Fund named Helme, NSPC, and survivors as defendants. [5] In its partial summary judgment motion, the Fund reiterated [***8] the single claim argument and also contended that it has no obligation to pay any amount exceeding $ 99,900 because Helme and NSPC breached their express contractual duty to cooperate by making the Damron agreement. The parties raised other issues in the trial court, but did not address them in their motions for summary judgment.

5 Only survivors have been represented in this action.

Without explanation, the trial court granted survivors' cross-motions for summary judgment on all counts. The court of appeals reversed. The court agreed with survivors that under established respondeat superior principles NSPC could be held liable for Helme's negligence, even if Helme was not named as a party. 153 Ariz. at 126-27, 735 P.2d at 448-49. However, the court determined that the negligence of Eisenbeiss and Helme was a "series of related omissions" that constituted only one "occurrence" under the Imperial policy. *Id.* at 127-28, 735 P.2d at 449-50. Although this holding meant that the Fund was liable for $ 99,900 [***9] only, two members of the court of appeals' panel also held that the Fund was not obligated to pay the second claim because Helme and NSPC had breached their duty to cooperate. *Id.* at 127-28, 735 P.2d at 449-50.

Neither side has requested review of the court of appeals' holding that survivors can recover from NSPC for Helme's negligence even though Helme was not a named defendant. We therefore accept that holding as the law of the case [6] and address only the following issues:

1. Were the negligent omissions of Eisenbeiss and Helme one "occurrence" under the Imperial policy, thus constituting only one "covered claim" pursuant to A.R.S. §§ 20-664(A)(1) and 20-661(3)?

2. Did Helme and NSPC breach the contractual duty of cooperation by entering into the settlement agreement with survivors?

6 NSPC was named as a party in the original complaint. The complaint sought damages for Eisenbeiss's act and for the negligence of other NSPC employees. Thus NSPC is vicariously liable for the negligent acts of both Eisenbeiss and Helme.

[***10] DISCUSSION

A. *Number of "Covered Claims"*

[HN3]The Fund is liable for a maximum of $ 99,900 per "covered claim." A.R.S. § 20-664(A)(1). [HN4]A "covered claim" is a claim that would have been covered by the insolvent insurer's policy. A.R.S. § 20-661(3). Neither the statutes nor the insurance policy defines "claim," but the parties agree that it means a third party's assertion of a legal right against an insured. As the parties and court of appeals recognized, the [*134] [**456] issue becomes a matter of interpreting the indemnity provisions of the Imperial policy.

Imperial contracted to indemnify its insureds separately up to the limit per occurrence for "each occurrence" in which an insured became legally obligated to pay damages because of professional negligence. Under A.R.S. § 20-664(A)(1), that limit became $ 99,900 per occurrence. The policy defines "occurrence" as "any incident, act or omission, *or series of related incidents, acts or omissions* resulting in injury . . . ." (emphasis added). The court of appeals held that the Fund is liable for only one covered claim (occurrence) because the failure of Eisenbeiss and Helme to look at Worsham's x-rays constituted [***11] a "series of related . . . omissions." This is so, according to the court of appeals, because the wrongful death complaint "asserted only one type of negligent conduct as it pertained to the continuous and ongoing patient care performed by various parties." 153 Ariz. at 127, 735 P.2d at 449. In addition, the court found that the omissions of the two doctors were "intimately related" and "identical." *Id.* at 127, 735 P.2d at 449. The number of doctors involved is irrelevant, according to the court. *Id.* at 127, 735 P.2d at 449.

We disagree with the court of appeals' analysis. First, the statement that the complaint "asserted only one type of negligent conduct," 153 Ariz. at 127, 735 P.2d at 449, is incorrect. The complaint did not specify those acts upon which it was based, and information developed during discovery supported various potential theories of recovery. More importantly, we disagree with the court of appeals' conclusion that the definition of "occurrence" is "clear and unambiguous." 153 Ariz. at 127, 735 P.2d at 449.

Ordinarily, [HN5]if an insurance policy uses "occurrence" without defining the term, the courts inquire whether "'there was but one proximate, uninterrupted, [***12] and continuing cause which resulted in all of the injuries and damages.'" *See* *American Indemnity Co. v. McQuaig*, 435 So.2d 414 (Fla.App.1983); Annot., 55 A.L.R.2d 1300 (1957 and Supp.1978); 8A J. APPLEMAN, INSURANCE LAW AND PRACTICE § 4891.25, at 16-19 (1981) (if a cause is interrupted or replaced by another cause, the chain of causation is broken and more than one occurrence has taken place). The Imperial policy definition of "occurrence" employs this causal test (acts or omissions "resulting in injury") but modifies it by using the phrase "series of related" acts or omissions. Under the Imperial policy, a "series of related" causes of an injury merge to constitute only one "occurrence."

Therefore, the question we must address is whether the failures of the two doctors should be treated as one "occurrence" because they constituted a "series of related incidents, acts or omissions" which resulted in the patient's death. Neither the Imperial policy, the parties, nor the court of appeals have defined the word "related" and our research does not reveal any generally accepted legal meaning; therefore, we will assume that the policy uses

"related" in its commonly accepted dictionary [***13] sense. Webster's dictionary defines the intransitive verb "relate" as "show[ing] or establish[ing] a logical or causal connection between." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY UNABRIDGED, at 1916 (1965). A "related" act or omission, therefore, is one that has a logical *or* causal connection with another act or omission.

We do not believe that the word "related" as used in the policy can be equated with the phrase "logical connection." Logic, like beauty, is in the eye of the beholder and greatly depends upon the subjective mental process of the reviewer. Incidents may be "logically related" for a wide variety of indefinable reasons. Causal connection depends, to a much greater extent, on objective facts in the record. If we were compelled to equate "related" with "logically connected," we would be compelled to find the policy provision ambiguous, and for that reason to find in favor of the claimant. *Parks v. American Casualty Co.*, 117 Ariz. 339, 341, 572 P.2d 801, 803 (1977). We have attempted to abandon this approach. *See Transamerica Insurance Group v. Meere*, 143 Ariz. 351, 355, [*135] [**457] 694 P.2d 181, 185 (1984). We prefer, instead, [***14] [HN6]to determine the meaning of a clause which is subject to different interpretations or constructions by examining the purpose of the clause, public policy considerations, and the transaction as a whole. *Id.*

The correlation between "series of related acts or omissions" and "causation" is apparent after examining arguments made by claimants in other multiple-act cases and the manner in which some courts have interpreted similar words when not expressly defined in the policy. *See, e.g., Home Indemnity Co. v. City of Mobile*, 749 F.2d 659 (11th Cir.1984) (200 homeowners argued that "occurrence" should be defined in terms of the resulting damage to each of their properties -- court holds that number of "occurrences" depends upon the number of causative acts, not the number of injuries resulting); *Travelers Indemnity Co. v. New England Box Co.*, 102 N.H. 380, 157 A.2d 765, 767 (1960) (several parties tried to collect "per accident" policy limits for damage to each of their properties -- words held to refer to multiple causes rather than multiple effects); *Bacon v. Miller*, 113 N.J. Super. 271, 273 A.2d 602 (1971) (plaintiff claimed more than one "accident" when car involved [***15] in collision careened into several pedestrians -- court restricted recovery to limit for one accident). These cases compel the conclusion that the number of causative acts is the key to interpreting "per occurrence" clauses.

We think it clear that Imperial limited "occurrence" by using the term "series of related incidents . . ." to protect itself from the contention that multiple, causally-connected negligent acts constituted more than one occurrence. The Fund reflected this concern in its briefs when it argued that under survivors' interpretation, "[i]t is foreseeable that each and every time any doctor saw or examined a patient, such failure to accurately re-diagnose the condition would constitute a separate occurrence." Limiting coverage for separate "occurrences" by construing a series of causally connected acts or omissions to be a single occurrence would address this concern adequately.

The Fund also argues that there was only one "occurrence" because there was only one injury. The cases, however, show that the number of causative acts, and not the number of injuries produced, determines the number of "occurrences." *See, e.g., St. Paul Fire & Marine Insurance Co. v.* [***16] *Hawaiian Insurance & Guaranty Co.*, 2 Haw.App. 595, 596, 637 P.2d 1146, 1147 (1981) (separate claims made out each time doctors negligently administered anesthetic to patient-decedent -- all causing a single result, death); *McQuaig, supra* (each of three shotgun blasts fired by homeowner was a separate "occurrence" although blasts only injured two people); *see also Maurice Pincoffs Co. v. St. Paul Fire & Marine Insurance Co.*, 447 F.2d 204 (5th Cir.1971) (each of eight sales of contaminated bird seed was a separate "occurrence" because each separate sale subjected the insured to liability); *St. Paul-Mercury Indemnity Co. v. Rutland*, 225 F.2d 689 (5th Cir.1955) (one "occurrence" when 16 freight cars owned by 14 different owners destroyed in a *single* accident); *Home Indemnity Co., supra* (each discrete act or omission or series of acts or omissions, by city which caused flooding is an "occurrence"); *Colbert County Hospital Board v. Bellefonte Insurance Co.*, 725 F.2d 651 (11th Cir.1984) (patient could recover for three "claims" against hospital for three separate surgeries negligently performed by same doctor -- each surgery allegedly producing separate injury). [***17]

Thus, we conclude that [HN7]the number of acts producing injury or damage, rather than the number of injuries caused, is the key on which the definition of "occurrence" turns. [HN8]Multiple acts causing a single injury will constitute multiple occurrences, while a single act will constitute a single occurrence even though it causes multiple injuries or multiple episodes of injury. It follows that Imperial's use of the word "related" in the phrase "series of related acts" was meant to exclude *causally related* acts from the rule that multiple causative acts constitute multiple occurrences. Therefore, we hold that the proper construction of Imperial's definition is that [*136] [**458] even though there have been multiple causative acts, there will be a single "occurrence" if the acts are causally *related to each other* as well as to the final result. We now turn to the record to see if it contains information from which a factfinder could infer that the omissions of the two doctors were causally con-

nected to each other and thus constituted only one "occurrence."

The record shows that Worsham's treating physician requested Eisenbeiss to do a neurological consultation after [***18] Worsham's April 29, 1975 accident. Eisenbeiss either failed to review Worsham's x-rays or, reviewing them, failed to recognize the problem, and thus did not diagnose or report a fracture dislocation of the spine. On May 1, 1975, Worsham's condition deteriorated and Helme, who was on call while Eisenbeiss had the day off, performed emergency surgery. During a 1979 deposition, Helme stated that he had examined Worsham's spinal x-rays before operating. In June 1982, he admitted that he had not followed his usual practice and had not looked at the x-rays before operating on Worsham. Helme conceded that had he done so and seen the fracture dislocation, he would have immobilized Worsham during surgery. The surgery without immobilization is alleged to have caused Worsham's spinal cord injury, hastening his quadriplegia and resulting death.

In essence, therefore, survivors claim that both doctors were negligent in failing to look at the x-rays in connection with separate activities -- consultation and surgery. Each of the diagnostic failures allegedly was a cause of injury and contributed to the ultimate result -- death. The doctors' failures clearly were separate causal acts of separate [***19] doctors on separate days. Nothing in the record indicates that Eisenbeiss's conduct caused Helme to fail to examine the x-rays. [7] Certainly, on this record the finder of fact could not find a causal connection. Accordingly, we find that the trial court did not err in holding that the doctors' omissions constituted two occurrences under the Imperial policy, and that survivors could recover for two "covered claims." We affirm the trial court's grant of partial summary judgment in favor of survivors on this issue.

7 The Fund tries to establish a causal connection by arguing that the omissions were "related" because Helme would not have operated on Worsham had it not been Eisenbeiss's day off. We believe this argument stretches the concept of causation to the point where every act is causally connected to every subsequent event. *See* W. PROSSER & W. KEETON, THE LAW OF TORTS § 41, at 264 (5th ed. 1984).

C. *Breach of Duty of Cooperation*

The Fund contends that if the doctors' omissions did give rise [***20] to two "covered claims," its obligation to pay survivors on the second claim has been discharged by the doctors' collusion and breaches of the express duty of cooperation and implied duty of good faith. The Imperial policy contains a standard cooperation clause: the insured "shall not, except at his own cost, voluntarily make any payment, assume any obligation, or incur any expense." [HN9]The guaranty law required Helme and NSPC to cooperate with the Fund to the same extent they would have been required to cooperate with Imperial. A.R.S. § 20-667(A). [8] Helme and NSPC breached this duty to cooperate, according to the Fund, and "were obviously willing to say anything necessary to save their personal backsides." The Fund contends that Helme and NSPC "set it up" by entering into an unauthorized settlement and by creating "an alleged 'claim' so that both groups could profit at the expense of public funds." [9]

8 Renumbered A.R.S. § 20-672(A) (Supp.1986).

9 We are puzzled by the allusion to public funds. The Fund is created by assessment against insurers and is a cost of doing business. No tax funds are involved. *See* A.R.S. §§ 20-662 and 20-666 (Supp.1986).

[***21] A cooperation clause such as Imperial's is used to protect the insurer's right to a fair adjudication of the insured's liability and to prevent collusion between the insured and the injured person. 8 J. APPLEMAN, *supra* § 4771, at 213 (1981). [HN10]Ordinarily, an insured's breach of the cooperation clause relieves a prejudiced insurer [*137] [**459] of liability under the policy. *Globe Indemnity Co. v. Blomfield*, 115 Ariz. 5, 8, 562 P.2d 1372, 1375 (App.1977); 8 J. APPLEMAN, *supra* § 4772, at 215. [HN11]Insurance policies, however, are governed by the basic contract law principle that if one party to a contract breaches the agreement, the other party is no longer obligated to perform his or her contractual obligations. A. WINDT, INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES AND INSUREDS § 3.10, at 97 (1982); 8 J. APPLEMAN, *supra* § 4786, at 316. Throughout this litigation, survivors have claimed that the doctors were justified in settling the claims against them because the Fund had breached the material obligations of the insurance contract first. Survivors suggest that the Fund "abandoned" its insureds by breaching both its express duties [***22] to defend and indemnify, and its implied duty of good faith. Because we find as a matter of law that the Fund anticipatorily repudiated its duty to indemnify, we need not address the other breaches raised by survivors.

The insurance policy expressly obligated Imperial to indemnify Helme and NSPC (for its vicarious liability for Helme's acts) against all sums they became legally obligated to pay as damages because of injury arising out of Helme's professional malpractice. This duty is the most fundamental of an insurer's obligations. A. WINDT, *supra* § 6.01, at 225. [HN12]In purchasing an

insurance company's express agreement to pay covered claims, the insured is buying "security from financial loss which he may sustain from claims against him . . . ." Rawlings v. Apodaca, 151 Ariz. 149, 154, 726 P.2d 565, 570 (1986).

The Fund interpreted the statutes and the Imperial policy as obligating it to pay a maximum of $ 99,900, no matter what amount of damages were found at trial. The Fund admits that it told its insureds that it would pay only one covered claim. This contraction of coverage was based on the Fund's erroneous interpretation of the policy's "occurrence" definition. [***23] We recently stated that [HN13]a party which repudiates its contract obligations on the basis of an incorrect interpretation of a contract has committed an anticipatory breach. Snow v. Western Savings & Loan Association, 152 Ariz. 27, 33-34, 730 P.2d 204, 210-11 (1986). The Fund, therefore, anticipatorily breached its contractual and statutory obligations as a matter of law.

[HN14]As a general matter, insurance carriers owe their insureds three duties, two express and one implied. These are the duties to indemnify, the duty to defend, and the duty to treat settlement proposals with equal consideration. *See generally* A. WINDT, *supra* § 4.01 to § 6.37, at 100-297. Any breach, actual or anticipatory, of these duties deprives the insured of the security that he has purchased because the breach leaves him exposed to personal judgment and damage which may not be covered or may exceed the policy limits. Accordingly, when such a breach occurs, the insured is generally held to be freed from his obligations under the cooperation clause. Damron v. Sledge, 105 Ariz. 151, 460 P.2d 997 (1969); State Farm Mutual Automobile Insurance Co. v. Paynter, 122 Ariz. 198, 593 P.2d 948 (App.1979); [***24] A. WINDT, *supra* §§ 3.10 to 3.11, at 97-99.

Although the insurers in *Damron* and *Paynter* breached by refusing to defend, the principle of those cases remains the same: [HN15]once an insurer breaches any duty to its insured, the insured is no longer fully bound by the cooperation clause. *Accord* 7C J. APPLEMAN, *supra* § 4714; A. WINDT, *supra* § 3.10, at 97 and § 4.09, at 120. No other rule is sensible. The insured exposed by his insurer "to the sharp thrust of personal liability . . . need not indulge in financial masochism . . . ." Damron, 105 Ariz. at 153, 460 P.2d at 999, quoting Critz v. Farmers Insurance Group, 230 Cal.App.2d 788, 801, 41 Cal. Rptr. 401, 408 (1964).

> Whatever may be [the insured's] obligation to the carrier, it does not demand that he bare his breast to the continued danger of personal liability. By [settling], he attempts only to shield himself from the danger to which the company has exposed him . . . . The insurer's [*138] [**460] breach so narrows the policyholder's duty of cooperation that the self-protective [settlement] does not violate it.

Critz, 230 Cal.App.2d at 801-02, 41 Cal.Rptr. at 408-09. [***25]

We do not hold that the [HN16]insurer's anticipatory repudiation eliminates the insured's duty of cooperation so that the insured may enter into *any* type of agreement or take *any* type of action that may protect him from financial ruin. We hold only that once the insurer commits an anticipatory breach of its policy obligations, the insured need not wait for the sword to fall and financial disaster to overtake. [HN17]The insurer's breach narrows the insured's obligations under the cooperation clause and permits him to take reasonable steps to save himself. Among those steps is making a reasonable settlement with the claimant. So long as that settlement agreement is neither fraudulent, collusive, nor otherwise against public policy, the insured has not breached the cooperation clause.

[HN18]Damron agreements are not inherently collusive or fraudulent. Paynter, 122 Ariz. at 201, 593 P.2d at 951; Miller v. Shugart, 316 N.W.2d 729, 734 (Minn.1982). The insureds did not breach their duty of cooperation merely by entering into the Damron agreement to protect themselves after the Fund denied the full extent of its potential financial responsibility, thus abandoning its duty to indemnify [***26] and to fairly consider settlement proposals. *See* Communale v. Traders & General Insurance Co., 50 Cal.2d 654, 328 P.2d 198 (1958). The court of appeals erred in holding that the making of the Damron agreement, without more, was a breach of the cooperation clause. The parties have not argued, and this opinion does not reach, any issue regarding the extent to which the stipulations which form part of the settlement agreement are binding upon the insurer.

This case must be remanded for a factual determination of issues not resolved by the partial summary judgment. These include the question of whether Helme and NSPC fraudulently misreported Helme's treatment of Worsham.

CONCLUSION

Survivors may recover for two covered claims because the doctors' negligent omissions constituted two "occurrences" under the Imperial policy. The Fund is not discharged from paying on the Helme claim because its insureds entered into a Damron agreement; once the Fund anticipatorily repudiated its duty to indemnify the doctors for two claims, the doctors were free to protect

their assets by entering into a reasonable settlement agreement.

The decision of the court of appeals is vacated in part. The [***27] trial court's grant of partial summary judgment in favor of survivors is affirmed and the case is remanded for proceedings consistent with this opinion.

BAY CITIES PAVING & GRADING, INC., Plaintiff and Respondent, v. LAWYERS' MUTUAL INSURANCE COMPANY, Defendant and Appellant.

No. S023292

SUPREME COURT OF CALIFORNIA

5 Cal. 4th 854; 855 P.2d 1263; 21 Cal. Rptr. 2d 691; 1993 Cal. LEXIS 3922; 93 Cal. Daily Op. Service 6082; 93 Daily Journal DAR 10395

August 12, 1993, Decided

PRIOR HISTORY: Superior Court of the City and County of San Francisco, No. 875397, Thomas Kongsgaard, Judge. *

* Retired judge of the Napa Superior Court sitting under assignment by the Chairperson of the Judicial Council.

DISPOSITION: The judgment of the Court of Appeal is reversed with directions to remand this action to the trial court with instructions to enter judgment in favor of appellant Lawyers' Mutual.

CASE SUMMARY:

PROCEDURAL POSTURE: Appeal from a decision of the California Court of Appeal that affirmed the judgment of the trial court in a legal malpractice action awarding appellee monies under a professional malpractice policy issued by appellant.

OVERVIEW: Appellee brought an action alleging appellant's insured committed acts of legal malpractice. The liability insurance policy at bar contained a provision limiting the amount of coverage for individual claims, as well as a provision providing that the per-claim limitation would apply to claims arising from related acts. The appeals court affirmed the trial court's judgment that the insured had committed two acts of legal malpractice, each giving rise to separate claims under the policy, and that the two claims were not related within the meaning of the policy. On appeal, the state Supreme Court reversed. The court held that appellee had a single injury, and thus, a single cause of action under the policy. The court also held that even if appellee had separate claims under the policy, such claims were subject to the per-claim limitation because the claims arose out of related acts.

OUTCOME: In reversing the appeals court, the court held that appellee had only a single policy claim because only a single injury occurred. The court also held that even if appellee's claims were separate, they would be subject to the policy's per-claim limitation because the claims arose out of related acts.

CORE TERMS: omission, coverage, occurrence, single claim, insured, ambiguity, insurer, ambiguous, insurance policy, italics, cause of action, causally, mutual, malpractice, mechanic's lien, contractor's, logical, claims arising, causal connections, per-claim, separate claims, owed, failure to file, present case, multiple claims, deductible, stop notice, single act, single injury, tax returns

LexisNexis(R) Headnotes

Governments > Courts > Judicial Precedents
Governments > Local Governments > Claims By & Against
[HN1]California has consistently applied the primary rights theory, under which the invasion of one primary right gives rise to a single cause of action.

Civil Procedure > Pleading & Practice > General Overview
[HN2]A cause of action is based upon the harm suffered, as opposed to a particular theory asserted by a litigant. Even where there are multiple legal theories upon which recovery might be predicated, one injury gives rise to only one claim for relief.

Civil Procedure > Pleading & Practice > General Overview
Civil Procedure > Remedies > General Overview
[HN3]A cause of action distinguishable from the remedy and the relief sought, for a plaintiff may frequently be entitled to several species of remedy for the enforcement of a single right.

Insurance Law > Claims & Contracts > General Overview

[HN4]When there is a single cause of multiple injuries (or a number of causes that result in a greater number of injuries), courts often look to the cause rather than the injuries in determining the amount of insurance coverage. In such a case, the result is a finding of only one claim, i.e., the court looks to the single cause rather than to the multiple injuries.

Insurance Law > Claims & Contracts > Premiums > General Overview

[HN5]In an appropriate case, the absence of an insurance policy definition, though perhaps not dispositive, might weigh, even strongly, in favor of finding an ambiguity, for example, when the term in question has no generally accepted meaning outside the context of the policy itself. The absence from a policy of a definition of a word or phrase does not by itself, however, necessarily create an ambiguity.

Contracts Law > Contract Interpretation > General Overview

Governments > Legislation > Interpretation

[HN6]Under statutory rules of contract interpretation, the mutual intention of the parties at the time a contract is formed governs interpretation. Cal. Civ. Code, § 1636. Such intent is to be inferred, if possible, solely from the written provisions of the contract. Cal. Civ. Code § 1639. The clear and explicit meaning of these provisions, interpreted in their ordinary and popular sense, governs unless used by the parties in a technical sense or a special meaning is given to them by usage. Cal. Civ. Code § 1644. Such rules control judicial interpretation. Cal. Civ. Code § 1638.

Contracts Law > Contract Interpretation > General Overview

Contracts Law > Defenses > Ambiguity & Mistake > General Overview

Contracts Law > Formation > Ambiguity & Mistake > General Overview

[HN7]An insurance policy provision is ambiguous when it is capable of two or more constructions, both of which are reasonable. Courts will not adopt a strained or absurd interpretation in order to create an ambiguity where none exists. Language in an insurance contract must be construed in the context of the instrument as a whole and can not be found to be ambiguous in the abstract. There cannot be an ambiguity per se, that is, ambiguity unrelated to an application.

Criminal Law & Procedure > Criminal Offenses > Vehicular Crimes > License Violations > General Overview

Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > General Overview

[HN8]Multiple or broad meanings relating to an insurance policy provision do not necessarily create ambiguity.

Insurance Law > Claims & Contracts > General Overview

[HN9]Even if there have been multiple causative acts, there will be a single occurrence for insurance coverage purposes if the acts are causally related to each other as well as to the final result.

Insurance Law > Claims & Contracts > Policy Interpretation > Ordinary & Usual Meanings

[HN10]The term "related" in an insurance policy is commonly understood and used encompasses both logical and causal connections. Restricting the word to only causal connections improperly limits the word to less than its general meaning. "Related" is a broad word, but it is not therefore a necessarily ambiguous word.

SUMMARY:

CALIFORNIA OFFICIAL REPORTS SUMMARY

A general contractor brought a professional malpractice action against its attorney based on the attorney's having failed to serve a stop notice on a project's construction lenders and having failed to file a complaint to foreclose a mechanic's lien. These omissions resulted in the contractor's being unable to collect the amount it was owed on the project. The attorney's professional liability insurance policy contained a provision limiting coverage to a maximum of $ 250,000 "for each claim" and further provided that two or more claims arising out of a single act or a series of related acts were to be treated as a single claim. Pursuant to a stipulation, the attorney was dismissed from the action, and his insurer was designated as the defendant. The trial court determined that the attorney had committed two acts of legal malpractice that were not related under the terms of the policy. Thus, the court awarded the contractor $ 169,000 in addition to the $ 250,000 the insurer had already paid the contractor under the stipulation. (Superior Court of the City and County of San Francisco, No. 875397, Thomas Kongsgaard, Judge. [*]) The Court of Appeal, First Dist., Div. Three, No. A049722, affirmed, determining that each of the errors gave rise to a separate claim under the policy,

and that the two claims were not "related" within the meaning of the policy.

* Retired judge of the Napa Superior Court sitting under assignment by the Chairperson of the Judicial Council.

The Supreme Court reversed the judgment of the Court of Appeal with directions to remand the action to the trial court with instructions to enter judgment in favor of the insurer. The court held that the attorney's two omissions constituted a single claim under the policy. It held that when a single client seeks to recover from a single attorney alleged damages based on a single debt collection matter for which the attorney was retained, there is a single claim under the attorney's professional liability policy. The court further held that, even assuming that the two omissions resulted in separate claims, they were subject to the policy provision requiring that claims arising out of a single act or a series related acts be treated as a single claim. The policy's failure to define the term "related" did not by itself render the term ambiguous. That term, as it is commonly understood and used, encompasses both logical and causal connections. The court held that the attorney's two errors were "related" in that they arose out of the same transaction, arose as to the same client, were committed by the same attorney, and resulted in the same injury, loss of the debt. No objectively reasonable insured could have expected that he or she would be entitled to coverage for two claims under the policy. (Opinion by Baxter, J., with Lucas, C. J., Mosk, Panelli, Arabian and George, JJ., concurring. Separate concurring opinion by Kennard, J.)

HEADNOTES

CALIFORNIA OFFICIAL REPORTS HEADNOTES
Classified to California Digest of Official Reports

(1a) (1b) Insurance Contracts and Coverage § 80--Risks Covered by Liability Insurance--Per-claim Limitation--Legal Malpractice--Number of Claims. --In a malpractice action against an attorney by a general contractor arising from defendant's failure to serve a stop notice on a project's construction lenders and his failure to file a complaint to foreclose a mechanic's lien, which omissions resulted in the contractor's inability to collect the amount it was owed on the project, the trial court erred in determining that the two omissions gave rise to two separate claims, each of which was subject to the $ 250,000 per claim limit of defendant's malpractice policy. Foreclosure of the mechanic's lien and the serving of a timely stop notice on the lenders were merely different remedies for the same nonpayment. When a single client seeks to recover from a single attorney alleged damages based on a single debt collection matter for which the attorney was retained, there is a single claim under the attorney's professional liability policy. Although a per-occurrence limitation is generally determined on the basis of the number of occurrences (i.e., causes), rather than the number of injuries, in the present circumstances the respective foci of "occurrence" and "claims-made" policies were different. (Disapproving *Beaumont-Gribin-Von Dyl Management Co.* v. *California Union Ins. Co.* (1976) 63 Cal.App.3d 617 [134 Cal.Rptr. 25], to the extent it can be read to suggest that under such circumstances, the type of policy--"claims-made" or "occurrence"--is not significant.)

(2) Actions and Special Proceedings § 6--Existence of Right of Action--Primary Rights Theory: Words, Phrases, and Maxims--Cause of Action--Pleading Count. --California applies the primary rights theory, under which the invasion of one primary right gives rise to a single cause of action. The cause of action is based upon the harm suffered, as opposed to the particular theory asserted by the litigant. Even where there are multiple legal theories upon which recovery might be predicated, one injury gives rise to only one claim for relief. The concept of a "cause of action" is not the same as that of pleading "counts," which are merely ways of stating the same cause of action differently, although the two terms are often used imprecisely and indiscriminately.

[See 4 **Witkin,** Cal. Procedure (3d ed. 1985) Pleading, § 23.]

(3a) (3b) Insurance Contracts and Coverage § 80--Risks Covered by Liability Insurance--Related-claims Limitation--Legal Malpractice. --An attorney's failure to serve a stop notice on a project's construction lenders and his failure to file a complaint to foreclose a mechanic's lien, which omissions resulted in the contractor's inability to collect the amount it was owed on the project, were subject to the provision of the attorney's malpractice policy requiring that claims arising out of a single act or a series of related acts be treated as a single claim, and thus were subject to the policy's $ 250,000 per claim limitation, even assuming that each omission were viewed as giving rise to a separate claim. The policy's failure to define the term "related" did not by itself render the term ambiguous. That term, as it is commonly understood and used, encompasses both logical and causal connections. The attorney's two errors were "related" in that they arose out of the same transaction, arose as to the same client, were committed by the same attorney, and resulted in the same injury, loss of the debt. No objectively reasonable insured could have expected that he or she would be entitled to coverage for two claims under the policy.

(4) Insurance Contracts and Coverage § 10--Rules in Aid of Interpretation of Contracts--Ambiguities. --An insurance policy provision is ambiguous when it is capable of two or more constructions both of which are reasonable. Courts will not adopt a strained or absurd interpretation in order to create an ambiguity where none exists.

(5) Contracts § 30--Construction and Interpretation--Ambiguities--In the Abstract. --Language in a contract must be construed in the context of that instrument as a whole, and in the circumstances of that case, and cannot be found to be ambiguous in the abstract. There cannot be an ambiguity per se, i.e., an ambiguity unrelated to an application.

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Arthur R. Abelson for Plaintiff and Respondent.

JUDGES: Opinion by Baxter, J., with Lucas, C. J., Mosk, Panelli, Arabian and George, JJ., concurring. Separate concurring opinion by Kennard, J.

OPINION BY: BAXTER, J.

OPINION

[*857] [**1264] [***692] A general contractor was owed money for its work on a construction project. The attorney who had been representing the contractor in connection with the project recorded a mechanic's lien but thereafter failed to serve a stop notice on the project's construction lenders and failed to file a complaint to foreclose the mechanic's lien. As a result of the attorney's omissions, the contractor was unable to collect the amount it was owed.

The contractor then commenced this action against its attorney. The attorney's professional liability insurance policy contains a provision limiting coverage to a maximum of $ 250,000 "for each claim" and further provides that, "Two or more claims arising out of a single act, error or omission or a series of related acts, errors or omissions shall be treated as a single claim."

The narrow issue before us is one of first impression. Does the policy's $ 250,000 per claim limit apply to the attorney's two omissions? We hold the limitation applies for two independent reasons: (1) The contractor's suit against its former attorney is a single claim within the meaning of the [*858] insurance policy's definition of "claim." (2) Even if the contractor's action could be viewed as comprising two claims within the policy definition, those claims must be treated as a single claim under the policy's provision limiting coverage for claims arising out of a series of related acts, errors, or omissions.

FACTS

The facts are few and undisputed. Respondent Bay Cities Paving & Grading, Inc. (Bay Cities), a licensed general contractor, retained Attorney Robert Curotto to represent Bay Cities in connection with construction work it was performing. Bay Cities completed its work on the project but was unable to collect a substantial portion of the amount it was owed. Curotto filed a mechanic's lien on Bay Cities' behalf. Curotto, however, did not serve a stop notice on the project's construction lenders. Nor did he timely seek to foreclose the mechanic's lien.

Bay Cities sued Curotto for legal malpractice, alleging that he had been negligent in failing to serve a stop notice and in failing to foreclose the mechanic's lien. Curotto tendered the defense of the action to his professional liability insurance carrier, appellant Lawyers' Mutual Insurance Company (Lawyers' Mutual).

Curotto, Bay Cities, and Lawyers' Mutual stipulated as follows: Coverage under the Lawyers' Mutual policy issued to Curotto was limited to $ 250,000 per claim and an annual aggregate of $ 750,000. Bay Cities contended it was asserting two separate claims within the meaning of the policy and that the limit of coverage was therefore $ 500,000. Lawyers' Mutual contended that only one claim was being asserted. Lawyers' Mutual would pay Bay Cities $ 250,000, and the parties would try before the court the issue of whether two claims were [**1265] [***693] being asserted within the meaning of the policy. If the court found there was only one claim, Bay Cities' recovery would be limited to the $ 250,000 stipulated payment. If the court found there were two claims, Bay Cities could recover additional damages up to a maximum of $ 187,000. Pursuant to the stipulation, Curotto was dismissed from the action, and Lawyers' Mutual was designated as the defendant.

The trial court ruled that Curotto had committed two acts of legal malpractice that were *not* related under the

terms of the policy: (1) the failure to file a stop notice, and (2) the failure to file a timely action to foreclose the mechanic's lien. Bay Cities was awarded $ 169,000 in addition to the $ 250,000 already paid under the stipulation.

Lawyers' Mutual appealed. The Court of Appeal affirmed, holding that: (1) each of Curotto's two errors gave rise to a separate claim under the [*859] policy, and (2) the two claims are not "related" within the meaning of the policy.

DISCUSSION

I. *MEANING OF "CLAIM" UNDER THE POLICY*

The attorney's liability policy states, " 'Claim' whenever used in this policy means a *demand,* including service of suit or institution of arbitration proceedings, *for money against the insured.*" (Italics added.) By any reasonable understanding, Bay Cities' suit against Curotto is a demand for money. Bay Cities does not contend otherwise. Rather, the dispute is centered on the policy's "Limits of Liability" section. It states, "*The liability of the company* under subsection 1 of the section of this policy entitled 'The Coverage' *for each claim* First Made Against the Insured During the Policy Period *shall not exceed the amount stated in the Declarations for 'each claim* . . ..' " (Italics added.) **(1a)** Bay Cities contends it is asserting two separate claims, each of which is subject to the per-claim limit of $ 250,000, because each of Curotto's two omissions resulted in a separate injury to Bay Cities. Lawyers' Mutual contends there is a single claim. The parties have stipulated that the pertinent portion of the policy is paragraph 3 of the policy's "Limits of Liability" section. It states: "The inclusion herein of more than one Insured or the making of claims or the bringing of suits by more than one person or organization shall not operate to increase the Company's limit of liability. *Two or more claims arising out of a single act, error or omission or a series of related acts, errors or omissions shall be treated as a single claim.*" (Italics added.) As we shall explain, Lawyers' Mutual has the better view. Bay Cities has a single claim under the policy.

In concluding two claims are presented, the Court of Appeal rejected Lawyers' Mutual's argument there is only one claim because there is only one lawsuit. The court's premise was that, "There are two distinct causes of action and the fact that they are included within one lawsuit should not be the deciding factor." We agree with the Court of Appeal's view that including multiple claims within a single action does not render them a single claim. That conclusion, however, begs the question of whether there is more than one claim in the first instance. The Court of Appeal erred on that threshold question by starting with the underlying premise that Bay Cities was asserting two causes of action. We do not suggest that the number of claims is determined by rules of pleading. A correct understanding, however, of the nature of a "cause of action" does shed light on the question before us.

[*860] **(2) (1b)** Bay Cities was not asserting two causes of action. Bay Cities had a single injury and thus a single cause of action against its attorney. [1] [HN1]"California has consistently applied the 'primary rights' theory, under which the invasion of one primary right gives rise to a single cause of action." (*Slater v. Blackwood, supra,* 15 Cal.3d 791, 795; [**1266] [***694] *Big Boy Drilling Corp. v. Rankin* (1931) 213 Cal. 646, 649 [3 P.2d 13]; 4 Witkin, Cal. Procedure (3d ed. 1985) Pleading, § 23, pp. 66-67.) Bay Cities had one primary right--the right to be free of negligence by its attorney in connection with the particular debt collection for which he was retained. He allegedly breached that right in two ways, but it nevertheless remained a single right.

1 Apparently, the Court of Appeal confused the concept of a "cause of action" with that of pleading "counts," which are merely ways of stating the same cause of action differently. We have previously noted that the two terms are often used imprecisely and indiscriminately. (*Slater v. Blackwood* (1975) 15 Cal.3d 791, 796 [126 Cal.Rptr. 225, 543 P.2d 593].)

Similarly, [HN2]"[T]he 'cause of action' is based upon the harm suffered, as opposed to the particular theory asserted by the litigant. . . . Even where there are multiple legal theories upon which recovery might be predicated, *one injury* gives rise to only one claim for relief." (*Slater v. Blackwood, supra,* 15 Cal.3d 791, 795, italics added.) Bay Cities suffered a single injury as a result of its attorney's omissions--the inability to collect the amount owed to Bay Cities for its work on the construction project.

In *Big Boy Drilling Corp. v. Rankin, supra,* 213 Cal. 646, 649, we considered the concept of a "cause of action" in connection with a contractor's efforts (through its assignee) to recover money owed for work done on real property. "Whether plaintiff accomplishes this purpose by the foreclosure of mechanics' liens or by way of a personal judgment, or both, is immaterial. Both demands having arisen out of the same transaction, there is but one cause of action with two forms of relief. The seeking of different kinds of relief does not establish different causes of action. . . . [HN3]The 'cause of action' is to be distinguished from the 'remedy' and the 'relief' sought, for a plaintiff may frequently be entitled to several species of remedy for the enforcement of a single right." (

Big Boy Drilling Corp. v. Rankin, supra, 213 Cal. 646, 649 [citations omitted].)

The reasoning as to proper pleading, though not controlling, is illustrative in the present case. Bay Cities contends it had two sources of payment of its construction work: (1) foreclosure of the mechanic's lien, and (2) serving a timely stop notice on the project's construction lenders. These two procedures, however, arose from the same transaction--Bay Cities' work on the project--and were merely different remedies for nonpayment of the amount [*861] owed to Bay Cities. Thus, Bay Cities had a single right--the right to payment for its construction. The loss of that right as a result of the attorney's two omissions resulted in a single injury.

We find it difficult to imagine how the loss of or damage to a single right could give rise to more than one claim under an attorney's professional liability policy. We need not speculate, however, as to whether or how such an unusual circumstance might arise because the least that can be said is that--when, as in this case, a *single* client seeks to recover from a *single* attorney alleged damages based on a *single* debt collection matter for which the attorney was retained--there is a *single* claim under the attorney's professional liability insurance policy.

Other factors, primarily the policy language and context, lead to the same conclusion. As noted above, the relevant policy language states that, "The inclusion herein of more than one Insured or the making of claims or the bringing of suits by more than one person or organization shall not operate to increase the Company's limit of liability. Two or more claims arising out of a single act, error or omission . . . shall be treated as a single claim." Under this language, if an attorney's single error harmed two clients and gave each of them a separate claim, those two claims would be treated as a single claim under the policy's limitation of liability. It would be anomalous to limit liability in that circumstance but to disregard the limitation when, as in this case, a single client suffers a single injury as a result of multiple errors.

Under Bay Cities' view, the greater the number of an attorney's negligent acts, the greater the number of claims under the policy, even if all the acts cause only a single injury. Such a rule would have the plainly undesired result of providing the attorney who has made one error with an incentive to then make as many additional [**1267] [***695] errors and omissions as possible, so as to increase the amount of insurance coverage.

Moreover, allowing a client to assert multiple claims under the policy would create a serious potential of prejudice to the attorney and to other clients. The professional liability policy in this case, like most such policies, has two independent coverage limitations. One is the per-claim limitation. The other is an aggregate limitation that applies regardless of the number of claims submitted during the policy period. If a particular client could obtain increased coverage by creating multiple claims for a single injury, less coverage would remain for other clients with claims against the attorney. That result could prejudice those clients. Conversely, the attorney could also [*862] be prejudiced because of an increased risk that the attorney's personal, noninsurance assets would have to be used to pay those clients' claims.

The multiplication of claims could prejudice the attorney in another material respect. This and other professional liability policies contain a "deductible," that is, a requirement that the insured bear a portion of the liability "[w]ith respect *to each claim.*" (Italics added.) The amount of the deductible can be significant. If a client could assert multiple claims based on a single injury, the attorney would be responsible for multiple deductibles, corresponding to the number of claims. Indeed, in some cases, insurers have contended that multiple claims were being presented, so as to increase the amount of the insured's deductible and thereby decrease the amount owed by the insurer. (*Combined Communications Corp. v. Seabord Sur. Co.* (9th Cir. 1981) 641 F.2d 743, 744.) Such result is obviously not favorable to the insured. It also works to the disadvantage of the insured's client because the insurer is responsible for a smaller portion of the damages, and the client must therefore attempt to obtain satisfaction from the attorney's other assets. [2] Courts have generally rejected insurers' attempts to apply multiple deductibles to single claims or related claims by third parties against insureds. (*Beaumont-Gribin-Von Dyl Management Co. v. California Union Ins. Co.* (1976) 63 Cal.App.3d 617 [134 Cal.Rptr. 25]; *Haerens v. Commercial Cas. Ins. Co.* (1955) 130 Cal.App.2d Supp. 892 [279 P.2d 211]; see generally Annot., Liability Insurance: What Is "Claim" Under Deductibility-Per-Claim Clause (1988) 60 A.L.R.4th 983, 987.) By parity of reasoning, the artificial multiplication of claims should not result in increased coverage. To construe a policy provision narrowly so as to find only one claim and thus limit the deductible, but to construe the same language expansively so as to find multiple claims and thereby increase coverage, would be a result- oriented approach we decline to follow.

2 At first blush, it might seem odd for an insurer to contend that a particular case presents multiple claims because doing so could increase the amount of coverage. Whether an insurer would choose to do so would depend on the facts of each case, but, as prior cases illustrate, a finding of multiple claims can benefit the insurer and disadvantage the insured and the client. For example, assume that a client obtains a judgment for $

25,000 in damages against the attorney, the per claim limitation is $ 100,000, and the per claim deductible is $ 5,000. If there is only one claim, the client is entitled to receive $ 25,000--$ 20,000 from the carrier and $ 5,000 from the attorney. If, however, the case is construed as presenting two claims, the client remains entitled to the same amount, $ 25,000, but the insurer is obligated only to pay $ 15,000, and the attorney is responsible for twice as much, $ 10,000. As explained above, this result works against both the insured and the client.

Bay Cities contends, "[I]t is almost the universal rule that in analyzing coverage issues, the courts look to the number of *causes* of damage as opposed to the number of *injuries* sustained." Such a principle *is* often stated. [*863] (*Michigan Chemical Corp. v. American Home Assur. Co.* (6th Cir. 1984) 728 F.2d 374, 379.) Its application and effect, however, do not support Bay Cities. [HN4]When there is a single cause of multiple injuries (or a number of causes that result in a greater number of injuries), courts often look to the cause rather than the injuries in determining the amount of insurance coverage. In such a case, the result is a finding of only one claim, i.e., the court looks to the single cause rather than to the multiple injuries. Under Bay [**1268] [***696] Cities' view, the converse of this rule should apply so that, when there are multiple causes of a single injury, the number of causes should determine the number of insurance claims. In other words, Bay Cities proposes we convert a principle that generally limits coverage into one that expands coverage. We decline to do so, at least in the circumstances before us.

The rule proposed by Bay Cities would have little logical or practical consistency and would be unworkable. For example, assume a policy with a $ 250,000 per-claim limitation, and that the client retains the attorney, as in the present case, to collect a debt of $ 1 million from a third party. The attorney commits a single error that results in loss of the debt. The client has been damaged in the amount of $ 1 million, and under Bay Cities' view, is limited to recovery of $ 250,000 because there was a single cause of the injury. If, however, a different client (or even the same client) lost a debt in the same amount ($ 1 million) because the attorney committed *three* errors, the recovery would be $ 750,000 (three errors times $ 250,000). The point is obvious. Under Bay Cities' rule, clients with the same injuries in the same amount would receive different recoveries based solely on the fortuity of how many errors the attorney commits.

A brief review of the primary cases on which Bay Cities relies further demonstrates why Bay Cities' proposed rule does not apply in this case. In *Michigan Chemical Corp. v. American Home Assur. Co., supra,* 728 F.2d 374, a chemical manufacturer, which produced both a livestock feed supplement and a toxic flame retardant, had erroneously shipped the flame retardant rather than the feed supplement to a feed distributor. (Apparently the bags were mislabelled.) The distributor mixed the toxin with regular feed and sold the resulting product to farmers. Thousands of head of livestock became ill and had to be destroyed. The farmers filed suit. The manufacturer contended that each action against it constituted a separate "occurrence" under its liability insurance policies. The insurers contended there was only one occurrence, the accidental shipment of the wrong chemical. Applying Illinois law, the court agreed with the insurer, explaining, "[T]he number of occurrences must be determined by examining the cause of the property damage, *i.e.,* the misshipment or misshipments of PBB [the toxin]." (*Id.,* at [*864] p. 382.) The court remanded the action to the trial court to determine the number of misshipments.

Similarly, in *Home Indem. Co. v. City of Mobile* (11th Cir. 1984) 749 F.2d 659, more than 200 claims were filed against a city for flood damages incurred during 3 rainstorms. The claimant property owners alleged the city had been negligent in its planning, construction, and operation of its water drainage system. The city contended each claim against it constituted a single occurrence in applying its insurance policy's per- occurrence limitation. The insurer contended each storm was a separate cause of the damage and that there were only three occurrences. Applying Alabama law, the court agreed with the insurer that the number of causes, not the number of injuries, was determinative and that each discrete act or series of acts causing damage was a separate occurrence under the policy. (*Id.,* at p. 663.) [3]

3 In the third case cited by Bay Cities on this point, the dispute was between two insurers for an attorney, one which had issued an "occurrence" policy, and the other which had subsequently issued a "claims-made" policy. The question was which insurer was liable for the claim against the attorney. There was no issue as to the amount of coverage, and the court explained that the "cause v. injury" test, advocated by Bay Cities, did not apply. (*American Home Assur. Co. v. Dykema, Gossett, et al.* (7th Cir. 1987) 811 F.2d 1077, 1084.) The case is thus inapposite and provides no support for Bay Cities.

Michigan Chemical Corp. v. American Home Assur. Co., supra, 728 F.2d 374, and *Home Indem. Co. v. City of Mobile, supra,* 749 F.2d 659, illustrate why Bay Cities' proposed rule does not properly apply in this case. First and foremost, those cases were decided under "occurrence" polices rather than "claims-made" policies.

Bay Cities asserts without analysis that the type of policy should make no difference in [**1269] [***697] our analysis. Not so. The language of the occurrence policies at issue in those cases was significantly different from the relevant provision in this case. [4] Indeed, after noting the general rule that a per-occurrence limitation is determined on the basis of the number of occurrences, i.e., the number of causes, rather than on the number of injuries, the *Michigan Chemical* court, *supra,* 728 F.2d 374, explained: "The definitions of 'occurrence' in the present insurance policies reflect this approach. First, these provisions in essence refer to an 'accident' which results in injury during the policy period. The language makes the accident constituting the occurrence logically distinct from the injuries which later take place. *Second, the insurance policies under review afford coverage on an 'occurrence' rather than on a 'claim' basis.* The use of the former term 'indicates [*865] that the polic[ies were] not intended to gauge coverage on the basis of individual accidents giving rise to claims, but rather on the underlying circumstances which resulted in the claim[s] for damages.' " (*Id., at p. 379*, italics added and bracketed material in original, quoting *Champion International Corp. v. Continental Casualty Co.* (2d Cir. 1976) 546 F.2d 502, 505-506.) We agree that the respective foci of "occurrence" and "claims-made" policies are different in the present context. [5]

4 For example, one of the policies in *Michigan Chemical Corp. v. American Home Assur. Co., supra,* 728 F.2d 374, stated: "The term 'Occurrence' wherever used herein shall mean *an accident or a happening or event* or a continuous or repeated exposure to conditions *which unexpectedly and unintentionally results in* personal injury, *property damage* or advertising liability *during the policy period.*" (*Id., at p. 378*, italics in original.) The other policy contained substantially identical language. (*Ibid.*)

5 In *Beaumont-Gribin-Von Dyl Management Co. v. California Union Ins. Co., supra,* 63 Cal.App.3d 617, the court decided that claims asserted by multiple third parties against a property management company constituted a single claim for purposes of computing the amount of the deductible under the company professional liability policy. Although this result is consistent with our view in this case, Bay Cities nevertheless cites the decision for its statement that, "[T]he label, whether 'claims made' or 'occurrence,' applied to an insurance policy is of little aid in its interpretation." (*Id., at p. 624*.) In the context of the question before that court, the observation may have been accurate. As explained in one of the cases cited by Bay Cities, however, the two types of policies are notably different in some respects, most importantly, the period for which they provide coverage. (*Chamberlin v. Smith* (1977) 72 Cal.App.3d 835, 845, fn. 5 [140 Cal.Rptr. 493].) Otherwise, there would be no need for or use of both types of policies. Depending on the question before a court, the type of policy--"claims-made" or "occurrence"--can be significant to the outcome. To the extent that it suggests otherwise, we disapprove of the statement in *Beaumont-Gribin-Von Dyl Management Co. v. California Union Ins. Co., supra,* 63 Cal.App.3d 617, 624.

Bay Cities also relies on *Transamerica Ins. Co. v. Keown* (D.N.J. 1978) 451 F.Supp. 397, in which an attorney acting as the trustee of an estate had been found liable to its beneficiaries for having breached the trust agreement by investing in real estate. The beneficiaries contended each year the attorney held the real estate gave rise to a separate claim. His insurer contended there was a single claim. The court agreed and noted that other decisions had been based on "whether the court focuses on cause or effect." (*Id., at p. 403*.) The *Keown* court then explained there was a single cause in that case. Based on that alone, Bay Cities cites the decision as supporting the "cause v. injury" test it espouses. Bay Cities reads too much into *Keown.* Properly understood, it supports our view. The *Keown* court, like us, looked to the injury. "The effect is also singular; one piece of real estate lost value to the detriment of a single estate." (*Ibid.*) The same logic applies here. To paraphrase *Keown,* "The effect is singular; one debt was lost to the detriment of one client."

As shown, the cases on which Bay Cities relies are largely distinguishable because they were decided under different policy language (in most cases, "occurrence" policies), different states' approaches to insurance policy construction, and different fact situations. Moreover, the "cause" approach resulted in a restriction of coverage, not the expansion Bay Cities seeks.

[*866] [**1270] [***698] For all the foregoing reasons, we hold that Bay Cities has a single claim against its attorney within the meaning of the professional liability insurance policy issued by Lawyers' Mutual.

II. *"RELATED" ACTS, ERRORS, AND OMISSIONS*

In light of its conclusion that there were two claims under the policy, the dispositive issue before the Court of Appeal then became whether they were "related" under the policy. Perhaps for that reason, most of the Court of Appeal's opinion dealt with the meaning of "related" as a policy term. Similarly, the parties' briefs in this court

also emphasize that issue. We therefore address that question as well.

(3a) Even if we were to view each of the attorney's two omissions as giving rise to a separate claim by Bay Cities, the per-claim limitation nevertheless would apply. The policy states, "Two or more claims arising out of a single act, error or omission or *a series of related acts, errors or omissions* shall be treated as a single claim." (Italics added.) The Court of Appeal deemed the term "related" to be ambiguous, construed it to mean only errors that are causally related to one another, and concluded this provision does not apply because neither of the attorney's two errors caused the other error. As we shall explain, the Court of Appeal's analysis and conclusion are flawed in several respects.

The Court of Appeal assumed an ambiguity merely because, ". . . no definition was provided [in the policy] for the term 'related,' " and reasoned that "The lack of definition [of 'related'] allows for ambiguity with respect to the 'Limits of Liability' clause." The absence from the policy of a definition of the term "related" does not *by itself* render the term ambiguous. We recently rejected the view that the lack of a policy definition necessarily creates ambiguity. (*Bank of the West v. Superior Court* (1992) 2 Cal.4th 1254, 1264- 1265 [10 Cal.Rptr.2d 538, 833 P.2d 545]; see also *Castro v. Fireman's Fund American Life Ins. Co.* (1988) 206 Cal.App.3d 1114, 1120 [253 Cal.Rptr. 833].) Indeed, any rule that rigidly presumed ambiguity from the absence of a definition would be illogical and unworkable. To avoid the ambiguity perceived by the Court of Appeal, an insurer would have to define every word in its policy, the defining words would themselves then have to be defined, their defining words would have to be defined, and the process would continue to replicate itself until the result became so cumbersome as to create impenetrable ambiguity. The present case illustrates the problem. The insurer contends that "related" means a logical connection, rather than only a causal connection as held by the Court of Appeal. Under the Court of [*867] Appeal's view, the insurer's position could prevail only if it had defined or somehow qualified "related," that is, by using the words "logically related," rather than the unqualified term "related." Of course, the addition of the word "logically" would not remove the ambiguity unless the word "logically" were itself defined in the policy. Every definition would require a further definition. We reject such a result. [HN5]Of course, in an appropriate case, the absence of a policy definition, though perhaps not dispositive, might weigh, even strongly, in favor of finding an ambiguity, for example, when the term in question has no generally accepted meaning outside the context of the policy itself. The absence from a policy of a definition of a word or phrase does not *by itself,* however, necessarily create an ambiguity.

The proper and settled approach is more refined. [HN6]"Under statutory rules of contract interpretation, the mutual intention of the parties at the time the contract is formed governs interpretation. (Civ. Code, § 1636.) Such intent is to be inferred, if possible, solely from the written provisions of the contract. (*Id.,* § 1639.) The 'clear and explicit' meaning of these provisions, interpreted in their 'ordinary and popular sense,' unless 'used by the parties in a technical sense or a special meaning is given to them by usage' (*id.,* § 1644) controls judicial interpretation. (*Id.,* § 1638.)" (*AIU Ins. Co. v. Superior Court* (1990) 51 Cal.3d 807, 821-822 [274 Cal.Rptr. 820, 799 P.2d 1253]; *Reserve Insurance Co. v. Pisciotta* (1982) 30 Cal.3d 800, 807 [180 Cal.Rptr. 628, 640 P.2d 764].) [**1271] [***699] This reliance on common understanding of language is bedrock.

Equally important are the requirements of reasonableness and context.

(4) [HN7]First, "An insurance policy provision is ambiguous when it is capable of two or more constructions both of which are *reasonable.*" (*Suarez v. Life Ins. Co. of North America* (1988) 206 Cal.App.3d 1396, 1402 [254 Cal.Rptr. 377], italics added.) "Courts will not adopt a strained or absurd interpretation in order to create an ambiguity where none exists." (*Reserve Insurance Co. v. Pisciotta, supra,* 30 Cal.3d 800, 807.)

(5) Second, "[*L*]*anguage in a contract* must be construed in the context of that instrument as a whole, and in the circumstances of that case, and *cannot be found to be ambiguous in the abstract.*" (*Bank of the West v. Superior Court, supra,* 2 Cal.4th 1254, 1265, original italics, quoting *Producers Dairy Delivery Co. v. Sentry Ins. Co.* (1986) 41 Cal.3d 903, 916, fn. 7 [226 Cal.Rptr. 558, 718 P.2d 920].) "There cannot be an ambiguity per se, i.e. an ambiguity unrelated to an application." (*California State Auto. Assn. Inter-Ins. Bureau v. Superior Court* (1986) 177 Cal.App.3d 855, 859, fn. 1 [223 Cal.Rptr. 246].)

(3b) Applying the foregoing principles in this case, the first question is whether the term "related" is ambiguous as to the specific issue in this case, [*868] that is, the question of whether the per-claim limitation applies. "Related" is a commonly used word with a broad meaning that encompasses a myriad of relationships. For example, a leading legal dictionary defines "related" to mean "standing in relation; connected; allied; akin." (Black's Law Dict. (6th ed. 1990) p. 1288, col. 1.) Similarly, a legal thesaurus lists many synonyms for "related." (Burton, Legal Thesaurus (1980) p. 925, col. 2.) In a coverage case (not involving a claim limitation), the court observed that "related" can denote a causal connec-

tion as well as the "notion of similarity." (*O'Doan v. Insurance Co. of North America* (1966) 243 Cal.App.2d 71, 78 [52 Cal.Rptr. 184, 33 A.L.R.3d 684].)

Although "related" is broad enough to encompass both logical as well as causal relationships, the Court of Appeal incorrectly found an inherent ambiguity. [HN8]Multiple or broad meanings do not necessarily create ambiguity. For example, assume that an insurance policy excluded coverage for any claim arising from the operation of a "motor vehicle." Obviously, a "motor vehicle" could be either an automobile or a truck, but that does not mean it must be only one or the other, rather than both. Likewise here, the fact that "related" can encompass a wide variety of relationships does not necessarily render the word ambiguous. To the contrary, a word with a broad meaning or multiple meanings may be used for that very reason--its breadth--to achieve a broad purpose. We need not, however, belabor the question of whether "related" is ambiguous in the abstract or in some hypothetical circumstance. That is not the question.

The proper question is whether the word is ambiguous in the context of *this* policy and the circumstances of *this* case. (*Bank of the West v. Superior Court, supra,* 2 Cal.4th 1254, 1265.) The provision will shift between clarity and ambiguity with changes in the event at hand." (*O'Doan v. Insurance Co. of North America, supra,* 243 Cal.App.2d 71, 77.) The linchpin of Bay Cities' argument is that "related" is ambiguous because it could have either a broad meaning, for example, meaning all services rendered by the attorney in connection with this particular matter, or, alternatively, a narrower meaning, that is, only those acts by the attorney that are *causally* related. The precise and narrow question is thus whether "related" in an attorney's professional liability insurance policy is ambiguous because the word is reasonably susceptible to both of these meanings.

We find no ambiguity because the construction of "related" advocated by Bay Cities is not reasonable. If an attorney's error causes one or more other errors, the result is a chain of causation that leads to *an* injury, that is, a single claim. One of the decisions on which Bay Cities relies [**1272] [***700] makes this very [*869] point. [HN9]"[E]ven though there have been multiple causative acts, there will be a single 'occurrence' if the acts are causally related to each other as well as to the final result." (*Ariz. Prop. & Cas. Ins. Guar. Fund v. Helme* (1987) 153 Ariz. 129, 136 [735 P.2d 451, 458, 64 A.L.R.4th 651], italics omitted.) A single claim is, of course, subject to the per-claim limitation of the policy. Similarly, if the chain of causally related events somehow led to two claims (a result difficult to imagine), they would be treated as a single claim under Bay Cities' view of "related", and would be subject to the per- claim limitation. Thus, if the related-acts limitation were applied only to causally related acts, the related-acts limitation would be duplicative of the per-claim limitation.

Moreover, the "causally related" test ignores the nature of the injury. For example, assume an attorney makes two separate omissions during a trial. The attorney fails to object to the admission of an otherwise inadmissible document submitted by the opponent and also fails to produce a key witness on behalf of the client. Each error independently leads to an adverse judgment against the client. Under Bay Cities' analysis, however, there are two claims because neither error caused the other error. If, however, the two claims were causally related, there would be only one claim under the policy. We are not persuaded. Regardless of whether the two errors are independent or causally related, the injury to the client is the same--the adverse judgment. Moreover, when two or more errors lead to the same injury, they are--for that very reason--"related" under any fair and reasonable meaning of the word.

The only attorney malpractice case on which the Court of Appeal relied is largely inapposite and unpersuasive in any event. *Estate of Logan v. Northwestern Nat. Cas.* (1988) 144 Wis.2d 318 [424 N.W.2d 179] involved no issue as to the amount of coverage or a per claim limitation. The underlying malpractice suit against the attorney arose out of his failure to file inheritance and estate tax returns for a decedent's estate and negligence in connection with other matters for the estate. The court held that his professional liability insurance policy provided no coverage for failure to file the inheritance and estate tax returns because he was aware when he applied for the policy that he had breached his professional duty as to the tax returns. (*Id.,* at p. 326 [424 N.W.2d at p. 181].) After having failed to file the tax returns, the attorney misplaced them, and he contended this error was a separate act for which he should be covered. The court squarely rejected this contention, holding that the attorney's ". . . initial failure to file and his subsequent misplacement of the tax returns are 'a series of related acts' which must be treated as a single claim." (*Id.,* at p. 344 [424 N.W.2d at p. 188].) The court [*870] noted that, if the attorney had not failed to file the tax returns, he would not have been in a position later to misplace them. The court did not, however, suggest that one error had caused the other.

In a brief paragraph, the *Logan* court, *supra,* 144 Wis.2d 318 [424 N.W.2d 179], also concluded that other negligent acts in connection with the estate were not related to the failure to file the tax returns. The court's reasoning is not entirely clear: "[T]he claim arising out of [the attorney's] negligence in failing to file timely the tax returns and the claims arising out of [his] alleged negligence in failing to file timely the fiduciary returns, to process the auction check, to close the estate, or to man-

age the cash assets of the estate are not a series of related acts which must be treated as one claim. The duties encompassed in the above claims would have arisen notwithstanding [the attorney's] failure to file the state tax returns in a timely matter." (*Id.,* at p. 345 [424 N.W.2d at p. 189].) Based on this passage, Bay Cities contends the *Logan* court adopted the causally related test advocated by Bay Cities for applying the per-claim limitation. This reads far too much into the decision. It had nothing to do with a per-claim limitation, and the court never explicitly referred to or discussed a causally related test. At most, the decision might be read to suggest that each of the acts of alleged negligence was a breach of a separate duty. We need not [**1273] [***701] decide whether we would agree with the Wisconsin court on the facts of that case, i.e., an estate taxation matter. Moreover, each of the attorney's errors apparently caused separate, identifiable monetary damage to the estate. That fact alone distinguishes *Logan* from the present case, in which the attorney's two errors related to the same debt he was retained to collect. Finally, to the extent the decision might be read broadly (probably more broadly than the court intended) to suggest that every breach of duty in connection with a particular matter necessarily gives rise to a separate insurance claim, we simply disagree. (See discussion at pp. 859-866, *ante.*) In short, *Logan* provides scant, if any, support for Bay Cities.

The other decision on which the Court of Appeal relied is more apposite but nevertheless unpersuasive. In *Ariz. Prop. & Cas. Ins. Guar. Fund v. Helme, supra,* 735 P.2d 451 (*Helme*), a state guaranty fund sought to limit its liability for claims against two physicians insured by an insolvent carrier. (For purposes of the coverage action, the fund was subject to the same rights and defenses as the insurer would have been under the policy.) Over a period of time, the two doctors had treated a patient who deteriorated and died. His survivors sued the doctors, alleging that they had repeatedly failed to examine the patient's X-rays or react to his worsening condition. The fund contended the doctors' alleged negligence constituted a single occurrence [*871] under their professional liability policy. (The policy was an "occurrence" policy, rather than a "claims-made" policy as in the present case.) The policy defined "occurrence" as being "any incident, act or omission, or series of *related* incidents, acts or omissions resulting in injury . . .." (*Id.,* at p. 456, italics added, original italics deleted.) The question was whether the various failures of the doctors constituted a series of "related incidents, acts or omissions" and thus only one occurrence. The court first acknowledged that "related" can mean either a logical or a causal connection. The court concluded, however, that "logic" is a subjective notion, that "causation" is more objective, and therefore that the policy term "related" should be limited to occurrences with a causal connection. (*Id.,* at pp. 456-457.)

For the reasons we have already discussed, we respectfully disagree with the *Helme* court, *supra,* 735 P.2d 451. Nor are we persuaded a "causal connection" is necessarily more precise than a "logical connection," especially in view of the multiple and imprecise meanings of causation. (*Mitchell v. Gonzales* (1991) 54 Cal.3d 1041, 1050-1054 [1 Cal.Rptr.2d 913, 819 P.2d 872] [noting the widespread confusion over causation].) More important, our function is not to redraft a policy term merely so that it might be more precise and easier for us to apply.

To support its contention that "related" must mean "causally" related, Bay Cities notes several cases for the proposition that the number of claims is generally determined by the number of causes rather than the number of injuries. This point seems more properly directed to the issue of whether there was one claim or two in the first instance, and we have discussed some of those decisions in connection with that point, explaining why they are either inapposite or unpersuasive. (See discussion at pp. 862-866, *ante.*) As important, however, those cases did not present any issue as to whether claims or occurrences were related. Thus, even in those cases which might be read as holding that the number of causes determines the number of claims or occurrences, those courts did not decide, or even discuss, whether the claims could be "related" under language like that in the policy before us. (*Eureka Federal S & L v. Amer. Cas. Co. of Reading* (9th Cir. 1989) 873 F.2d 229; *Okada v. MGIC Indem. Corp.* (9th Cir. 1986) 823 F.2d 276; *Pioneer Nat. Title Ins. Co. v. Andrews* (5th Cir. 1981) 652 F.2d 439; *North River Ins. Co. v. Huff* (D.Kan. 1985) 628 F.Supp. 1129; *St. Paul Fire & Marine Ins. Co. v. Hawaiian Ins. & Guar. Co.* (1981) 2 Hawaii App. 595 [637 P.2d 1146]; *Hyer v. Inter-Insurance Exchange, etc.* (1926) 77 Cal.App. 343 [246 P. 1055].)

[**1274] [***702] Several of these decisions are also distinguishable for reasons other than the absence of any discussion of the meaning of "related." For example, [*872] three of the cases arose out of errors and omissions of the officers and directors of savings and loan associations that resulted in the associations' insolvency, and the question was whether various acts and omissions leading to the insolvency constituted multiple losses or, alternatively, whether the insolvency itself was the sole loss. The facts of those cases and the nature of the injuries were not similar to the facts of the present case. (*Eureka Federal S & L v. Amer. Cas. Co. of Reading, supra,* 873 F.2d 229; *Okada v. MGIC Indem. Corp., supra,* 823 F.2d 276; *North River Ins. Co. v. Huff, supra,* 628 F.Supp. 1129.) Moreover, the holdings of those cases are not as broad as Bay Cities suggests. As one court explained, "We thus hold that the mere existence of

an aggressive loan policy is insufficient as a matter of law to transform disparate acts and omissions by five directors in connection with issuance of loans to over 200 unrelated borrowers into a single loss. We do not foreclose the possibility, however, that loans to separate borrowers may be aggregated as a single loss in an appropriate fact situation." (*Eureka Federal S & L v. Amer. Cas. Co. of Reading, supra,* 873 F.2d 229, 235.) Unlike *Eureka,* the present case does not have five defendants committing multiple errors in unrelated loan transactions that injured two hundred clients. We have one defendant, one client, and one injury.

Far more apposite and persuasive is the decision in *Gregory v. Home Ins. Co.* (7th Cir. 1989) 876 F.2d 602 (*Gregory*), in which an attorney's liability policy contained a provision like that in the present case: "Two or more claims arising out of a single act, error, or omission or personal injury or a series of related acts, errors, omissions or personal injuries shall be treated as a single claim." (*Id.,* at p. 604, italics omitted.) In connection with the marketing of a videotape investment program, the attorney drafted a "production service agreement" and promissory note for his client, the broker of the videotapes. The attorney also drafted a tax and security opinion letter that his client distributed to prospective buyers of the videotapes. The letter stated that the tapes were not securities that needed to be registered with the Securities and Exchange Commission and that buyers of the tapes would obtain certain tax advantages. The tax and securities advice proved to be incorrect and resulted in actions against the attorney by the investors and by his client.

The *Gregory* court, *supra,* 876 F.2d 602, acknowledged and agreed with the observation in *Helme, supra,* 735 P.2d 451, that "related" can mean both causal and logical connections. "However, we don't think the rule requiring insurance policies to be construed against the party who chose the language requires such a drastic restriction of the natural scope of the definition of the word 'related' [to mean only a causal connection]. . . . At some point, of [*873] course, a logical connection may be too tenuous reasonably to be called a relationship, and the rule of restrictive reading of broad language would come into play." (*Gregory, supra,* 876 F.2d 602, 606, fn. omitted.) Having rejected the causally related test, the *Gregory* court held that claims against the attorney by his client and by the class of investors were a single claim because they "comfortably fit within the commonly accepted definition of the concept [of 'related']." (*Id.,* at p. 606; see also *Home Ins. Co. v. Wiener* (N.D.Ill. 1989) 716 F.Supp. 10, 11 (holding that independent errors committed by two attorneys in a firm gave rise to a single claim by the client).)

We agree with the court in *Gregory, supra,* 876 F.2d 602, [HN10]that the term "related" as it is commonly understood and used encompasses both logical and causal connections. Restricting the word to only causal connections improperly limits the word to less than its general meaning. "Related" is a broad word, but it is not therefore a necessarily ambiguous word. We hold that, as used in this policy and in these circumstances, "related" is not ambiguous and is not limited only to causally related acts.

[**1275] [***703] We do not suggest, however, that, in determining the amount of coverage, the term "related" would encompass every conceivable logical relationship. At some point, a relationship between two claims, though perhaps "logical," might be so attenuated or unusual that an objectively reasonable insured could not have expected they would be treated as a single claim under the policy. In the present case, there is no attenuation or surprise to the insured. The two errors by the attorney are "related" in multiple respects. They arose out of the same specific transaction, the collection of a single debt. They arose as to the same client. They were committed by the same attorney. They resulted in the same injury, loss of the debt. No objectively reasonable insured under this policy could have expected that he would be entitled to coverage for two claims under the policy.

DISPOSITION

The judgment of the Court of Appeal is reversed with directions to remand this action to the trial court with instructions to enter judgment in favor of appellant Lawyers' Mutual.

Lucas, C. J. Mosk, J. Panelli, J., Arabian, J., and George, J., concurred.

CONCUR BY: KENNARD, J.

CONCUR

I concur in the judgment. In my view, however, much of the discussion in the majority opinion is unnecessary. As I shall explain, the majority interjects a doctrine of civil pleading into an insurance dispute that has nothing to do with pleading. Moreover, the majority reaches out to [*874] decide an issue concerning the scope of "related" acts or omissions under an insurance contract that is superfluous to a resolution of the narrow dispute in this case, and decides the issue in unnecessarily broad terms.

I

This is an insurance case. The question here is whether, when an attorney commits two separate acts of negligence in the same matter that preclude his client's

right to recover a single sum against either of two other parties, on either of two legal theories, the attorney's malpractice insurer is liable for only one claim under the policy, or is liable for two claims. The majority determines that under these circumstances the insurer can be liable for only one claim. I agree with the result, but not the reasoning, of the majority opinion.

The majority analyzes the question of whether one or two claims were made under the insurance policy in this case in terms of the "primary rights" doctrine. This doctrine concerns pleadings filed in court. But a claim made under an insurance policy is not the same as a pleading filed in court. Instead, the determination of rights under an insurance policy is a question of *contract law*. (*Mid-Century Ins. Co. v. Bash* (1989) 211 Cal.App.3d 431, 436 [259 Cal.Rptr. 382]; 1 Witkin, Summary of Cal. Law (9th ed. 1987) Contracts, § 682, p. 616; Civ. Code, § 1635 ["All contracts, whether public or private, are to be interpreted by the same rules, except as otherwise provided by this code."].) The parties to a contract can define "claim" any way they want. Here, they defined it without reference to the rules of civil pleading.

The parties defined "claim" as "a demand . . . for money against the Insured." This definition can be applied to the facts of this case without reference to pleading doctrines. As the record in this case shows, the former client of the insured, Bay Cities Paving & Grading, Inc., made a demand on the insured attorney, Robert Curotto, through a letter written by new counsel it had retained. The demand letter stated it was asserting "two separate claims," premised on Curotto's two acts of negligence that precluded Bay Cities from recovering from either of two responsible parties. But the demand letter sought payment of a single amount, based on the work performed by Bay Cities on a construction project. Therefore, Bay Cities made a *single* "demand for money against the Insured."

Accordingly, analyzing the main issue in this case without reference to doctrines of [**1276] [***704] pleading, but as a question of contract interpretation, I reach the same result as the majority.

[*875] II

Although the majority concludes that Bay Cities made a single claim, thus resolving the issue on which review was granted, it goes on to discuss at considerable length whether, assuming that Bay Cities had made two claims, the claims would be "related" within the meaning of the policy. This discussion is not only unnecessary to the disposition of the case, but also misleading, as I shall explain.

The pertinent policy language is this: " 'Two or more claims arising out of a single act, error or omission or a series of related acts, errors or omissions shall be treated as a single claim.' " (Maj. opn., *ante,* at p. 866, italics omitted.) The policy does not define the term "related."

Bay Cities argues that the term "related" is ambiguous because it could have a broad meaning--all acts or omissions related in some way--or a narrow meaning of *causally* related. Because the term is not defined in the policy, Bay Cities argues it should be interpreted against the drafting party, in conformance with standard rules of insurance contract interpretation. (1 Witkin, Summary of Cal. Law, *supra,* § 699, p. 632; see *AIU Ins. Co. v. Superior Court* (1990) 51 Cal.3d 807, 821-822 [274 Cal.Rptr. 820, 799 P.2d 1253]; *Universal Underwriters Ins. Co. v. Gewirtz* (1971) 5 Cal.3d 246, 250 [95 Cal.Rptr. 617, 486 P.2d 145]; *Gray v. Zurich Ins. Co.* (1966) 65 Cal.2d 263, 269 [54 Cal.Rptr. 104, 419 P.2d 168].) The majority rejects this argument, saying Bay Cities' interpretation is "not reasonable." (Maj. opn., *ante,* at p. 868.) The majority concludes that "[r]estricting the word ['related'] to only causal connections improperly limits the word to less than its general meaning." (Maj. opn., *ante,* at p. 873.)

I am unconvinced. There are any number of ways in which two acts giving rise to claims under a malpractice insurance policy might be said to be "related" in the general sense of the term. A law firm that has a single policy may commit, through two lawyers, two acts of malpractice affecting the same client on the same day. These claims could be said to be related in at least three ways: temporally (same day), thematically in one sense (same client), and thematically in another sense (two real estate matters involving boundary disputes). Accordingly, the two claims could reasonably be said to be "related" within the "general meaning" of the term. But it is unlikely, given that the acts of malpractice occurred in two separate matters, that the claims would be considered "related" within the meaning of the policy. Thus, the necessity arises to impose some limiting construction on the policy term "related acts or omissions."

[*876] When the language of an insurance policy is ambiguous the courts look to the expectations of a reasonable insured. (*American Star Ins. Co. v. Insurance Co. of the West* (1991) 232 Cal.App.3d 1320, 1331 [284 Cal.Rptr. 45]; see *AIU Ins. Co. v. Superior Court, supra,* 51 Cal.3d at p. 822 [stating that to protect an insured's objectively reasonable expectations, coverage clauses of insurance policies are interpreted broadly].) Here, the context suggests that a reasonable attorney/insured would have thought that under the policy two claims made in the circumstances of this case would be classed as related, but *only* because the element of damages from each was identical and coextensive. Thus, the majority's conclusion that the claims are related within the meaning of the policy is correct, but its endorsement of the policy

language "related acts, errors or omissions" as inherently unambiguous is not.

Thus, although the majority has reached the correct result in this case, I cannot subscribe to its reasoning.

COLUMBIA CASUALTY COMPANY, Appellant v. CP NATIONAL, INC. AND NATIONAL EMERGENCY SERVICES, INC., Appellees

NO. 01-00-01406-CV

COURT OF APPEALS OF TEXAS, FIRST DISTRICT, HOUSTON

175 S.W.3d 339; 2004 Tex. App. LEXIS 8362

September 16, 2004, Opinion Issued

PRIOR HISTORY: [**1] On Appeal from the 189th District Court. Harris County, Texas. Trial Court Cause No. 2000-17720. Date Filed: 12/28/2000. Trial Judge: JEFFERY K. WORK. Trial Court: 189th District Court. Trial County: Harris.
Columbia Cas. Co. v. CP Nat'l, Inc., 2004 Tex. App. LEXIS 4759 (Tex. App. Houston 1st Dist., May 27, 2004)

DISPOSITION: Reversed and rendered.

CASE SUMMARY:

PROCEDURAL POSTURE: A trial court granted summary judgment in favor of appellee insureds in connection with their action against appellant insurer seeking a declaratory judgment concerning the limits of the policy. The court issued an opinion, and the insureds sought en banc reconsideration.

OVERVIEW: The insureds comprised a management company and its affiliate. The insureds and two physicians, who worked for the affiliate, were sued for medical malpractice related to the ultimate death of a patient. The insurer defended the insureds, but a dispute arose as to the policy limits. The insureds argued that the policy afforded a separate limit of $1 million for each of the claims against the physicians. The insurer argued that the policy provided for a single, total per loss event limit of liability of $1 million. The trial court granted the insureds summary judgment. The court reversed. The policy was clear that the per loss event limit applied to all insureds for all damages for injuries to one patient. The medical incidents involved the same patient at the same facility during the same period of time with regard to the same x-ray. All of the acts of malpractice alleged against the physicians allegedly led to a single result that formed the basis of the malpractice action. Thus, the medical incidents were related medical incidents under the plain language of the policy, and the insurer's total liability was limited to $1 million.

OUTCOME: The court denied the motion for reconsideration, but withdrew its earlier opinion and substituted this one. The court reversed the trial court's grant of summary judgment and rendered judgment that the insurer's total liability was limited as it claimed.

CORE TERMS: insured, limit of liability, patient, x-ray, malpractice, doctor's, lawsuit, coverage, summary judgment, occurrence, derivative, logical, damage arising, causal connection, claims-made, emergency, lymphoma, chest, insurance policy, ambiguous, ambiguity, logically, emergency room, declaratory judgment, named insured, en banc, policy period, medical malpractice, triggered, insurer

LexisNexis(R) Headnotes

Civil Procedure > Summary Judgment > Appellate Review > Standards of Review
Civil Procedure > Summary Judgment > Standards > General Overview
[HN1]Summary judgment is proper only when a movant establishes that there is no genuine issue of material fact and that the movant is entitled to judgment as a matter of law. In reviewing a summary judgment, the appellate court indulges every reasonable inference in favor of the non-movant, assumes that all evidence favorable to the non-movant is true, and resolves any doubts in its favor.

Contracts Law > Defenses > Ambiguity & Mistake > General Overview
Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > General Overview
Insurance Law > Claims & Contracts > Policy Interpretation > Ordinary & Usual Meanings
[HN2]Insurance policies are contracts and therefore are controlled by rules of construction applicable to contracts generally. When construing a contract, including an insurance policy, the court's primary focus is to ascertain the true intent of the parties as expressed in the written

document. Whether a policy or contract is ambiguous is a question of law for the court to determine. A written contract that can be given a definite or certain legal meaning is not ambiguous. If the policy or contract contains no ambiguity, the words used are to be given their ordinary meaning. If, however, the language of the policy or contract is subject to two or more reasonable interpretations, the policy is ambiguous and the construction that would afford coverage to the insured must be adopted. A court should consider a contract, such as an insurance policy, as a whole, giving effect to each part; no single phrase, sentence, or section of the contract or policy should be isolated and considered apart from the other provisions.

Insurance Law > Claims & Contracts > Claims Made Policies > Coverage
Insurance Law > Claims & Contracts > Claims Made Policies > Occurrence Policies
Torts > Vicarious Liability > Corporations > General Overview
[HN3]In insurance contracts generally, a "loss event" is the event that gives rise to the insurance company's liability under the contract. Under claims-made policies, versus occurrence policies, the mere fact that an insured loss-causing event occurs during the policy period is not sufficient to trigger insurance coverage of the loss. Rather, the insured generally must give notice to the insurer of any claims asserted against the insured, as well as of any occurrences that have caused or will potentially cause an insured loss. The basic distinction between claims-made and occurrence policies is that, while the occurrence policy is triggered by the insured's liability-producing conduct, the claims-made policy is triggered by the presentation of a claim.

Healthcare Law > Actions Against Healthcare Workers > Doctors & Physicians
Insurance Law > General Liability Insurance > Occurrences
Torts > Malpractice & Professional Liability > Healthcare Providers
[HN4]Although a malpractice event may involve numerous independent grounds of negligence that constitute a series of acts, Texas law indicates that they can still be related and form a single malpractice claim.

COUNSEL: FOR APPELLANT: James M. Corbett, Giessel, Barker & Lyman, Inc., Houston, TX, William H. Briggs, Ross, Dixon & Bell, L.L.P., Washington, DC.

FOR APPELLEE: John E. Chapoton, Cunningham, Welsh, Darlow, Zook & Chapoton, LLP, Houston, TX, Jon Todd Powell, San Antonio, TX.

JUDGES: Panel consists of Justices Nuchia, Jennings, and Keyes.

OPINION BY: Evelyn V. Keyes

OPINION

[*341]

OPINION ON DENIAL OF EN BANC RECONSIDERATION

The court has considered appellees' motion for en banc reconsideration and is of the opinion that the motion should be denied. However, we withdraw our opinion and judgment dated May 27, 2004 and substitute those issued today to clarify our opinion.

This is an appeal from a summary judgment rendered in favor of appellees/plaintiffs, CP National, Inc. (CPN) and National Emergency Services, Inc, (NES) in a suit for breach of contract, breach of [**2] the duty of good faith and fair dealing, and declaratory judgment against appellant, Columbia Casualty Company (Columbia). In its sole point of error, Columbia contends that the trial court erred in rendering summary judgment on CPN's and NES's claim for declaratory judgment regarding Columbia's policy limits because the insurance policy provides a single "per loss event" limit. We reverse and render.

Facts

NES's and CPN's Suit Against Columbia

NES is a physician practice management company. CPN is one of its affiliates that provides emergency room care physicians in the District of Columbia at Sibley Memorial Hospital. Drs. Richard Doyan and Cooper Pearce are employees of CPN who worked at Sibley. Columbia provided NES, its affiliates (including CPN), and physicians under contract with NES coverage under certain professional liability insurance policies against claims and suits arising out of alleged medical malpractice. The Policy at issue is a "Claims-Made Medical Practitioners Policy" that insured NES and its affiliates and subsidiary companies as "Named Insured" [*342] against claims covered by the Policy and reported to the carrier, Columbia.

In 1998, Howard [**3] and Jill Flax filed a lawsuit in the Superior Court of the District of Columbia against Lucy Webb Hayes National Training School for Deaconesses and Missionaries d/b/a Sibley Memorial Hospital, CPN, Drs. Groover, Christie & Merritt, P.C., and Drs.

Doyan and Newman. In an amended pleading, Jill Flax, individually and as personal representative of the deceased Howard Flax, added Dr. Pearce and NES as additional defendants. Pursuant to the Policy, Columbia defended NES, CPN, and Drs. Doyan and Pearce. A dispute arose, however, concerning the applicable limits of the Columbia Policy. Columbia claimed that the Policy expressly provided for a single "per loss event" limit of liability of $ 1,000,000. NES and CPN argued that the policy afforded a separate $ 1,000,000 limit each for claims against Dr. Doyan and Dr. Pearce, totaling $ 2,000,000.

NES and CPN filed a petition in Harris County District Court against Columbia, alleging breach of contract and breach of the duty of good faith and fair dealing, and seeking a declaratory judgment concerning the limits of the Policy. Each party moved for summary judgment. The trial court granted NES's and CPN's motion for partial summary judgment [**4] as it related to the declaratory judgment concerning the dispute over the monetary limits available to NES and CPN. After disposing of NES's, CPN's, and Columbia's other motions, the trial court entered a final judgment.

The Underlying Suit

On the evening of December 1, 1996, Howard Flax sought treatment at Sibley emergency room complaining of persistent fever and a cough. Dr. Doyan, the emergency room physician on duty, examined Flax and, as part of the physical exam, ordered a chest x-ray. Dr. Doyan performed a preliminary reading of the x-ray and concluded that it was negative for pneumonia but that there was possibly a large lymph node. He diagnosed Flax as suffering from acute bronchitis and proscribed Hycomine and a Ventolin inhaler; he told Flax to continue taking the antibiotics he had been taking, and to take Tylenol or Advil if necessary.

The next day, Dr. Newman, a radiologist, interpreted the chest x-ray as "probably normal" and suggested a repeat x-ray in 30 to 60 days to exclude any growth in the left hilum, which contained very minimal fullness, probably representing vascular structures rather than pleural disease. He sent his report to the emergency [**5] room that day. Dr. Pearce was the emergency room physician on duty when the radiology report arrived at the emergency room. As the Director of the Emergency Department at Sibley, Dr. Pearce was responsible for reporting the x-ray interpretations from the radiologist to Flax and to his private physician. Dr. Pearce allegedly failed to inform Flax's private physician about the x-ray and failed to communicate to Flax that, although the x-ray looked normal, there was the possible presence of an abnormality and that a follow-up x-ray was recommended in 30 to 60 days.

Flax was later diagnosed as having peripheral T-cell lymphoma, which ultimately caused his death. The lymphoma was alleged to have been present on December 1, 1996, when he went to the Sibley emergency room. The Flaxes contended in their suit that Dr. Doyan misdiagnosed Flax's condition, misinterpreted the chest x-ray, and misrepresented to Flax that the results of his x-rays were normal. They also argued that Dr. Pearce was negligent in failing to inform Mr. Flax that he needed to obtain a follow-up chest x-ray because it would have detected the peripheral T-cell [*343] lymphoma much earlier than it was ultimately detected. Overall, [**6] the *Flax* lawsuit alleged that "the defendants misinterpreted, mishandled, and miscommunicated the results of Mr. Flax's chest x-rays taken at Sibley Hospital on December 1, 1996 . As a result . . . the correct diagnosis and initiation of treatment for Mr. Flax's cancer was delayed for more than one year. . . [This] delay was a substantial factor in eliminating or significantly reducing Mr. Flax's chance of surviving the disease." The first complaint included claims for medical negligence and loss of consortium against Dr. Doyan and CEP, but not against Dr. Pearce or NES. In her second amended complaint, Mrs. Flax added Dr. Pearce and NES as defendants and asserted additional claims for wrongful death and a survival action.

Discussion

Columbia's sole issue on appeal is whether the trial court erred in rendering summary judgment for CPN and NES declaring that the Policy afforded a separate $ 1,000,000 limit each for Drs. Doyan and Pearce. Columbia contends that the insurance policy at issue provides only a single limit of liability in the amount of $ 1,000,000 for the claims arising out of the injury to Flax. CPN and NES, on the other hand, argue that the trial [**7] court did not err in granting a summary judgment in its favor and ruling that two separate limits of liability, in the total amount of $ 2,000,000, were available under the Policy for the claims made against Drs. Doyan and Pearce in the *Flax* lawsuit.

Standard of Review

[HN1]Summary judgment is proper only when a movant establishes that there is no genuine issue of material fact and that the movant is entitled to judgment as a matter of law. *Randall's Food Mkts., Inc. v. Johnson,* 891 S.W.2d 640, 644, 38 Tex. Sup. Ct. J. 167 (Tex. 1995). In reviewing a summary judgment, we indulge every reasonable inference in favor of the non-movant, assume that all evidence favorable to the non-movant is true, and resolve any doubts in its favor. *Id.*

Construction of Insurance Contracts

[HN2]Insurance policies are contracts and therefore are controlled by rules of construction applicable to contracts generally. Barnett v. Aetna Life Ins. Co., 723 S.W.2d 663, 665, 30 Tex. Sup. Ct. J. 191 (Tex. 1987). When construing a contract, including an insurance policy, our primary focus is to ascertain the true intent of the parties as expressed in the written document. Nat'l Union Fire Ins. Co. v. CBI Indus., Inc., 907 S.W.2d 517, 520, 39 Tex. Sup. Ct. J. 7 (Tex. 1995). [**8] Whether a policy or contract is ambiguous is a question of law for the court to determine. *Id.* A written contract that can be given a definite or certain legal meaning is not ambiguous. *Id.* If the policy or contract contains no ambiguity, the words used are to be given their ordinary meaning. Puckett v. U.S. Fire Ins. Co., 678 S.W.2d 936, 938, 28 Tex. Sup. Ct. J. 55 (Tex. 1984). If, however, the language of the policy or contract is subject to two or more reasonable interpretations, the policy is ambiguous and the construction that would afford coverage to the insured must be adopted. Nat'l Union, 907 S.W.2d at 520. A court should consider a contract, such as an insurance policy, as a whole, giving effect to each part; no single phrase, sentence, or section of the contract or policy should be isolated and considered apart from the other provisions. Forbau v. Aetna Life Ins. Co., 876 S.W.2d 132, 133, 37 Tex. Sup. Ct. J. 345 (Tex. 1994).

The Policy

The issue on appeal is whether the Policy provides a single limit of liability of $ 1,000,000 for the claims made against Drs. Doyan and Pearce in the *Flax* lawsuit, as Columbia argues, or two separate [*344] limits of liability, [**9] of $ 1,000,000 each, for a total of $ 2,000,000, for the claims made against Drs. Doyan and Pearce, as CPN and NES argue.

The dispute over the limits of the Policy arises primarily from two Policy provisions, Section III and Endorsement 12. Section III provides for the limits of liability for each claim:

The limit of liability stated for 'each claim' is the limit of our liability **for all injury or damage arising out of, or in connection with, the same or related medical incident**.

This limit shall apply separately to:

1. each individual specifically named in this policy who qualify [*sic*] for coverage under the definition of you; and

2. to the Partnership, Association or Corporation specifically named as the named insured, collectively with such personnel included as you by occupational description, but not specifically named in this policy.

This limit applies regardless of the number of persons or organizations who are covered under this policy.

(Emphasis added.) "Claim" is defined as "the receipt by you of a demand for money or services, naming you and alleging a medical incident." "Claim" also "means a medical incident which you report to us during the [**10] policy period which might result in a claim." The limit of liability for "each claim" is "the limit of our liability for all injury or damage arising out of, or in connection with, the same or related medical incident." "Medical incident" is defined as "any act, error, or omission in the providing of or failure to provide professional services by you."

Endorsement 12 of the Policy provides:

We agree with you, [1] that the professional liability limits shown on the policy Declarations page are amended to include the following:

$ 1,000,000 Per Loss Event (Indemnity & Expense)

$ 3,000,000 Any One Person Policy Aggregate (Indemnity and Expense)

The "Per Loss Event" limit applies to all Insureds for all Damages to all persons for injuries to one patient.

Endorsement 12 thus provides for a $ 1,000,000 Per Loss Event limit which applies to "all Insureds for all Damages to all persons for injuries to one patient."

1 The Policy defines "You" or "Your" as (1) "the persons or organization named on the Declarations of this policy as the named insured; (2) any approved locum tenens employed by you while acting within the scope of their duties as such . . .; (3) any physician or surgeon who becomes a partner, stockholder, or employee during the policy period . . .; (4) any of your employees other than a physician or surgeon, but only while acting within the scope of their duties as such." Endorsement 5 to the Policy amended this definition to include "any physician or surgeon, but only for professional services provided on behalf of the organization named on the declarations of this policy as the Named Insured, and only at a location specified on the Schedule of Locations attached to this policy."

[**11] ***"Loss Event"***

As appellees point out in their motion for en banc consideration, the term "Per Loss Event" of Endorsement 12 is not defined in the Policy. Defining "per loss event" in the context of a medical malpractice insurance policy appears to be a matter of first impression for Texas. [HN3]In insurance contracts generally, a "loss event" is the event that gives rise to the insurance company's li-

ability under the contract. *See* Helvering v. LeGierse, 312 U.S. 531, 539, 85 L. Ed. 996, 61 S. Ct. 646 (1941); *AMERCO v. Subsidiaries v. C.I.R.,* 96 T.C. 18, 38-39 (1991). Columbia, however, provided CPN and NES professional liability insurance [*345] written on a claims-made basis. Under claims-made policies, versus occurrence policies, "the mere fact that an insured loss-causing event occurs during the policy period is not sufficient to trigger insurance coverage of the loss." *F.D.I.C. v. Mijalis,* 15 F.3d 1314, 1330 (5th Cir. 1994). Rather, the insured generally must give notice to the insurer of any claims asserted against the insured, as well as of any occurrences that have caused or will potentially cause an insured loss. *Id.* The basic distinction between claims-made [**12] and occurrence policies is that, while the occurrence policy is triggered by the insured's liability-producing conduct, the claims-made policy is triggered by the presentation of a claim. *Continental Cas. Co. v. Maxwell,* 799 S.W.2d 882, 886 (W.D. Mo. 1990).

Here, Columbia's liability is triggered when a claim is made. Section III defines a claim as the receipt of a demand for money or services that names the insured and alleges a medical incident, and it limits Columbia's liability for each claim for injury "arising out of, or in connection with the same or related medical incident." When Section III and Endorsement 12 are read together, the $ 1,000,000 "per loss event" limit is Columbia's limit of liability for each claim, which, Section III provides, is "the limit of our liability for all injury or damage arising out of, or in connection with, the same or related medical incident." [2]

2 Our definition of per loss event as $ 1,000,000 for each claim for injury or damage arising out of, or in connection with, the same or related medical incident, is consistent with that used by CPN and NES. In their original brief, CPN and NES defined the per loss event limit as "the $ 1 million limit for indemnity and cost of defense for each claim that asserts a medical incident."

[**13] ***The "Loss Event" Limit***

Columbia interprets Endorsement 12 literally. It contends that the "per loss event" limit of $ 1,000,000 "applies to *all Insureds* for *all Damages* to *all persons* for injuries to *one patient*." (Emphasis added.) Thus, because there is only one patient, there is only one $ 1,000,000 limit for any "loss event," *i.e.*, for any damages "arising out of, or in connection with, the same or related medical incident."

NES and CPN, on the other hand, ask us to interpret Endorsement 12 as limiting Columbia's $ 1,000,000 liability per loss event only with respect to all persons asserting claims for injuries to one patient, *i.e.,* with respect to derivative claims, but not as limiting Columbia's liability with respect to the *insureds* against whom the claims are asserted, *i.e.*, with respect to separate claims made against separate physicians. Accordingly, NES and CPN argue that "Endorsement 12 operates to bring within the first Per Loss Event limit all claims the Flaxes asserted against Doyan and within the second Per Loss Event limit all claims the Flaxes asserted against Pearce."

NES and CPN urge us to follow the reasoning in *Tumlinson v. St. Paul Insurance Company*, 786 S.W.2d 406 [**14] (Tex. App.--Houston [1st Dist.] 1990, writ denied), where we construed language of a policy that limited liability "for all claims resulting from the injury . . . of any one person." In *Tumlinson*, we held that only one limit applied to separate claims filed by an injured child and its parents; thus, "the insurance company's liability is limited under the policy to $ 500,000 for the injury of the child, regardless of the economic injury to the parents resulting from the child's injury." *Id.* at 408. However, *Tumlinson* does not support NES's and CPN's position because it addressed *only* derivative claims; therefore, it does not preclude our [*346] finding that not only derivative claims, but also claims against different insureds with respect to the same patient are subject to a single 'per loss event' limit of liability.

While we agree with NES and CPN that Endorsement 12 limits derivative claims, we find that Endorsement 12 limits more than *only* derivative claims. Endorsement 12 is clear and unambiguous. Breaking down the sentence into its logical parts, the per loss event limit applies to *all insureds* (NES, CPN, Dr. Doyan, and Dr. Pearce) for *all Damages* [**15] (any damages sought in the *Flax* suit) to *all persons* (Mrs. Flax and the Flax estate) for injuries to *one patient* (Flax).

Although a literal interpretation of Endorsement 12 seems to focus heavily on the one patient aspect, it must be remembered that Endorsement 12 is limited by Section III and its limit of liability for injury arising out of, or in connection with "the same or related medical incident." Therefore, if one doctor committed an act of malpractice against a patient, and, six months later, the patient returned to the same hospital where a second doctor committed a second, *completely independent* act of malpractice on the same patient, there would *not* be one "loss event" despite there being only one patient; because the two doctors did not cause an injury arising out of, or in connection with, the "same or related medical incident," (the second doctor's act was completely independent) the insurance company's limit of liability would not be limited, and there would be two per loss event limits. This is not the case here, however, because, as will be discussed later, we find that the medical incidents form-

ing the basis of the *Flax* lawsuit are related [**16] medical incidents.

NES's and CPN's interpretation of Endorsement 12 ignores the literal language of the Endorsement and requires us to read "all persons" restrictively and "all insureds" liberally, without any justification in the plain language of the Policy for interpreting these phrases differently. Moreover, if Endorsement 12 served to limit only derivative claims, as NES and CPN claim, there would be no limit as to any underlying claim because, as NES and CPN acknowledge, the $ 1,000,000 figure, limiting claims per loss event, is located in the Policy only in Endorsement 12. Furthermore, if we were to follow NES's and CPN's argument to its logical conclusion, Columbia's liability limits in the Policy would be meaningless. If, for example, 15 doctors, over the course of a week, examined, misinterpreted, mishandled, and miscommunicated the results of a patient's x-rays, all in slightly varying capacities, according to NES and CPN, 15 limits of liability in the amount of $ 15,000,000 would be available under the Policy for the claims made against the 15 doctors. We do not believe this is the intended result of Endorsement 12. Rather, the plain language of the policy limits the total [**17] recovery for "all injury or damage arising out of, or in connection with, the same or related medical incident" to $ 1,000,000, regardless of the number of insureds sued.

Section III

Columbia argues that Section III of the Policy's Professional Liability Coverage offers further support for its interpretation of the Policy limits; NES and CPN disagree.

Columbia contends that, under Section III, claims arising out of "related medical incidents" are subject to a single limit of liability and, because the claims made by the *Flax* plaintiffs against Drs. Doyan and Pearce are related medical incidents, only one limit of liability applies. NES and CPN argue, in response, that the medical incidents alleged against Drs. Doyan and Pearce in the *Flax* lawsuit as separate [*347] claims are not related because the doctors' actions were not causally related to one another; therefore, they are separate claims and are subject to the "limit of liability" stated for "each claim."

The question of defining "related" in a medical malpractice insurance policy appears to be one of first impression for Texas. The parties look to and provide supporting authority from other jurisdictions.

[**18] NES and CPN, rely primarily [3] on *Arizona Property & Casualty Insurance Guaranty Fund v. Helme*, 153 Ariz. 129, 735 P.2d 451 (Ariz. 1987), in which the Supreme Court of Arizona construed the term "related" to apply to the question of whether a causal relation existed between the acts or omissions of physicians treating patients. 735 P.2d at 455. While the *Helme* court recognized that "related," in its commonly accepted dictionary sense, means having a logical or causal connection, the court nevertheless refused to apply this definition and noted, "We do not believe that the word 'related' as used in the policy can be equated with the phrase 'logical connection.' . . . Incidents may be 'logically related' for a wide variety of indefinable reasons. Causal connection depends, to a much greater extent, on objective facts in the record. " *Id.* at 456. The *Helme* court, therefore, required a causal connection between one physician's negligence and the second physician's negligence in order to find related medical incidents.

3 NES and CPN suggest that we do not even need to address whether the claims made against the two doctors arose out of *related* medical incidents, because "medical incident" is defined in terms of a physician's services, not a patient, and therefore, because two doctors each provided their services and each committed alleged malpractice arising from his services, there must be two separate limits of liability. However, the fact that allegedly negligent services are provided by two different physicians does not entail that the acts are not logically related to each other, *i.e.*, do not arise out of a common nexus of logically connected events.

[**19] Columbia relies heavily on *Bay Cities Paving & Grading, Inc. v. Lawyers' Mutual Insurance Co.*, 5 Cal. 4th 854, 21 Cal. Rptr. 2d 691, 855 P.2d 1263 (Cal. 1993). In that case, the California Supreme Court defined "related claims" as those encompassing "both logical and causal connections," noting that "restricting the word only to causal connections improperly limits the word to less than its general meaning." *Id.* at 1264*; see also* *Paradigm Ins. Co. v. P & C Ins. Sys., Inc.*, 747 So. 2d 1040, 1042 (Fla. Dist. Ct. App. 2000) (rejecting *Helme*, 735 P.2d at 451, and relying on *Bay Cities* in concluding that failure to notify excess insurance carrier was logically "related" act for purposes of notice provision of policy when both acts of negligence were said to have caused or contributed to absence of insurance coverage for loss). The Policy itself does not indicate that any particular definition, or a limited or restrictive definition, such as NES and CPN suggest, should be used to replace the plain, ordinary, and generally accepted meaning of "related." [4] *See* *W. Reserve Life Ins. v.* [*348] *Meadows*, 152 Tex. 559, 261 S.W.2d 554, 557 (Tex. 1953). [**20] Moreover, [HN4]although a malpractice event may involve numerous independent grounds of negligence that constitute a series of acts, Texas law indicates that they can still be related and form a single malpractice claim. *See* *Am. Physicians Ins. Exch. v. Garcia*, 876 S.W.2d

842, 853 n.21, 37 Tex. Sup. Ct. J. 561 (Tex. 1994) (comparing definition and ramifications of "Each Claim Occurrence" in commercial liability policy and medical malpractice policy; although "each claim occurrence" in medical malpractice policy has coverage effect similar to continuous or repeated exposure directive in commercial liability policy, malpractice event may involve independent malpractice grounds that cannot be classified as repeated exposure to same conditions but can constitute series of acts that are related). Thus, giving the term "related" its ordinary and generally accepted meaning, we conclude that "related" means having a logical or causal connection. *See* MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 1050 (11th ed. 2003).

4 NES and CPN argue that if we determine that both parties have presented reasonable interpretations of Section III, ambiguous terms must be construed strictly against the insurer and liberally in favor of the insured, them. However, "not every difference in the interpretation of an insurance policy amounts to an ambiguity. *Potomac Ins. Co. of Illinois v. Jayhawk Med. Acceptance Corp.,* 198 F.3d 548, 551 n.3 (5th Cir. 2000). The mere absence of a policy definition does not give rise to a finding of ambiguity. *Id.* Similarly, although the insured and the insurer take conflicting views of coverage, neither conflicting expectations nor dialectics are sufficient to create ambiguity. *Forbau,* 876 S.W.2d 132, 134.

[**21] Here, all the medical incidents involve the same patient, at the same facility, during the same period of time, with regard to the same x-ray. All of the acts of malpractice alleged against doctors Doyan and Pearce allegedly led to a single result that formed the basis of the *Flax* lawsuit--failure to apprise Flax of his lymphoma, leading to a delayed diagnosis and thus Flax's early death from lymphoma. We hold, therefore, that the medical incidents that form the basis of the *Flax* lawsuit are related medical incidents under the plain meaning of the Policy language.

We sustain Columbia's point of error.

Conclusion

We hold that, as a matter of law, the plain language of the Policy at issue in this case limits total recovery to $ 1,000,000 for each loss event encompassing the same or related "medical incidents," including all claims made by any and all persons against any and all insureds in the *Flax* lawsuit. We reverse and render judgment that Columbia's total liability under the Policy is limited to $ 1,000,000.

Evelyn V. Keyes

Justice

LEXSEE 876 S.W.2D 132

EDWADINE FORBAU, AS NEXT FRIEND OF AMY MILLER, PETITIONER v. AETNA LIFE INSURANCE COMPANY, RESPONDENT

No. D-1235

SUPREME COURT OF TEXAS

876 S.W.2d 132; 1994 Tex. LEXIS 14; 37 Tex. Sup. J. 345; 17 Employee Benefits Cas. (BNA) 2163

January 5, 1994, Delivered

PRIOR HISTORY: [**1] ON APPLICATION FOR WRIT OF ERROR TO THE COURT OF APPEALS FOR THE SEVENTH DISTRICT OF TEXAS.

This Opinion Substituted by Court for Withdrawn Opinion of May 5, 1993, Reported at: 1993 Tex. LEXIS 105.

JUDGES: CORNYN, PHILLIPS, GONZALEZ, HECHT, ENOCH, SPECTOR, DOGGETT, HIGHTOWER, GAMMAGE

OPINION BY: JOHN CORNYN

OPINION

[*132] JUSTICE CORNYN delivered the opinion of the Court, in which CHIEF JUSTICE PHILLIPS, JUSTICE GONZALEZ, JUSTICE HECHT, JUSTICE ENOCH, and JUSTICE SPECTOR join.

Petitioner's motion for rehearing is overruled. We withdraw our opinion of May 5, 1993, and substitute the following opinion in its place.

In this case we are called upon to determine whether the insurance policy at issue created a vested right in unlimited lifetime benefits, or restricted benefits to the recovery of medical expenses incurred while the policy was in effect. The trial court rendered judgment on a jury's verdict in [*133] favor of Petitioner, Edwadine Forbau, as next friend of Amy Miller. The court of appeals reversed the trial court's judgment, holding that under the unambiguous terms of the policy, Petitioner's recovery was limited to those medical expenses incurred while Aetna's policy was in effect. 808 [**2] S.W.2d 664. We agree that Aetna's policy is unambiguous and does not afford the coverage claimed by Petitioner. We thus affirm the judgment of the court of appeals. [1]

1 We also agree with the court of appeals that the issue of whether the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 (1988)(ERISA), preempts Petitioner's state law claims in this case is "immaterial." 808 S.W.2d at 665 n.2.

We do note, however, that although the result -- a judgment favorable to Aetna -- would be the same in this case under ERISA and state contract law, we disapprove of the court of appeals' statement to the extent that it suggests that the remedies under ERISA are identical to those available under a state law contract action. The remedies available under ERISA are a declaratory judgment on entitlement to benefits, an injunction against a plan administrator's improper refusal to pay benefits, removal of the fiduciary, and an award of benefits due and attorneys' fees. 29 U.S.C. § 1132(a)(3). ERISA's remedies are exclusive, and do not include extracontractual compensatory or punitive damages. *See Pilot Life*

Ins. Co. v. Dedeaux, 481 U.S. 41, 53, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987).

[**3] I.

In March of 1983 fourteen-year old Amy Miller suffered serious, permanent, and disabling injuries as a result of a motor vehicle accident. At the time, Amy's father, Mike Miller, was insured under an Aetna group insurance policy (Group Policy) issued to Affiliated Foods, Inc., a cooperative of grocery stores of which his employer, E Triple M, Inc., was a member. Miller's premiums and those of his dependents, including Amy's, were paid by E Triple M. Miller was eligible as an "individual" under the plan, defined as an "employee of any store owner who is a participant under this plan;" Amy was eligible for dependent coverage as an "individual's unmarried child under nineteen years of age." Group Policy at 1500, 1550.

After Amy's accident, Aetna paid her medical expenses as incurred until April 30, 1985, when Affiliated terminated the group contract with Aetna. Aetna continued to pay benefits until May 1, 1986, under the policy's one-year extension of benefits clause. After that date, Petitioner submitted claims to Safeco Life Insurance Company as Aetna's successor insurer for Affiliated's members. A dispute eventually arose between Petitioner and Safeco, which resulted in a lawsuit [**4] and settlement.

After settling with Safeco, Petitioner filed this lawsuit against Aetna, alleging breach of contract and of fiduciary duty, and violations of the Texas Deceptive Trade Practices Act and the Insurance Code. Only the breach of contract claims were submitted to the jury. In accordance with the jury's verdict, the trial court awarded Amy $ 238,000 in past damages, $ 2.5 million in future damages, and $ 500,000 in attorneys' fees.

II.

Interpretation of insurance contracts in Texas is governed by the same rules as interpretation of other contracts. *Upshaw v. Trinity Cos.*, 842 S.W.2d 631, 633 (Tex. 1992); *Western Reserve Life Ins. Co. v. Meadows*, 152 Tex. 559, 261 S.W.2d 554, 557, (Tex. 1953).

When construing a contract, the court's primary concern is to give effect to the written expression of the parties' intent. *Ideal Lease Serv., Inc. v. Amoco Prod. Co.,* 662 S.W.2d 951, 953 (Tex. 1983); *R & P Enterprises v. LaGuarta, Gavrel & Kirk*, 596 S.W.2d 517, 518 (Tex. 1980). This court is bound to read all parts of a contract together to ascertain the agreement of the parties. *See Royal Indem. Co. v. Marshall*, 388 S.W.2d 176, 180 (Tex. 1965); *Pan* [**5] *Am. Life Ins. Co. v. Andrews*, 161 Tex. 391, 340 S.W.2d 787 (Tex. 1960). The contract must be considered as a whole. *Reilly v. Rangers Management, Inc.*, 727 S.W.2d 527, 529 (Tex. 1987); *Coker v. Coker*, 650 S.W.2d 391, 393 (Tex. 1983). Moreover, each part of the contract should be given effect. *See Barnett v. Aetna Life Ins. Co.*, 723 S.W.2d 663, 666 (Tex. 1987). For example, when a contract provision makes a general statement of coverage, and another provision specifically [*134] states the time limit for such coverage, the more specific provision will control. *See* 3 ARTHUR L. CORBIN, CONTRACTS §§ 545-54 (1960). This is but an application of our long-established rule that "no one phrase, sentence, or section [of a contract] should be isolated from its setting and considered apart from the other provisions." *Guardian Trust Co. v. Bauereisen*, 132 Tex. 396, 121 S.W.2d 579, 583 (Tex. 1938); *see also Wynnewood State Bank v. Embrey*, 451 S.W.2d 930, 932 (Tex. Civ. App.--Dallas 1970, writ ref'd n.r.e.).

III.

The operative language in this policy states that Aetna will pay for "covered medical expenses *incurred during a calendar year for treatment of a covered family* [**6] *member*." Group Policy at 6210 (emphasis added). Under the contract, Aetna is obligated only to a covered family member, that is, a covered individual or dependent. A person ceases to be a covered individual when the policy has been discontinued or the individual is no longer employed by the policy's sponsor. When this occurs, dependent coverage also terminates. [2]

2 Coverage of an individual terminates when the policy is discontinued or when the individual's employment terminates. Group Policy at 6000. "Any Dependant Coverage of an individual will terminate . . . when the individual ceases to be in a class of individuals eligible for such Dependant Coverage." Group Policy at 6010.

The policy also states that "this policy does not provide insurance for any of the following: Charges incurred while he is not a covered family member." Under the unambiguous language of the contract, Aetna's

obligation to pay benefits under the contract terminated upon the discontinuance of Affiliated's policy, unless some other [**7] provision of the policy extended coverage. As the contract contains such a provision, [3] which extended Petitioner's benefits for one additional year, she was entitled to the additional benefits Aetna paid for this time period only. [4] Under basic tenets of contract law, these provisions must be read together with the other sections of the contract to comprehensively address the rights and obligations of all parties to the insurance contract.

3 The policy provides:

> If coverage for a family member . . . terminates while he is totally disabled, any benefit provided . . . for that family member will continue to be available for expenses incurred while he continues to be totally disabled but not beyond 12 months from the termination date. Group Policy at 6210.

This section applies only to claims made under the Major Medical, Comprehensive Dental, or Comprehensive Benefit sections of the contract.

4 From May 1, 1985, until April 30, 1986, Aetna paid claims for medical benefits and nursing care under the policy's one-year extension of coverage. After that year passed, Petitioner submitted no further proofs of loss to Aetna.

[**8] Petitioner urges that the policy afforded her a right to receive payment for all future medical services related to any accident occurring during the policy period. That interpretation is based on the following clause:

> If any benefit ceases to apply to an individual or a dependent, coverage for that benefit will cease immediately but without prejudice to any rights under the benefit established by this person while the coverage was in force.

Group Policy at 1850. Petitioner further urges that even if this clause does not explicitly provide her with coverage, it at least creates an ambiguity which must be interpreted in favor of coverage. However, not every difference in the interpretation of a contract or an insurance policy amounts to an ambiguity. Both the insured and the insurer are likely to take conflicting views of coverage, but neither conflicting expectations nor disputation is sufficient to *create* an ambiguity. *See Preston Ridge Fin. Servs. v. Tyler*, 796 S.W.2d 772, 777 (Tex. App.--Dallas 1990, writ denied); *Medical Towers v. St. Luke's Epis. Hosp.*, 750 S.W.2d 820, 822 (Tex. App.--Houston [14th Dist.] 1988, writ denied). The "without prejudice" [**9] clause by its own terms preserves the right to benefits "established . . . while the coverage was in force." It does not create new rights or benefits beyond those afforded by the other provisions of the policy. And it is undisputed that Aetna paid the benefits to which Petitioner was entitled -- payment of charges incurred while she was a covered dependent and for the one-year extension.

[*135] Accordingly, we affirm the judgment of the court of appeals.

John Cornyn

Justice

OPINION DELIVERED: January 5, 1994

DISSENT BY: LLOYD DOGGETT

DISSENT

Justice Doggett, joined by JUSTICE HIGHTOWER and JUSTICE GAMMAGE, delivered this Supplemental Dissenting Opinion on Petitioner's Motion for Rehearing

In again rejecting Amy's plea for relief, the majority leaves all Texans without the security that should be at very core of health insurance.

At least today's substituted opinion has abandoned footnote five of the majority's prior writing, which suggested that ambiguities are not to be resolved against the insurer in an ERISA plan. *See* 36 Tex. Sup. J. 860, 864 n.5. I have previously explained the reasons for rejecting this regressive rule. *See* 36 Tex. Sup. J. 860, 865-66, 869 [**10] (Doggett, J., dissenting).

However, the decision announced today remains wrong now for the other reasons it was wrong before, specifically the same "sweeping anti-consumer alteration of our longstanding method for interpreting insurance policies." *Id.* at 866. For this reason, I continue to dissent.

Lloyd Doggett

Justice

Opinion Delivered: January 5, 1994

GUIDEONE ELITE INSURANCE COMPANY F/K/A PREFERRED ABSTAINERS INSURANCE COMPANY, PETITIONER, v. FIELDER ROAD BAPTIST CHURCH, RESPONDENT

NO. 04-0692

SUPREME COURT OF TEXAS

197 S.W.3d 305; 2006 Tex. LEXIS 608; 49 Tex. Sup. J. 877

October 20, 2005, Argued
June 30, 2006, Opinion Delivered

SUBSEQUENT HISTORY: [**1] Released for Publication August 29, 2006.
Rehearing denied by, 08/25/2006

PRIOR HISTORY: ON PETITION FOR REVIEW FROM THE COURT OF APPEALS FOR THE SECOND DISTRICT OF TEXAS.
Fielder Rd. Baptist Church v. GuideOne Elite Ins., Co., 139 S.W.3d 384, 2004 Tex. App. LEXIS 4557 (Tex. App. Fort Worth, 2004)

DISPOSITION: The court affirmed the appellate court's judgment.

CASE SUMMARY:

PROCEDURAL POSTURE: Petitioner insurer sought a declaratory judgment that it had no duty to defend or indemnify respondent insured. The trial court granted the insurer summary judgment and relied on extrinsic evidence to the policy and pleadings in reaching its decision. The Court of Appeals for the Second District of Texas reversed, finding that the use of extrinsic evidence was error, and remanded the issue of attorney fees. The insurer sought review.

OVERVIEW: The insurer issued a commercial general liability insurance policy to the insured, a church. A church member filed a sexual misconduct lawsuit against the insured and a youth minister. The insurer sought a declaration that it had no duty to defend or indemnify the insured. The trial court ruled in the insurer's favor, but the appellate court reversed. On appeal, the court affirmed. The court rejected the use of overlapping evidence as an exception to the eight-corners rule because it posed a significant risk of undermining the insured's ability to defend itself in the underlying litigation. The church member alleged that the minister sexually assaulted her during the policy period. These allegations were sufficient to trigger the insurer's duty to defend, as the appellate court found. Application of the eight-corners rule conformed with the parties' contract, and the court agreed with the appellate court that the circumstances of the case presented no basis for an exception to that rule. The appellate court did not err in remanding the issue of attorney fees and costs, raised by the insured in its amended summary judgment motion, to the trial court.

OUTCOME: The court affirmed the appellate court's judgment.

CORE TERMS: church, duty to defend, coverage, extrinsic evidence, insured, insurer, youth, sexual misconduct, bodily injury, sexually, sexual, fraudulent, declaratory judgment action, policy period, overlapping, extrinsic, falsity, invoke, underlying claim, attorney's fees, indemnify, claimant's, times material, supervision, lawsuit, duty to indemnify, insurance policy, issue of coverage, summary judgment, groundless

LexisNexis(R) Headnotes

Insurance Law > General Liability Insurance > Obligations > Allegations in Complaints
[HN1]The eight-corners rule provides that when an insured is sued by a third party, the liability insurer is to determine its duty to defend solely from terms of the policy and the pleadings of the third-party claimant. Resort to evidence outside the four corners of these two documents is generally prohibited.

Insurance Law > General Liability Insurance > Obligations > Allegations in Complaints
[HN2]Under the eight-corners or complaint-allegation rule, an insurer's duty to defend is determined by the third-party plaintiff's pleadings, considered in light of the policy provisions, without regard to the truth or falsity of those allegations. The rule takes its name from the fact that only two documents are ordinarily relevant to the

determination of the duty to defend: the policy and the pleadings of the third-party claimant. Facts outside the pleadings, even those easily ascertained, are ordinarily not material to the determination and allegations against the insured are liberally construed in favor of coverage.

Insurance Law > General Liability Insurance > Obligations > Allegations in Complaints
[HN3]The Texas Supreme Court has never expressly recognized an exception to the eight-corners rule.

Insurance Law > General Liability Insurance > Obligations > Allegations in Complaints
[HN4]The Texas Supreme Court rejects the use of overlapping evidence as an exception to the eight-corners rule because it poses a significant risk of undermining the insured's ability to defend itself in the underlying litigation.

Insurance Law > General Liability Insurance > Obligations > Defense
Insurance Law > General Liability Insurance > Obligations > Indemnification
[HN5]Although the duties to defend and indemnify are created by contract, they are rarely coextensive. The duty to defend and the duty to indemnify are distinct and separate.

Insurance Law > General Liability Insurance > Obligations > Allegations in Complaints
Insurance Law > General Liability Insurance > Obligations > Defense
Insurance Law > General Liability Insurance > Obligations > Indemnification
[HN6]It is often the case in a commercial general liability insurance policy to define the duty to defend more broadly than the duty to indemnify and is, in fact, the circumstances assumed to exist under the eight-corners rule. Because the respective duties differ in scope, they are invoked under different circumstances. A plaintiff's factual allegations that potentially support a covered claim is all that is needed to invoke the insured's duty to defend, whereas, the facts actually established in the underlying suit control the duty to indemnify.

Insurance Law > General Liability Insurance > Obligations > Defense
[HN7]The duty to defend coverage protects policyholders against the expense of suits seeking damages.

Civil Procedure > Declaratory Judgment Actions > State Judgments > Uniform Declaratory Judgment Act
Civil Procedure > Trials > Jury Trials > Province of Court & Jury
Civil Procedure > Remedies > Costs & Attorney Fees > Attorney Expenses & Fees > Statutory Awards
[HN8]The Declaratory Judgments Act provides that in any proceeding under the Act the court may award costs and reasonable and necessary attorney's fees as are equitable and just. Tex. Civ. Prac. & Rem. Code Ann. § 37.009. The reasonable and necessary requirements are questions of fact to be determined by the factfinder; the equitable and just requirements are questions of law for the trial court to decide.

COUNSEL: For Petitioner: Ms. Sandra Cockran Liser, Mr. Grant Liser, Ms. Jennifer L. Willingham, Brown Dean Wiseman Liser Proctor & Hart, L.L.P., Fort Worth TX.

For Respondent: Mr. James E. Lobert, Mr. Jerry R. Hoodenpyle, Mr. David Graham Petter, Hoodenpyle & Lopert, P.C., Arlington, TX; Mr. Robert M. Roach Jr., Mr. Robert J. Cunningham, Cook & Roach, L.L.P., Houston, TX; Mr. Robert B. Dubose, Alexander Dubose Jones & Townsend LLP, Houston, TX.

For Amicus Curiae: Mr. David M. Pruessner, The Law Offices of David M. Pruessner, Dallas, TX; Mr. Wade Caven Crosnoe, Thompson Coe Cousins & Irons, L.L.P., Austin TX; Mr. Steven Goode, University of Texas Law School, Austin, TX.

JUDGES: JUSTICE MEDINA delivered the opinion of the Court, joined by CHIEF JUSTICE JEFFERSON, JUSTICE O'NEILL, JUSTICE GREEN, and JUSTICE JOHNSON. JUSTICE HECHT filed a concurring opinion, joined by JUSTICE WAINWRIGHT, JUSTICE BRISTER, and JUSTICE WILLETT.

OPINION BY: David M. Medina

OPINION

[*306] In this declaratory judgment action, we are asked to create an exception [**2] [*307] to the complaint-allegation or eight-corners rule. [HN1]The eight-corners rule provides that when an insured is sued by a third party, the liability insurer is to determine its duty to defend solely from terms of the policy and the pleadings of the third-party claimant. Resort to evidence outside the four corners of these two documents is generally prohibited.

The trial court, relying on evidence extrinsic to the policy and pleadings, declared that the insurer had no duty to defend the underlying claim against its insured. The court of appeals, however, reversed, concluding that because the circumstances of the case presented no reason to create an exception to the eight-corners rule, the trial court had erred in using extrinsic evidence to defeat the insurer's duty to defend. 139 S.W. 3d 384. We agree and, accordingly, affirm the court of appeals' judgment.

I

GuideOne Elite Insurance Company issued a commercial general liability insurance policy to Fielder Road Baptist Church, effective March 31, 1993. The policy included the following liability coverage for sexual misconduct:

> We agree to cover your legal liability for damages because of bodily injury, excluding [**3] any sickness or disease, to any person arising out of sexual misconduct which occurs during the policy period. We shall have the right and duty to investigate any claim . . . and to defend any suit brought against you seeking damages, even if the allegations of the suit are groundless, false or fraudulent, and we may make any settlement we deem expedient.

The policy expired on March 31, 1994.

On June 6, 2001, Jane Doe filed a sexual misconduct lawsuit against the Church and Charles Patrick Evans. In her pleadings, Jane Doe alleged that "[a]t all times material herein from 1992 to 1994, Evans was employed as an associate youth minister and was under Fielder Road's direct supervision and control when he sexually exploited and abused Plaintiff." The Church demanded that GuideOne defend it in the lawsuit and indemnify it for any judgment or settlement. GuideOne agreed to defend, but questioned coverage under the policy and reserved its rights to determine that issue at a later time.

A few months later, GuideOne filed this declaratory judgment action seeking the policy's construction and a declaration that GuideOne had no duty to defend or indemnify the Church in the underlying [**4] sexual misconduct lawsuit. In this action, GuideOne sought discovery of Evans' church employment history. The Church objected, asserting that GuideOne's duty to defend should be determined from the pleadings and the insurance policy, without resort to extrinsic evidence. The trial court, however, declined to block the discovery request, and the Church thereafter advised GuideOne that Evans ceased working for it on December 15, 1992, before the GuideOne policy took effect.

After both parties filed motions for summary judgment, the trial court granted GuideOne's motion, denied the Church's, and rendered judgment declaring that GuideOne had no duty to defend the Church in the underlying sexual misconduct case. The court of appeals, however, reversed the summary judgment, concluding that the trial court had erred in considering extrinsic evidence to defeat GuideOne's duty to defend its insured. 139 S.W. 3d 384. The court of appeals further concluded that Jane Doe's allegations were sufficient to invoke that duty, remanding the case to the trial court for a hearing only on costs and attorney's fees. *Id.* at 390-91. GuideOne petitioned this Court for review.

[**5] [*308] II

GuideOne argues that it had no duty to defend the Church against the underlying claim of sexual misconduct because Evans left his job as a youth minister before the policy's effective date. Because Jane Doe's allegations against the Church involved Evans' conduct while a youth minister, GuideOne suggests, that extrinsic evidence of when that relationship ended establishes no coverage existed for Evans' acts during the policy period. Recognizing the eight-corners rule as an impediment to its argument, however, GuideOne contends a number of reasons support its proposition that extrinsic evidence regarding Evans' employment status be considered as an exception to the rule.

First, GuideOne argues that an exception should apply because the extrinsic evidence here was primarily relevant to the issue of coverage, rather than the merits of the plaintiff's underlying claim. Alternatively, GuideOne argues that extrinsic evidence is needed to supplement the plaintiff's allegations because those allegations alone are insufficient to determine coverage or the duty to defend. Finally, GuideOne submits that should the Court conclude that the employment evidence is relevant both to coverage [**6] and liability, an exception to the eight-corners rule should nevertheless be recognized for this type of "mixed" or "overlapping" extrinsic evidence.

[HN2]Under the eight-corners or complaint-allegation rule, an insurer's duty to defend is determined by the third-party plaintiff's pleadings, considered in light of the policy provisions, without regard to the truth or falsity of those allegations. *Argonaut Sw. Ins. Co. v. Maupin*, 500 S.W.2d 633, 635, 17 Tex. Sup. Ct. J. 40 (Tex. 1973); *Heyden Newport Chem. Corp. v. S. Gen. Ins. Co.*, 387 S.W.2d 22, 24, 8 Tex. Sup. Ct. J. 187 (Tex. 1965). The rule takes its name from the fact that only two documents are ordinarily relevant to the determination of the duty to defend: the policy and the pleadings of the third-party claimant. *King v. Dallas Fire Ins. Co.*, 85

S.W. 3d 185, 187, 45 Tex. Sup. Ct. J. 1224 (Tex. 2002). Facts outside the pleadings, even those easily ascertained, are ordinarily not material to the determination and allegations against the insured are liberally construed in favor of coverage. *Nat'l Union Fire Ins. Co. v. Merchants Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141, 40 Tex. Sup. Ct. J. 353 (Tex. 1997).

Although [HN3]this Court has never expressly recognized [**7] an exception to the eight-corners rule, other courts have. [1] Generally, these courts have drawn a very narrow exception, permitting the use of extrinsic evidence only when relevant to an independent and discrete coverage issue, not touching on the merits of the underlying third-party claim. [2] Recently, the Fifth [*309] Circuit observed that if this Court were to recognize an exception to the eight-corners rule, it would likely do so under similar circumstances, such as: "when it is initially impossible to discern whether coverage is potentially implicated *and* when the extrinsic evidence goes solely to a fundamental issue of coverage which does not overlap with the merits of or engage the truth or falsity of any facts alleged in the underlying case." *Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d 523, 531 (5th Cir. 2004) (emphasis in original).

1 *See generally*, 1 ROWLAND H. LONG, THE LAW OF LIABILITY INSURANCE § 5. 02[2][b][ii] at 5-27 (2006) ("When the extrinsic facts relied on by the insurer are relevant to the issue of coverage, but do not affect the third party's right of recovery, courts have held that the insurer may refuse to defend third-party actions even though the allegations in the complaint indicate coverage."); 1 ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES § 4:4 *Insurer's refusal to defend based on existence of extrinsic facts* (4th ed. 2001) (citing cases which recognize that insurer may use extrinsic evidence to explain or refute factual allegations that are immaterial or extraneous to the merits of the third-party's claim but relate solely to the question of coverage).

[**8]

2 *See, e.g.*, *W. Heritage Ins. Co. v. River Entm't*, 998 F.2d 311, 313 (5th Cir. 1993) ("However, when the petition does not contain sufficient facts to enable the court to determine if coverage exists, it is proper to look to extrinsic evidence in order to adequately address the issue."); *Westport Ins. Corp. v. Atchley, Russell, Waldrop & Hlavinka, L.L.P.*, 267 F. Supp. 2d 601, 621-22 (E. D. Tex. 2003) (extrinsic evidence admissible in deciding the duty to defend where fundamental policy coverage questions can be resolved by readily determined facts that do not engage the truth or falsity of the allegations in the underlying petition, or overlap with the merits of the underlying suit); *State Farm Fire & Cas. Co. v. Wade*, 827 S.W.2d 448, 452-53 (Tex. App.-Corpus Christi 1992, writ denied) (concluding that extrinsic evidence could be admitted in deciding the duty to defend when the facts alleged are insufficient to determine coverage and "when doing so does not question the truth or falsity of any facts alleged in the underlying petition"); *Gonzales v. Am. States Ins. Co.*, 628 S.W.2d 184, 187 (Tex. App.--Corpus Christi 1982, no writ) (holding that facts extrinsic to the petition relating only to coverage, not liability, may be considered to determine a duty to defend, where such evidence does not contradict any allegation in the petition); *Cook v. Ohio Cas. Ins. Co.*, 418 S.W.2d 712, 715-16 (Tex. Civ. App.--Texarkana 1967, no writ) ("[T]he Supreme Court draws a distinction between cases in which the merit of the claim is the issue and those where the coverage of the insurance policy is in question. In the first instance the allegation of the petition controls, and in the second the known or ascertainable facts are to be allowed to prevail."); *Int'l Serv. Ins. Co. v. Boll*, 392 S.W.2d 158, 161 (Tex. Civ. App.--Houston 1965, writ ref'd n.r.e.) (considering extrinsic evidence of identity of driver of insured vehicle by stipulation to conclude no duty to defend or indemnify arose).

[**9] GuideOne relies on extrinsic evidence that is relevant both to coverage and the merits and thus does not fit the above exception to the rule. Hence, GuideOne argues that we should broaden the exception to include this type of "mixed" or "overlapping" extrinsic evidence. But very little support exists for this position, and the Fifth Circuit Court of Appeals has previously rejected a similar use of overlapping facts for this purpose. In *Gulf Chemical & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, one of the plaintiffs in the underlying toxic-tort action alleged that one of the defendants, Gulf, was strictly liable because it had sold or shipped molyoxide. 1 F.3d 365, 367 (5th Cir. 1993). The petition did not specifically state when Gulf had shipped molyoxide, but the petition did allege that the plaintiffs had suffered injures from exposure to the toxin between 1946 and 1990. *Id.* at 368. Extrinsic evidence would have established that Gulf had not shipped any molyoxide until January 20, 1986, which was three days after the expiration of the insurance policy in question. *Id.* at 368, 370. Although the fact at issue [**10] concerned both the merits and coverage, the Fifth Circuit, applying Texas law, rejected the use of extrinsic evidence under these circumstances. *Id.* at 371. [HN4]We likewise reject the use of overlapping evidence as an exception to the eight-

corners rule because it poses a significant risk of undermining the insured's ability to defend itself in the underlying litigation. *See* Ellen S. Pryor, *Mapping the Changing Boundaries of the Duty to Defend in Texas*, 31 TEX. TECH LAW REV. 869, 891-95 (2000) (discussing risks associated with using overlapping evidence as an exception to the eight-corners rule). [3]

3 One amicus suggests that the Church here might have a coverage-related incentive to prove that Evans was at least apparently employed by the Church during GuideOne's policy term in order to secure insurance coverage. This proof, once obtained by the third-party claimant through discovery, would undermine the insured's defense to those claims. Similarly, the insurer might have a coverage-related incentive to develop proof that the third-party claim is based on criminal or intentional conduct to establish a policy exclusion.

[**11] [*310] Those courts that have recognized an exception to the eight-corners rule have done so under limited circumstances involving pure coverage questions. For example, in *International Service Insurance Co. v. Boll*, 392 S.W.2d 158, 160 (Tex. Civ. App.--Houston 1965, writ ref'd n.r.e.), the insurer refused to defend its insured in an auto-collision case because of a policy endorsement that excluded coverage for "any claim arising from accidents which occur while any automobile is being operated by Roy Hamilton Boll." The plaintiff's petition alleged that the insured's son was driving the insured's car when the accident occurred, but did not otherwise identify the driver. After resolving the third-party claim, the insured sued his insurer to recover his defense costs. During this subsequent litigation, the parties stipulated that the insured's only son, Roy Hamilton Boll, was driving the insured vehicle. The court of appeals concluded that the stipulation established the accident had not been covered and that the insurer had no duty to defend.

The extrinsic evidence in *Boll*, however, went strictly to the coverage issue. It did not contradict any allegation in the third-party [**12] claimant's pleadings material to the merits of that underlying claim. In contrast, the extrinsic evidence here concerning Evans' employment directly contradicts the plaintiff's allegations that the Church employed Evans during the relevant coverage period, an allegation material, at least in part, to the merits of the third-party claim. Under the eight-corners rule, the allegation's truth was not a matter for debate in a declaratory judgment action between insurer and insured.

Moreover, were we to recognize the exception urged here, we would by necessity conflate the insurer's defense and indemnity duties without regard for the policy's express terms. [HN5]Although these duties are created by contract, they are rarely coextensive. *See* *Utica Nat'l Ins. Co. of Texas v. Am. Indem. Co.*, 141 S.W. 3d 198, 203, 47 Tex. Sup. Ct. J. 845 (Tex. 2004) (observing that duty to defend and duty to indemnify are distinct and separate); *Whatley v. City of Dallas*, 758 S.W.2d 301, 304 (Tex. App.--Dallas 1988, writ denied) (duty to defend is defined by the terms of the contract). The policy here obligated GuideOne to indemnify the Church in the event of a meritorious claim for sexual misconduct, but [**13] with respect to the duty to defend, the contract provided that GuideOne should "defend any suit brought against [the insured] seeking damages, even if the allegations of the suit are groundless, false or fraudulent . . . ."

The policy thus defined the duty to defend more broadly than the duty to indemnify. [HN6]This is often the case in this type of liability policy and is, in fact, the circumstances assumed to exist under the eight-corners rule. Because the respective duties differ in scope, they are invoked under different circumstances. *Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 821-22, 40 Tex. Sup. Ct. J. 583 (Tex. 1997). A plaintiff's factual allegations that potentially support a covered claim is all that is needed to invoke the insured's duty to defend, *Heyden Newport Chemical Corp.*, 387 S.W.2d at 26; whereas, the facts actually established in the underlying suit control the duty to indemnify. *Trinity Universal Ins. Co.*, 945 S.W.2d at 821.

Jane Doe alleged that Evans sexually assaulted her during the policy period and was a youth minister at the Church at the time. As the court of appeals observed, the allegations were sufficient to trigger [**14] [*311] GuideOne's duty to defend. 139 S.W. 3d at 389.

GuideOne contends that it should not have to defend because it *knows* that Evans was not in fact an employee of the Church during this period, but the duty to defend does not turn on the truth or falsity of the plaintiff's allegations. One amicus argues, however, that it should because ignoring the truth invites fraudulent and even collusive pleadings. The amicus further suggests that we should adopt a true-facts exception to the eight-corners rule to prevent the rule's recurring use as a tool for fraud. But the record before us does not suggest collusion or the existence of a pervasive problem in Texas with fraudulent allegations designed solely to create a duty to defend.

Under the present policy, GuideOne agreed to defend the Church against allegations of sexual misconduct potentially within coverage, even if the plaintiff's allegations were false or fraudulent. Therefore if GuideOne knows these allegations to be untrue, its duty is to establish such facts in defense of its insured, rather than as an adversary in a declaratory judgment action. *Heyden Newport Chemical Corp.*, 387 S.W.2d at 25 (observing

[**15] that [HN7]the duty to defend coverage protects policyholders against the expense of suits seeking damages). Application of the eight-corners rule here thus conforms with the parties contract, and accordingly we agree with the court of appeals that the circumstances of this case present no basis for an exception to that rule.

III

GuideOne also argues that Doe's pleadings failed to invoke its duty to defend because her allegations did not sufficiently describe her bodily injury. The policy defined "bodily injury" to mean "bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time." [4] GuideOne maintains it had no duty to defend because Doe's pleadings sought damages for emotional and psychological injuries rather than "bodily injury."

4 Although not relevant here, the sexual misconduct clause of the policy excluded sickness or disease from the definition, making the definition of "bodily injury" in this context somewhat circular.

The court of appeals disagreed, [**16] noting that Doe's allegations of sexual assault, abuse, molestation and violation were sufficient. 139 S.W. 3d at 390. Because the policy attributed no technical or special meaning to the term "bodily injury," the court applied its ordinary and generally accepted meaning, concluding that bodily injury is commonly understood to be a consequence of sexual assault and abuse. *Id*. We agree.

Finally, GuideOne complains that the court of appeals erred in remanding the case to the trial court for determination of costs and attorneys' fees because Doe did not herself file a declaratory judgment action and did not pray for attorneys' fees in the proceedings below. Contrary to GuideOne's argument, however, the Church asked in its second amended motion for summary judgment that the court not only grant its motion, but also conduct a hearing and award it attorneys' fees. [HN8]The Declaratory Judgments Act provides that in any proceeding under the Act "the court may award costs and reasonable and necessary attorney's fees as are equitable and just." TEX. CIV. PRAC. & REM. CODE § 37.009. The reasonable and necessary requirements are questions of fact [**17] to be determined by the factfinder; the equitable and just requirements are questions of law for the trial court to decide. *Bocquet* [*312] *v. Herring*, 972 S.W.2d 19, 21, 41 Tex. Sup. Ct. J. 650 (Tex. 1998). The court of appeals therefore did not err in remanding the issue of attorneys' fees and costs to the trial court.

* * * *

Finding no error in the court of appeals' judgment, we affirm.

David M. Medina

Justice

CONCUR BY: Nathan L. Hecht

CONCUR

Argued October 20, 2005

JUSTICE HECHT, joined by JUSTICE WAINWRIGHT, JUSTICE BRISTER and JUSTICE WILLETT, concurring in the judgment.

Fielder Road Baptist Church and its insurer, GuideOne Elite Insurance Co., have reached a stipulation about the nature and duration of the Church's relationship with a former youth worker, Charles Patrick Evans, alleged to have sexually abused Jane Doe. GuideOne argues that the stipulation should be considered in determining whether it has a duty to defend the Church against Doe's lawsuit, and the Court rejects that argument. The Church argues that even if the stipulation were considered, Doe's pleadings would still invoke GuideOne's duty to defend. Because the Church is correct, the Court's discussions of the so-called [**18] "eight-corners rule", and whether there should ever be exceptions to it, is unnecessary. I would not address these difficult issues in a case in which they cannot affect the result. Accordingly, I join only in the Court's judgment.

Doe sued the Church and Evans, alleging in her petition the following:

> At all times material herein, Charles Patrick Evans was an associate youth minister. At all times material herein, Charles Evans remained under the retention, direct supervision, agency and control of Defendant Church. From approximately early 1992 to 1994, Defendant Evans was an associate youth minister at Fielder Road Baptist Church in Arlington, Texas. During this period Fielder Road knew or should have known that Evans engaged in forbidden sexual conduct which was both actually and potentially damaging to other persons including Plaintiff. . . . Fielder Road had knowledge that Evans had made inappropriate sexual advances to other young girls in the church. Despite these reports, Fielder Road continued to place Evans in a position as a youth minister with access and authority over young girls.

> From approximately 1992 to 1994, Evans sexually molested Jane Doe at church functions [**19] and church sponsored trips, as well as at her own home.
>
> * * *
>
> Despite allegations of previous incidents, Fielder Road failed to warn parents of the children in the church youth ministry of the sexual tendencies of Defendant Evans.
>
> * * *
>
> At all times material herein from 1992 to 1994, Evans was employed as an associate youth minister and was under Fielder Road's direct supervision and control when he sexually exploited and abused Plaintiff. Defendant Evans came to know Plaintiff and gained access to her because of his status as a youth minister. Defendant Evans engaged in this wrongful conduct while in the course and scope of his employment with Defendant Fielder Road. Therefore, Defendant Fielder Road is liable for the wrongful conduct of Defendant Evans. Plaintiff therefore pleads *Respondeat Superior*, agency, apparent agency and [*313] agency by estoppel, vicarious and derivative liability.
>
> Defendant Fielder Road negligently selected, hired and/or continued the employment of Defendant Evans in a position of trust, confidence and authority as a youth minister in direct contact with minors when it knew or should have known of his dangerous sexual propensities.
>
> Fielder Road failed [**20] to warn Plaintiff or her family of Evans' dangerous sexual propensities.
>
> Fielder Road failed to provide reasonable supervision of Evans.
>
> Fielder Road, as a religious organization, is granted special privileges and immunities by society and is in a special fiduciary relationship with Plaintiff. Defendant owed Plaintiff the highest duty of trust and confidence and is required to act in Plaintiff's best interest. Defendant knowingly violated the relationship. Defendant knowingly breached Plaintiff's trust when Fielder Road failed to act with the highest degree of trust and confidence to protect Plaintiff from its sexually predatory minister. This knowing breach of fiduciary duty proximately caused injury to Plaintiff.
>
> * * *
>
> Fielder Road also committed fraud by misrepresentation that proximately caused Plaintiff's damages. Fielder Road committed fraud when it represented that Evans was sexually safe, when it knew or should have known of his pedophilic tendencies.
>
> * * *
>
> Plaintiff alleges that the actions of these Defendants have inflicted emotional distress upon Plaintiff.
>
> Plaintiff alleges that the negligence of Fielder Road resulted in bodily injury to Plaintiff.

The Church [**21] has stipulated that the petition's allegation that "Evans was an associate youth minister" at the Church from "approximately early 1992 to 1994" is false. Specifically, the Church has stipulated:

> Charles Patrick Evans became a part-time intern in the youth department of Defendant FRBC on November 14, 1991. On January 1, 1992, Charles Patrick Evans was hired as a part-time associate in the youth department of Defendant FRBC. Charles Patrick Evans left employment with Defendant FRBC on or about December 15, 1992. Charles Patrick Evans never served, nor was he ever authorized to so act, as an officer or director of Defendant FRBC. Charles Patrick Evans did not serve, nor was he ever authorized to act, as an employee, or volunteer of Defendant FRBC at any time after December 1992. Charles Patrick Evans was officially removed as a member of Defendant FRBC in February of 1993.

From March 31, 1993, to March 31, 1994, GuideOne insured the Church against "legal liability for damages because of bodily injury . . . to any person arising out of sexual misconduct which occurs during the policy period" and agreed to "defend any suit brought against [the Church] seeking damages, even if [**22] the allega-

tions of the suit are groundless, false or fraudulent". GuideOne argues that because the Church did not employ Evans or authorize him to act on its behalf during that period, Doe's accusations are not covered by the policy. That is simply incorrect.

Doe alleges that Evans' sexually molested her "[f]rom approximately 1992 to 1994" -- within the policy period. Doe further alleges that she suffered bodily injury because of Evans' sexual misconduct, for which the Church is liable. If the Church is correct that it did not employ Evans [*314] within the policy period, then Doe's claim against the Church for vicarious liability would fail. But that is clearly not Doe's only claim. She claims that the Church knew or should have known of Evans' sexual misconduct from "approximately early 1992 to 1994" and should have warned her and her family. She also claims that Evans was the Church's apparent agent, that the Church breached its fiduciary duty to her, and that the Church made misrepresentations to her. Whether those and other claims have merit, legally or factually, they assert liability against the Church that may not depend on the period of Evans' association with the Church and [**23] thus invoke the duty to defend. GuideOne concedes that if it has a duty to defend any of Doe's claims, it has a duty to defend them all. [1]

1 *Maryland Cas. Co. v. Moritz*, 138 S.W.2d 1095, 1097 (Tex. Civ. App.- Austin 1940, writ ref'd).

The "eight-corners" rule applies whether the Church's stipulation is considered or not. Thus, we have no need to consider what exceptions the rule might have, and given the importance of this difficult issue, I would express no opinion on it.

Accordingly, I concur only in the judgment.

Nathan L. Hecht

Justice

NORTH AMERICAN SPECIALTY INSURANCE COMPANY, as successor in interest to Commercial Underwriters Insurance Company, Plaintiff - Appellant v. ROYAL SURPLUS LINES INSURANCE COMPANY; EVANSTON INSURANCE COMPANY, Defendants - Appellees

No. 07-20488

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

541 F.3d 552; 2008 U.S. App. LEXIS 18131

August 22, 2008, Filed

PRIOR HISTORY: [**1]
Appeal from the United States District Court for the Southern District of Texas. 4:03-CV-2922. Melinda Harmon, US District Judge.
Heritage Hous. Dev., Inc. v. Carr, 199 S.W.3d 560, 2006 Tex. App. LEXIS 6930 (Tex. App. Houston 1st Dist., 2006)
Commer. Underwriters Ins. Co. v. Royal Surplus Lines Ins. Co., 345 F. Supp. 2d 652, 2004 U.S. Dist. LEXIS 26567 (S.D. Tex., 2004)

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff, an excess insurer, appealed a summary judgment that the United States District Court for the Southern District of Texas entered in favor of defendants, primary insurers, on disputes between the excess and primary insurers regarding coverage claims arising out of a tort action brought against an insured nursing home.

OVERVIEW: In the underlying tort action, a resident's spouse alleged that the resident suffered injuries as a result of the nursing home's pattern and practice of neglect. Plaintiff paid $ 1.625 million to settle the tort action. Defendants paid more than $ 1 million in defense and indemnity costs. Plaintiff conceded that defendants owed nothing further if the tort action implicated only one primary policy limit and only one primary policy type. Plaintiff argued that the primary coverage limits should be stacked temporally, that the stacking principal applied to indemnity coverage and defense costs, and that defense costs could be allocated to the commercial general liability (CGL) part of the primary insurance policies rather than the hospital professional liability (HPL) part. The court held that the primary policies could not be stacked for indemnity or defense purposes because the liability arising from the underlying action involved a continuing pattern of neglect rather than a series of discrete events. The presence of CGL coverage did not result in more coverage for the underlying claim because the claim for breach of professional standards fell within the HPL coverage.

OUTCOME: The court affirmed the order granting summary judgment to defendants.

CORE TERMS: coverage, insured, stacking, nursing home, health care, indemnity, policy limits, equitable subrogation, liability claims, covering, eroding, summary judgment, primary carriers, coverage limits, policy periods, temporally, occurrence, discrete, insurer's, omission, primary insurers, neglect, lawsuit, insurance policies, excess carrier, nursing home, duty to defend, triggered, unrelated, stacked'

LexisNexis(R) Headnotes

Civil Procedure > Summary Judgment > Appellate Review > Standards of Review
Civil Procedure > Appeals > Standards of Review > De Novo Review
[HN1]The court of appeals reviews a grant of summary judgment de novo.

Civil Procedure > Summary Judgment > Standards > General Overview
[HN2]Summary judgment is proper when the pleadings and evidence on file show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

Insurance Law > Excess Insurance > Subrogation
[HN3]Texas cases providing a right of equitable subrogation to an excess carrier involve an excess carrier suing a primary carrier, where their respective policies overlap temporally. An excess carrier cannot step into the shoes

of its insured as to a primary carrier to which the excess carrier is not excess.

Insurance Law > Claims & Contracts > General Overview

[HN4]Stacking refers to the concept of taking policy limits from multiple, but not overlapping, policies potentially covering the same lawsuit and adding those limits together.

Insurance Law > Claims & Contracts > General Overview

[HN5]When a single occurrence triggers more than one policy, covering different policy periods, an insured's indemnity limit should be whatever limit applied at the single point in time during the coverage periods of the triggered policies when the insured's limit was highest.

Insurance Law > General Liability Insurance > Occurrences

[HN6]Whether there was one occurrence or more is determined by the respective terms of insurance policies.

Insurance Law > Claims & Contracts > General Overview

[HN7]In determining the facts established in underlying litigation, the court reviews the record from the underlying suit, which includes the pleadings, the trial transcript, the insurance policy, and the judgment.

Civil Procedure > Summary Judgment > Appellate Review > General Overview
Civil Procedure > Summary Judgment > Evidence

[HN8]Fed. R. Civ. P. 56 does not impose upon the district court a duty to sift through the record in search of evidence to support a party's opposition to summary judgment. Nor is it the appellate court's duty to do so on appeal.

Insurance Law > General Liability Insurance > Obligations > Defense

[HN9]In an eroding policy, an insurer's payments to defense counsel to defend the liability suit count against the policy limits.

Insurance Law > Claims & Contracts > General Overview

[HN10]An insured is entitled to select the policy that provides the most coverage from those potentially providing coverage, thereby allowing the insured to select an applicable year in which the individual or aggregate limits are the highest.

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview

[HN11]Interpretation of insurance contracts in Texas is governed by the same rules as interpretation of other contracts. When a contract provision makes a general statement of coverage, and another provision specifically states the time limit for such coverage, the more specific provision will control.

Insurance Law > General Liability Insurance > Obligations > Defense

[HN12]Under Texas law, a duty to defend is determined under the eight corners rule. In Texas, the eight-corners rule provides that when an insured is sued by a third party, the liability insurer is to determine its duty to defend solely from terms of the policy and the pleadings of the third-party claimant. Resort to evidence outside the four corners of these two documents is generally prohibited. The duty to defend does not depend upon the truth or falsity of the allegations: A plaintiff's factual allegations that potentially support a covered claim are all that is needed to invoke the insurer's duty to defend.

Healthcare Law > General Overview

[HN13]A plaintiff's legal theories and labels do not control the question of whether a claim is a health care liability claim subject to former Tex. Rev. Civ. Stat. Ann. art. 4590i (2003), known as the Medical Liability and Insurance Improvement Act (MLIIA). Plaintiffs cannot use artful pleading to avoid the MLIIA's requirements when the essence of the suit is a health care liability claim. To determine whether a cause of action falls under the MLIIA's definition of a "health care liability claim," the court examines the claim's underlying nature. If the act or omission alleged in the complaint is an inseparable part of the rendition of health care services, then the claim is a health care liability claim. One consideration in that determination may be whether proving the claim would require the specialized knowledge of a medical expert.

Healthcare Law > Insurance > General Overview

[HN14]Under Texas law, hospital professional liability coverage policies provides for breaches of professional standards of health care, while commercial general liabil-

ity coverage provides for other non-care related negligence.

Insurance Law > Claims & Contracts > General Overview
Insurance Law > General Liability Insurance > Obligations > Defense
[HN15]Texas law prohibits stacking policies that do not overlap to provide more coverage than the highest limits of any one policy. That rule applies to both the indemnity and defense portions of an eroding policy. Insureds who contract for an eroding policy are not entitled to a more favorable stacking rule than insureds who pay more for an unlimited defense.

COUNSEL: For NORTH AMERICAN SPECIALTY INSURANCE CO, as successor in interest to Commercial Underwriters Insurance Company, Plaintiff - Appellant: Philip D Nizialek, Rathwell & Nizialek, The Woodlands, TX.

For ROYAL SURPLUS LINES INSURANCE CO, Defendant - Appellee: Noel Terry Adams, Jr, Hilary Channing Borow, Henry Sim Platts, Jr, Jay W Brown, Beirne, Maynard & Parsons, Houston, TX.

For EVANSTON INSURANCE CO, Defendant - Appellee: Gary J Siller, Strasburger & Price, Houston, TX.

JUDGES: Before SMITH, WIENER and HAYNES, Circuit Judges.

OPINION BY: HAYNES

OPINION

[*553] HAYNES, Circuit Judge:

This case involves a dispute between two primary insurers, Royal Surplus Lines Insurance Company ("Royal") and Evanston Insurance Company ("Evanston"), and an excess insurer, North American Specialty Insurance Company ("North American"), [1] [*554] and arises out of a tort suit against a nursing home. North American appeals the district court's grant of summary judgment in favor of Royal and Evanston. For the reasons set forth below, we AFFIRM.

1 North American is a successor to Commercial Underwriters Insurance Company, under whose [**2] name the original suit was brought.

I. BACKGROUND

Velma Carr sued the Heritage Sam Houston Gardens nursing home, its parent company Heritage Housing, and a number of its employees in state court for "continuing negligence" in the nursing home's care of her husband, Raymond Carr. Mr. Carr resided at the nursing home from February 1999 to June 2000, when he was transferred to another home. He died in 2002. The suit alleged that the nursing home's "pattern and practice of ongoing neglect" caused Mr. Carr to suffer from "a dislocated shoulder, pressure sores, skin tears and contusions, ulcers," and other "pain" and "indignity" resulting from failures of basic care. At trial, a jury awarded over $ 4.5 million in actual and punitive damages. Royal thereafter settled the case with Mrs. Carr on behalf of the individual nurse defendants and took the position that its coverage was thereby exhausted. [2]

2 Evanston took the position that, because the Royal policy afforded the most coverage, Royal should handle the defense with Evanston contributing to it. At oral argument, Evanston stated that it has settled all claims with Royal regarding their respective obligations to each other.

The two corporate [**3] defendants appealed, with North American paying the costs of the appeal, and a state appellate court reversed the trial judgment against them. *Heritage Housing Dev., Inc. v. Carr,* 199 S.W.3d 560, 572 (Tex. App.--Houston [1st Dist.] 2006, no pet.). It rendered judgment in favor of Heritage Housing and remanded for a new trial against the nursing home. [3] *Id.* Subsequently, North American paid $ 1.625 million to settle with the Carrs on behalf of the nursing home before another trial was held.

3 The remand was based upon the appellate court's determination that submission of Heritage Housing's negligence as part of the question asking the jury to calculate each party's percentage of responsibility led to an incorrect result.

Meanwhile, North American filed a lawsuit, which was removed to federal court, over liability coverage for damages and defense costs incurred by insureds in the underlying tort suit. During the period over which Mrs. Carr alleged negligence, the insureds had three successive, non-overlapping insurance policies providing primary liability coverage: a $ 1 million policy from Royal covering April 1998 to April 1999; a $ 1 million policy from Royal covering April 1999 to [**4] April 2000; and a $ 500,000 policy from Evanston covering April 2000 to April 2001. Concurrent with the primary policies, the insureds also had two policies providing excess coverage: a $ 5 million policy from North American covering April 1998 to April 1999 and a $ 5 million policy from North American covering April 1999 to April 2000. All of these policies were issued to the insureds with knowledge that the business being insured was a

long-term health care facility. As Evanston noted, North American did not have an excess policy for the period covered by the Evanston policy. It is undisputed that, in combination, Evanston and Royal have paid more than $ 1 million in defense and indemnity costs for the Carr lawsuit. North American concedes that if only one policy amount and only one policy type is implicated by the Carr lawsuit, then Appellees owe nothing further.

In the coverage case, North American argued, inter alia, that Mrs. Carr had sued for discrete acts of negligence occurring [*555] over the course of the three primary policy periods such that the primary coverage limits should be "stacked." North American's excess coverage then would not be triggered until the limit of the total [**5] of all three primary policies ($ 2.5 million) has been reached. North American further argued that the stacking principle should apply to defense costs, in addition to indemnity coverage. Finally, North American argued that the defense costs incurred on behalf of the nursing home's parent company should be allocated to the Commercial General Liability ("CGL") part of the primary insurance policies rather than the Hospital Professional Liability ("HPL") part. [4]

4 Because the coverage limits applied separately to each part, a policy with a $ 1 million limit allowed $ 1 million of CGL coverage and $ 1 million of HPL coverage. Thus, North American's argument, if successful, would provide for more primary coverage before reaching its excess layer.

On October 29, 2004, the district court granted partial summary judgment to Royal and Evanston, holding that the policies could not be temporally "stacked" for purposes of indemnity payments and that defense costs could not be allocated to the CGL portion of the policy. *Commercial Underwriters Ins. Co. v. Royal Surplus Lines Ins. Co.*, 345 F. Supp. 2d 652, 658 (S.D. Tex. 2004). Thereafter, the court granted further partial summary judgment to Royal [**6] and Evanston, holding that the policies could not be temporally "stacked" for defense cost allocation purposes. Ultimately, the court issued final summary judgment as to all parties and issues, and this appeal followed.

II. STANDARD OF REVIEW

[HN1]We review a grant of summary judgment de novo. *Allstate Ins. Co. v. Disability Servs. of the Sw. Inc.*, 400 F.3d 260, 262-63 (5th Cir. 2005). [HN2]Summary judgment is proper when the pleadings and evidence on file "show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986) (citations omitted).

III. DISCUSSION

This case involves, in essence, two forms of stacking: (1) temporal, across policies covering different time periods; and (2) subject matter, across policies within a time period that cover different potential liabilities. Within the first category, North American seeks stacking of two different things -- indemnity payments and defense costs.

A. Equitable Subrogation

North American's lawsuit is based on its contention that it is entitled to equitable subrogation as an excess carrier against primary carriers. At the outset, then, [**7] the question arises whether North American can assert such a claim here. Evanston also challenges whether North American sought recovery on an equitable subrogation theory in the district court. [HN3]Texas cases providing a right of equitable subrogation to an excess carrier involve an excess carrier suing a primary carrier, where their respective policies overlap temporally. *See, e.g., Am. Centennial Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480, 481 (Tex. 1992) (allowing equitable subrogation by an excess carrier to the insured's *Stowers* [5] claim against the primary carrier). That is not the case here as to Evanston. [*556] As a result, North American cannot "step into the shoes" of its insured as to a primary carrier to which North American is not excess. [6] *Royal Ins. Co. v. Caliber One Indem. Co.*, 465 F.3d 614, 625 (5th Cir. 2006). [7] North American cannot recover against Evanston under a theory of equitable subrogation. [8] Because Evanston's arguments under the stacking theory are also correct, we discuss the Evanston policy along with the Royal policies in that analysis below.

5 *G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved).

6 Evanston also argues [**8] that North American never raised the principle of equitable subrogation in the trial court; North American concedes it did not "use the magic words" but argues that it adequately raised the concept below.

7 We are puzzled by North American's contention at oral argument that this case was decided under Louisiana law. The opinion expressly states that it was decided under Texas law.

8 Thus, we need not determine if North American properly raised this ground in the trial court.

This case potentially presents the issue of whether recent Texas cases have eroded the underpinnings of

Canal even in cases of temporally overlapping excess and primary policies, such as those of North American and Royal. *See* *Excess Underwriters at Lloyd's v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42, 48-50 (Tex. 2008) (holding that absent an express agreement to the contrary, a carrier who settles a claim later determined not to be covered by its policy cannot sue the insured for reimbursement of the excess amount); *Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co.*, 236 S.W.3d 765, 768 (Tex. 2007) (holding that in the absence of an agreement with each other, a primary carrier for the same policy period [**9] as another primary carrier has no right of contribution against the other carrier even if it pays more than its pro rata share of the defense or indemnity costs). *Mid-Continent* distinguishes *Canal* as follows: "In *Canal,* we recognized equitable subrogation as a basis for an excess insurer's recovery against a primary insurer to prevent a primary insurer from taking advantage of an excess insurer, acting solely as such, when a potential judgment approaches the primary insurer's policy limits." 236 S.W.3d at 776 (citing *Canal,* 843 S.W.2d at 483). *Canal* involved an equitable subrogation claim based upon the insured's own *Stowers* claim against the primary carrier.

At oral argument, Royal's counsel conceded that the principles of equitable subrogation announced in *Canal* have not been abrogated by later decisions. Because we resolve this case on the stacking arguments, we need not decide the question of whether equitable subrogation applies to the Royal policies.

B. Temporal Stacking

1. Indemnity

Thus, we turn to the stacking issues. [HN4]"Stacking" refers to the concept of taking policy limits from multiple, but not overlapping, policies potentially covering the same lawsuit and adding those limits [**10] together. *Am. Physicians Ins. Exch. v. Garcia,* 876 S.W.2d 842, 854-55 (Tex. 1994). In *Garcia,* the Texas Supreme Court considered what coverage limit to apply when there are consecutive policies covering distinct policy periods and a claim occurrence extends throughout multiple policy periods. The court held that the coverage limits "could not be 'stacked' to multiply coverage for a single claim involving indivisible injury" such that the coverage limit would be the "sum of the [*557] limits provided by the applicable policies." [9] *Id.* at 853-54. Instead, [HN5]when "a single occurrence triggers more than one policy, covering different policy periods, . . . the insured's indemnity limit should be whatever limit applied at the single point in time during the coverage periods of the triggered policies when the insured's limit was highest." *Id.* at 855.

9 The court explained the rationale for this rule:

> [The argument for stacking] rests on the assumption that [the insured] had three times more insurance than he purchased. At no time during the four relevant coverage years did any two policies overlap. Thus, at no time during the four years did [the insured] carry liability insurance with a per-occurrence [**11] limit greater than $ 500,000. [The insured] did not purchase malpractice insurance for $ 1.5 million in coverage, as he might have done by purchasing excess or umbrella coverage, and therefore he may not claim to benefit from $ 1.5 million in coverage by stacking temporally distinct policies.

Garcia, 876 S.W.2d at 854-55.

The parties in this case do not dispute the validity of *Garcia's* anti-stacking rule. Rather, they disagree about whether the liability arising from Mrs. Carr's suit involved a single covered event or multiple discrete covered events. Under *Garcia's* rule, if the negligence at the nursing home constituted a single covered event, it would trigger only one coverage limit. But if the negligence consisted of multiple, discrete covered events, each such event would trigger its own separate coverage limit.

In answering this question, we begin with the policy language. The Royal policies cover medical incidents and define a "medical incident" as "any act or omission: a. In the providing of or failure to provide professional health care services to your patients, including: (1) The providing or dispensing of food, beverages, medications or medical supplies or appliances in connection [**12] with such services; . . . ." They further state that "[a]ll related 'medical incidents' arising out of the providing of or failure to provide professional health care services to any one person shall be considered one 'medical incident.'" The Evanston policy likewise provides that its Professional Liability coverage insures sums "the Insured shall become legally obligated to pay as damages because of malpractice arising out of the rendering of, or failure to render, . . . the following professional services in the Named Insured's . . . , nursing home . . . : medical . . . or nursing treatment to a patient, including the furnishing of food or beverages in connection therewith." It fur-

ther states that "[t]wo or more claims arising out of a single act, error, omission or occurrence or a series of related acts, errors, omissions, or occurrence[s] shall be treated as a single claim." [10]

10 As our court has previously held, [HN6]"Whether there was one occurrence or more is determined by the policies' respective terms." *Caliber One,* 465 F.3d at 621.

The key word in both of these policies is the same: "related." Under both policies, a series of multiple incidents becomes a single continuing incident [**13] or occurrence only if they are "related." [11] Although the policies do not further clarify the meaning of "related," a Texas appellate court has construed the term in a similar insurance contract to mean "having a logical or causal connection." *Columbia Cas. Co. v. CP Nat'l, Inc.,* 175 S.W.3d 339, 347 (Tex. App.--Houston [1st Dist.] 2004, pet. denied).

11 Under the Royal policy, the incidents must also relate to a single person. That requirement is not at issue here, as the incidents all related to Mr. Carr.

In this case, the district court considered summary judgment evidence consisting [*558] of the pleadings, trial transcript, and jury findings of the underlying suit, and concluded that the negligent acts at the nursing home were related. [12] Mrs. Carr's complaint alleged "serious bodily injuries" which were "proximately caused by the continuing negligence" of the insureds. 345 F. Supp. 2d at 667-68. Elsewhere it referred to the nursing home's "continuing course of repeated negligence." *Id.* at 668. The court summarized:

> [T]he plaintiff's theory in the underlying suit, a theory upon which she prevailed, was that Mr. Carr was injured by a series of acts and omissions that were *related,* having both [**14] causal connections (*i.e.,* the pattern of negligence was caused by management's focus on cutting costs) and logical connections (*i.e.,* all of the relevant acts/omissions are logically connected to the concept of professional nursing home care, to which Mr. Carr was entitled).

Id.

12 North American argues that it was error for the district court to rely in part on the complaint and jury findings. There is no support for this assertion. To the contrary, [HN7]in determining "the facts established in the underlying litigation," we "review the record from the underlying suit, which includes the pleadings, the trial transcript, the insurance policy, and the judgment." *Great Am. Lloyds Ins. Co. v. Mittlestadt,* 109 S.W.3d 784, 787 n.1 (Tex. App.--Fort Worth 2003, no pet.). In the related circumstance of apportioning a settlement between covered and uncovered claims, we have held that the trial court may look to all relevant evidence, whether or not it would have been admissible in the liability case. *Am. Int'l Specialty Lines Ins. Co. v. Res-Care, Inc.,* 529 F.3d 649, 657-58 (5th Cir. 2008). We agree that the presence of a broad form submission to the jury of the negligence question is not dispositive [**15] on the question of whether there was a continuing pattern of neglect. Here the entire theory of the case -- from pleadings through trial -- was that of a continuing pattern of neglect, rather than a series of unrelated and disconnected wrongs.

Thus, while one could argue that each day the nursing home committed an act of negligence in failing to properly feed or treat Mr. Carr, these events are all "related." North American points out that Mr. Carr's problems began with poor nutritional care, followed by a shoulder injury, which led to mobility problems, which led to sores, skin ulcers and similar conditions. While North American contends these are discrete events, they all stemmed from a pattern of neglect and incompetence. Indeed, as noted above, the district court concluded that the Carrs' theory of the case in its complaint, continuing into its presentation of evidence at trial, was one of a continuing pattern of neglect, not a series of discrete events. [13] In this appeal, North American has not pointed to any specific evidence showing discrete, unrelated injuries leading to discrete damages with individualized, unrelated damages. [HN8]"Rule 56 does not impose upon the district court [**16] a duty to sift through the record in search of evidence to support a party's opposition to summary judgment. Nor is it our duty to do so on appeal." *Stults v. Conoco, Inc.,* 76 F.3d 651, 657 (5th Cir. 1996) (citations omitted).

13 Although the jury verdict in the underlying liability case was ultimately vacated by the appellate court and remanded for a new trial as to the nursing home, both sides and the district court relied upon the evidence from the first trial. We conclude that it is appropriate to rely upon such evidence in assessing the question of the basis for the settlement. If North American wished to bring any other relevant evidence before the district court, it could have done so.

We conclude that *Garcia* applies to prevent North American from temporally stacking the policies for indemnity purposes. Under *Garcia,* the insured (and North American as its "equitable subrogee") [*559] is entitled to "whatever limit applied at the single point in time during the coverage periods of the triggered policies when the insured's limit was highest." *Garcia,* 876 S.W.2d at 855. In this case, that is $ 1 million.

2. Defense Costs

The policies in question are "eroding" policies. Liability insurance [**17] policies often have two components: defense and indemnity. In many liability policies, the policy limits refer only to the indemnity obligation (i.e., the duty to pay covered claims), and the obligation to defend a liability suit is not capped by the policy limits. [HN9]In an eroding policy, by contrast, the insurer's payments to defense counsel to defend the liability suit count against the policy limits. *Westchester Fire Ins. Co. v. Admiral Ins. Co.,* 152 S.W.3d 172, 192 (Tex. App.--Fort Worth 2004, pet. denied). For example, if the eroding policy limits are $ 10,000, and the insurer pays $ 10,000 in reasonable defense fees, the policy limits for that occurrence are exhausted.

Thus, in the *Garcia* case, the focus of the inquiry was the indemnity obligation, because the duty to defend did not have a policy limit. Here, the three policies do have a limit on defense costs because those costs, including attorneys' fees, are included in the "per medical incident" limits.

North American argues that even if the *Garcia* anti-stacking rule applies to prevent stacking for indemnity purposes, it should allow stacking for defense purposes. North American cited no cases for this proposition and acknowledges [**18] that there are few cases nationwide addressing eroding policies at all, much less in the context of stacking. It suggests, then, that even if *Garcia* requires the insured to select one policy under which obligations would be measured, we should allow the insured to select one policy for indemnity and another for defense, because of the eroding nature of the policies.

North American makes two arguments in support of this contention, unsupported by any precedent. First, North American argues that fairness dictates that the insured should get the benefit of having paid multiple premiums over the years. This argument would make sense if the Carr family were the only potential claimant in any of those years. But insurance is purchased to cover unintended, unexpected events, few or many, year after year. An insured who buys car insurance every year for twenty-five years and never has an accident is not entitled to a refund of premiums. He received what he bargained for -- insurance for each year.

Here, we have no information about other claimants, but it matters not whether they were few or many. The nursing home bargained for insurance year after year, and it received that insurance. If what [**19] it wanted was more coverage *each* year, it could obtain that by paying more -- as it did by buying the excess policies for two of the three years. If it wanted higher primary policy limits, it could obtain that by paying more for increased coverage. What it did instead was insure itself temporally under policies providing that related incidents involving one injured person constitute one claim, whether year after year or within one year.

Even more importantly, if the insured wanted a policy that had an unlimited defense obligation, rather than an eroding one, it should have contracted for such a policy. North American's argument would actually give the nursing home the benefit of an additional $ 1 million in defense costs coverage, despite its failure to contract for that coverage. Thus, the "fairness" argument [*560] is unpersuasive. [14]

14 Additionally, under *Garcia,* [HN10]the insured is entitled to select the policy that provides the most coverage from those potentially providing coverage, thereby allowing the insured to select an applicable year in which the individual or aggregate limits are the highest. *Garcia,* 876 S.W.2d at 855.

North American makes a second argument directed only at the Royal [**20] policies, citing the following policy language:

> The limits of this Coverage Part apply separately to each consecutive annual period and to any remaining period of less than 12 months, starting with the beginning of the policy period shown in the Declarations, unless the policy period is extended after Issuance for an additional period of less than 12 months. In that case, the additional period will be deemed part of the last preceding period for purposes of determining the Limits of Insurance.

North American argues that this language permits the limits to restart each year on a continuing medical incident, despite specific policy language to the contrary.

[HN11]"Interpretation of insurance contracts in Texas is governed by the same rules as interpretation of other contracts. . . . [W]hen a contract provision makes a general statement of coverage, and another provision specifically states the time limit for such coverage, the

more specific provision will control." *Forbau v. Aetna Life Ins. Co.,* 876 S.W.2d 132, 133-34 (Tex. 1994). Here, the policy specifically provides that all related medical incidents constitute one incident. The more general language quoted above does not purport to change [**21] this specific limitation; instead, it explains what generally happens to policy limits, including aggregate limits, if a policy is renewed or extended for an additional year or subset thereof. Thus, this language does not start a new limit of liability running in favor of the insured on the same medical incident.

C. Subject-Matter Stacking

This leads us to North American's last stacking argument. North American impliedly concedes that the actual settlement it paid was for a claim covered under the HPL portion of the policy. However, North American argues for a stacking of sorts as to the CGL and HPL portions of each policy for defense costs. North American reasons that Heritage Housing's defense actually triggered the CGL portion of the policies in lieu of or in addition to the HPL policies.

[HN12]Under Texas law, a duty to defend is determined under the "eight corners" rule. In Texas, "[t]he eight-corners rule provides that when an insured is sued by a third party, the liability insurer is to determine its duty to defend solely from terms of the policy and the pleadings of the third-party claimant. Resort to evidence outside the four corners of these two documents is generally prohibited." [**22] *GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church,* 197 S.W.3d 305, 307 (Tex. 2006). The duty to defend does not depend upon the truth or falsity of the allegations: "A plaintiff's factual allegations that potentially support a covered claim is [sic] all that is needed to invoke the insurer's duty to defend . . . ." *Id.* at 310 (citing *Heyden Newport Chem. Corp. v. S. Gen. Ins. Co.,* 387 S.W.2d 22, 26 (Tex. 1965)). North American contends that, under the eight corners rule, Royal was obligated to defend Heritage Housing under the CGL portion of the policy. Thus, it argues that at least another $ 1 million in policy limits are available here.

North American's contention is based upon the argument that, until 2005, Texas [*561] law treated claims for faulty supervision in a health care setting as "ordinary," rather than "health care" negligence claims. Under this argument, the claims against Heritage Housing for inadequate staffing and funding were not health care liability claims. Questions about what claims constitute health care liability claims often have arisen in Texas because health care liability claims are subject to strict pleading and proof requirements under Texas law. *See* TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.001-.507 [**23] (Vernon 2005) (replacing TEX. REV. CIV. STAT. ANN. art. 4590i (Vernon 2003)). Thus, the question of whether a claim was or was not a health care liability claim was important in contexts other than insurance. North American contends that the 2005 decision of *Diversicare Gen. Partner, Inc. v. Rubio,* 185 S.W.3d 842 (Tex. 2005) changed Texas law regarding what constitutes a health care liability claim, and made understaffing and underbudgeting claims "health care liability" claims for the first time. Thus, since the *Carr* litigation was defended before that date, North American reasons that the defense obligation should be viewed under the law existing at the time, making the claims against Heritage Housing CGL claims.

We need not decide whether subject-matter allocation of defense costs under an eroding policy is judged by the law at the time of defense or some time later, because North American's argument rests on a faulty premise. In fact, *Rubio* did not change Texas law. For at least a decade before *Rubio,* the Texas Supreme Court (and numerous intermediate appellate courts) had made clear that [HN13]a plaintiff's legal theories and labels do not control the question of whether a claim is a [**24] health care liability claim subject to (then existing) Article 4590i, known as the Medical Liability and Insurance Improvement Act ("MLIIA"). *Garland Cmty. Hosp. v. Rose,* 156 S.W.3d 541, 543-44 (Tex. 2004) (citing authorities dating back to 1994).

> Plaintiffs cannot use artful pleading to avoid the MLIIA's requirements when the essence of the suit is a health care liability claim. . . . To determine whether a cause of action falls under the MLIIA's definition of a "health care liability claim," we examine the claim's underlying nature. . . . If the act or omission alleged in the complaint is an inseparable part of the rendition of health care services, then the claim is a health care liability claim. . . . One consideration in that determination may be whether proving the claim would require the specialized knowledge of a medical expert.

Id. These same standards were used to determine *Rubio* as they had been in numerous cases before. Given the many cases defining health care claims by substance rather than form, *Rubio* was not some revolutionary change in Texas law.

[HN14]Under Texas law, HPL coverage like that in the Royal and Evanston policies provides for breaches of professional standards [**25] of health care, while CGL coverage provides for other non-care related negligence.

See generally *Utica Nat'l Ins. Co. of Tex. v. Am. Indem. Co.*, 141 S.W.3d 198, 201 (Tex. 2004) (addressing a professional services exclusion in a CGL policy). Mrs. Carr's suit was manifestly a claim alleging breach of professional care. North American points to a reference in Mrs. Carr's complaint to a corporate policy of underbudgeting and understaffing. However, this reference is not a claim of negligence unrelated to standards of professional care. It is not an actionable tort merely to underbudget or understaff. Rather, Mrs. Carr's allegation amounted to a claim of negligence because the alleged Heritage Housing policy of underbudgeting and understaffing *caused* the nursing home to [*562] deliver inadequate medical care to Mr. Carr. Indeed, the only way to know whether a nursing home is properly staffed is by resort to professional standards of care. This claim fell squarely within the HPL side of the policies at issue. The decision to defend the *Carr* case under the HPL coverage, rather than the CGL coverage, was proper, and North American's argument does not result in more coverage.

IV. CONCLUSION

[HN15]Texas law [**26] prohibits stacking policies that do not overlap to provide more coverage than the highest limits of any one policy. That rule applies to both the indemnity and defense portions of an eroding policy. Insureds who contract for an eroding policy are not entitled to a more favorable stacking rule than insureds who pay more for an unlimited defense. The primary insurers in this case defended and paid under their HPL policies, and the presence of CGL coverage does not provide more coverage for this medical incident. The district court's order granting summary judgment to Evanston and Royal is AFFIRMED.

PINE OAK BUILDERS, INC., PETITIONER, v. GREAT AMERICAN LLOYDS INSURANCE COMPANY, RESPONDENT

No. 06-0867

SUPREME COURT OF TEXAS

279 S.W.3d 650; 2009 Tex. LEXIS 30; 52 Tex. Sup. J. 348

February 7, 2008, Argued
February 13, 2009, Opinion Delivered

NOTICE:

PUBLICATION STATUS PENDING. CONSULT STATE RULES REGARDING PRECEDENTIAL VALUE.

SUBSEQUENT HISTORY: Rehearing denied by, Motion denied by Pine Oak Builders, Inc. v. Great Am. Lloyds Ins. Co., 2009 Tex. LEXIS 261 (Tex., May 1, 2009)

PRIOR HISTORY: [**1]
ON PETITION FOR REVIEW FROM THE COURT OF APPEALS FOR THE FOURTEENTH DISTRICT OF TEXAS.
Pine Oak Builders, Inc. v. Great Am. Lloyds Ins. Co., 2006 Tex. App. LEXIS 5950 (Tex. App. Houston 14th Dist., July 6, 2006)

CASE SUMMARY:

PROCEDURAL POSTURE: In a dispute arising from respondent insurer's denial of any duty to defend petitioner insured in lawsuits brought by five different homeowners alleging various construction defects, the Court of Appeals for the Fourteenth District of Texas affirmed a summary judgment relating to one of the suits that had been entered in favor of the insurer, but concluded the insurer had a duty to defend the four other suits. Both parties sought review.

OVERVIEW: The court of appeals also held that the Prompt Payment of Claims statute, Tex. Ins. Code Ann. §§ 542.051-.061, did not apply to an insurer's breach of its duty to defend under a liability policy. The court found that the insurer's argument that the insured's faulty-workmanship claims did not allege "property damage" caused by an "occurrence" under the terms of the policies was foreclosed by a prior case in which the court had held that a claim of faulty workmanship against a homebuilder was a claim for property damage caused by an occurrence under a commercial general liability (CGL) policy. The court held that the Prompt Payment of Claims statute applied to an insurer's breach of its duty to defend under a liability policy. In determining what triggered coverage under the parties' occurrence-based CGL policy, the court found that the actual-injury rule applied, under which property damage occurred during the policy period if actual physical damage to the property occurred during the policy period. The court concluded that evidence extrinsic to the eight corners of the policy and one of the underlying lawsuits could not be used to establish the insurer's duty to defend.

OUTCOME: The court affirmed in part and reversed in part the court of appeals' judgment, and remanded the case to the trial court for further proceedings. On remand, the trial court was to apply the actual-injury rule to any remaining disputes about whether the property-damage claims fell within the terms of the policies.

CORE TERMS: insurer's, duty to defend, coverage, insured, property damage, subcontractor, underlying suits, extrinsic evidence, defective work, policy language, occurrence, duty to indemnify, property-damage, summary judgment, homeowner, policy period, declaratory judgment, faulty workmanship, introduce, trigger, urges, occurrence-based, contradicts, insurance coverage, physical damage, legally obligated to pay, actual-injury, homebuilder, extrinsic, lawsuit

LexisNexis(R) Headnotes

Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Duty to Defend
Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Payments
[HN1]The Prompt Payment of Claims statute, Tex. Ins. Code Ann. §§ 542.051-.061, applies to an insurer's breach of its duty to defend under a liability policy.

Insurance Law > General Liability Insurance > Occurrences
[HN2]The Texas Supreme Court has adopted instead the actual-injury rule, under which property damage occurs during a policy period if actual physical damage to the property occurred during the policy period. The key date is when injury happens, not when someone happens upon it--that is, the focus should be on when damage comes to pass, not when damage comes to light.

Insurance Law > Claims & Contracts > Policy Interpretation > Parol Evidence > Extrinsic Evidence
Insurance Law > General Liability Insurance > Obligations > Allegations in Complaints
[HN3]Under the eight-corners rule, the duty to defend is determined by the claims alleged in a petition and the coverage provided in a policy. If a petition does not allege facts within the scope of coverage, an insurer is not legally required to defend a suit against its insured. Although the Texas Supreme Court has never expressly recognized an exception to the eight-corners rule, other courts have. Generally, these courts have drawn a very narrow exception, permitting the use of extrinsic evidence only when relevant to an independent and discrete coverage issue, not touching on the merits of the underlying third-party claim. Without recognizing an exception to the eight-corners rule, the Texas Supreme Court has held that any such exception would not extend to evidence that was relevant to both insurance coverage and the factual merits of the case as alleged by the third-party plaintiff.

Insurance Law > General Liability Insurance > Obligations > Allegations in Complaints
[HN4]If a petition only alleges facts excluded by a policy, an insurer is not required to defend.

Insurance Law > General Liability Insurance > Obligations > Allegations in Complaints
[HN5]A reviewing court will not read facts into the pleadings. Nor will it look outside the pleadings, or imagine factual scenarios that might trigger coverage. Instead, an insurer is entitled to rely solely on the factual allegations contained in the petition in conjunction with the terms of the policy to determine whether it has a duty to defend.

Insurance Law > Claims & Contracts > Policy Interpretation > Parol Evidence > Extrinsic Evidence
Insurance Law > General Liability Insurance > Obligations > Defense
[HN6]In deciding the duty to defend, a court should not consider extrinsic evidence from either an insurer or an insured that contradicts the allegations of the underlying petition. The duty to defend depends on the language of the policy setting out the contractual agreement between insurer and insured. A defense of third-party claims provided by the insurer is a valuable benefit granted to the insured by the policy, separate from the duty to indemnify. But the insurer's duty to defend is limited to those claims actually asserted in an underlying suit.

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview
[HN7]Interpretation of insurance contracts in Texas is governed by the same rules as interpretation of other contracts. When construing a contract, a court's primary concern is to give effect to the written expression of the parties' intent.

Insurance Law > General Liability Insurance > Obligations > Defense
Insurance Law > General Liability Insurance > Obligations > Indemnification
[HN8]The duty to defend and the duty to indemnify by an insurer are distinct and separate duties. The duty to indemnify protects insureds from payment of damages they may be found legally obligated to pay, while duty to defend protects the same parties against the expense of any suit seeking damages covered by the policy.

Insurance Law > General Liability Insurance > Obligations > Defense
Insurance Law > General Liability Insurance > Obligations > Indemnification
[HN9]The duty to defend turns on the factual allegations that potentially support a covered claim, while the facts actually established in the underlying suit control the duty to indemnify. The duty to defend protects an insured by requiring a legal defense to allegations without regard to whether they are true, but it does not extend to allegations, true or false, that have not been made.

JUDGES: JUSTICE WILLETT delivered the opinion of the Court.

OPINION BY: Don R. Willett

OPINION

[*651] Upon being sued by five different homeowners alleging various construction defects, Pine Oak Builders, Inc. made written demand on its insurers, including Great American Lloyds Insurance Co., for a de-

fense. When the insurers denied any duty to defend, Pine Oak sued for breach of the insurers' defense obligations. This coverage dispute revisits issues addressed in three of our recent cases, which decide some matters in Pine Oak's favor and some in Great American's favor.

I. Background

Great American issued occurrence-based commercial general liability (CGL) policies to Pine Oak, a homebuilder, covering April 1993 to April 2001. Another insurer, Mid-Continent Casualty Co., issued CGL policies covering April 2001 to April 2003. Between February 2002 and March 2003, five homeowners sued Pine Oak, alleging their homes suffered water damage because [*652] of defective construction. Four of the suits alleged improper installation of a synthetic stucco product known as an Exterior Insulation and Finish System (EIFS). The other suit, the Glass suit, alleged [**2] water damage due to improper design and construction of columns and a balcony.

The insurers denied Pine Oak's request for a defense in the homeowner suits, prompting Pine Oak to file this suit. The insurers in turn sought a declaratory judgment that they had no obligation to defend or indemnify Pine Oak. Both sides sought summary judgment--Pine Oak arguing its right to a defense and damages, and Great American arguing the policies did not cover the claims in the underlying suits. The trial court granted summary judgment for the insurers on all issues.

The court of appeals [1] affirmed the summary judgment for Mid-Continent because of an EIFS exclusion found in Mid-Continent's policies, and Pine Oak does not appeal this ruling. As for Great American, the court affirmed the summary judgment relating to the Glass suit, reasoning that it only alleged defective work by Pine Oak that was excluded under the policies' "your work" exclusion. However, the court concluded Great American had a duty to defend the four other homeowner suits, though Pine Oak could not recover statutory damages under the Prompt Payment of Claims statute [2] for Great American's failure to defend the suits. We granted the [**3] parties' cross-petitions. [3]

1 S.W.3d .
2 TEX. INS. CODE §§ 542.051-.061 (previously codified as TEX. INS. CODE art. 21.55).
3 240 S.W.3d 869, 50 Tex. Sup. Ct. J. at 1073-74 (Aug. 31, 2007).

II. Discussion

A. *Lamar Homes* -- Whether Faulty Workmanship Claims Are Covered and Whether Insurance Code Article 21.55 Applies

Great American urges us to hold that Pine Oak's faulty-workmanship claims do not allege "property damage" caused by an "occurrence" under the terms of the policies. This argument is foreclosed by *Lamar Homes, Inc. v. Mid-Continent Casualty Co*., where we held that a claim of faulty workmanship against a homebuilder was a claim for property damage caused by an occurrence under a CGL policy. [4] The relevant policy language in the Great American policies is identical to the policy language we construed in *Lamar Homes*. [5]

4 242 S.W.3d 1, 4-5, 16 (Tex. 2007).
5 Great American's briefing concedes that the occurrence and property-damage issues presented in this case are identical to the issues then pending in *Lamar Homes*.

Pine Oak asks us to reverse the court of appeals' holding that the Prompt Payment of Claims statute does not apply to an insurer's breach of its duty to defend under a liability policy. [**4] We agree, as *Lamar Homes* again controls, making clear [HN1]the statute does apply to such situations. [6]

6 *Lamar Homes*, 242 S.W.3d at 5, 20.

B. *Don's Building Supply* -- What Triggers Coverage Under an Occurrence-Based CGL Policy

The underlying suits concern homes built in 1996 and 1997. Great American's policies, consecutive one-year policies, cover the period from April 5, 1993 to April 5, 2001. On the question of whether Great American's policies were triggered under facts alleged in the underlying suits, the court of appeals followed the "exposure rule" for determining whether a property-damage claim is covered under an occurrence-based CGL policy. [7] Great American urges us to adopt the [*653] "manifestation rule" for deciding whether a property-damage claim is covered.

7 S.W.3d at .

We rejected both of these rules in *Don's Building Supply, Inc. v. OneBeacon Insurance Co*., [8] another case involving insurance coverage of EIFS claims. [HN2]We adopted instead the actual-injury rule, under which property damage occurs during the policy period if "actual physical damage to the property occurred" during the policy period. [9] As we explained in that case, "the key date is when injury happens, not when someone [**5] happens upon it"--that is, the focus should be on "when damage comes to pass, not when damage comes to light." [10] The policy language construed in *Don's Building Supply* is identical to the relevant language in Great American's policies. [11] So property damage occurred under the Great American policies "when a home that is the

subject of an underlying suit suffered wood rot or other physical damage." [12] On remand, the trial court should apply the actual-injury rule to any remaining disputes about whether the property-damage claims fall within the terms of the Great American policies.

8 267 S.W.3d 20 (Tex. 2008).
9 *Id.* at 24.
10 *Id.* at 22.
11 The Great American policies provided:

> We will pay those sums that the Insured becomes legally obligated to pay as damages because of . . . "property damage" to which this insurance applies. We will have the right and duty to defend any "suit" seeking those damages.
>
> . . . .
>
> This insurance applies to . . . "property damage" only if . . . the . . . "property damage" is caused by an "occurrence" . . . and . . . the . . . "property damage" occurs during the policy period.
>
> . . . .
>
> "Occurrence" means an accident, including continuous or repeated exposure to substantially [**6] the same general harmful conditions.
>
> . . . .
>
> "Property damage" means . . . physical injury to tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it.

12 *Don's Bldg.*, 267 S.W.3d at 24.

C. *GuideOne Elite* -- Extrinsic Evidence and the Eight-Corners Rule

The final issue is whether evidence extrinsic to the eight corners of the policy and the underlying lawsuit may be used to establish the insurer's duty to defend. Exclusion "*l*" of the CGL policy removes coverage for property damage to the insured's completed work. This exclusion contains an exception "if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor." As *Lamar Homes* explained, coverage therefore depends in part on whether the alleged defective work was performed by Pine Oak or a subcontractor. [13]

13 *See Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 11 (Tex. 2007) (describing identical policy language).

In four of the underlying suits against Pine Oak, the petitions expressly alleged defective work by one or more subcontractors. In the Glass case, the petition [**7] contains no allegations of defective work by a subcontractor. The petition asserted causes of action for breach of contract and warranty, violation of the Residential Construction Liability Act, [14] and negligence, based on Pine Oak's alleged failure to perform its work in a good and workmanlike [*654] manner and a failure to make requested repairs.

14 TEX. PROP. CODE §§ 27.001-.007.

In this coverage suit, Pine Oak submitted evidence that the defective work alleged in the Glass case was performed by subcontractors. Based on this extrinsic evidence, Pine Oak contends Great American had a duty to defend Pine Oak in the Glass case.

[HN3]Under the eight-corners rule, the duty to defend is determined by the claims alleged in the petition and the coverage provided in the policy. [15] "If a petition does not allege facts within the scope of coverage, an insurer is not legally required to defend a suit against its insured." [16]

15 *See Nat'l Union Fire Ins. Co. of Pittsburgh, PA, v. Merchs. Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141 (Tex. 1997); *Heyden Newport Chem. Corp. v. S. Gen. Ins. Co.*, 387 S.W.2d 22, 26 (Tex. 1965).
16 *Nat'l Union*, 939 S.W.2d at 141.

In *GuideOne Elite Insurance Co. v. Fielder Road Baptist* [**8] *Church*, issued six days before the court of appeals' decision in this case, the plaintiff in an underlying suit alleged that an employee of the insured had sexually abused her. [17] The insurer brought a declaratory judgment action to determine coverage. [18] The underlying third-party petition alleged that the abuse occurred from 1992 to 1994. [19] The insurer sought to introduce extrinsic evidence that the employee ceased working for the insured on December 15, 1992, before the insurance policy took effect. [20] We stated:

> Although this Court has never expressly recognized an exception to the eight-

> corners rule, other courts have. Generally, these courts have drawn a very narrow exception, permitting the use of extrinsic evidence only when relevant to an independent and discrete coverage issue, not touching on the merits of the underlying third-party claim. [21]

17 197 S.W.3d 305, 307 (Tex. 2006).
18 *Id.*
19 *Id.*
20 *Id.*
21 *Id.* at 308 (footnotes omitted).

Without recognizing an exception to the eight-corners rule, we held that any such exception would not extend to evidence that was relevant to both insurance coverage and the factual merits of the case as alleged by the third-party plaintiff. [22] We further [**9] reasoned that

> the extrinsic evidence here concerning Evans' employment directly contradicts the plaintiff's allegations that the Church employed Evans during the relevant coverage period, an allegation material, at least in part, to the merits of the third-party claim. Under the eight-corners rule, the allegation's truth was not a matter for debate in a declaratory judgment action between insurer and insured. [23]

22 *Id.* at 309.
23 *Id.* at 310. Our analysis in *GuideOne Elite* did not consider whether an exception to the eight-corners rule might exist where the parties to the underlying suit collude to make false allegations that would invoke the insurer's duty to defend, because the record did not indicate collusion. *Id.* at 311.

The extrinsic fact Pine Oak seeks to introduce in this coverage action contradicts the facts alleged in the Glass suit. The petition in the Glass suit alleges that Pine Oak agreed to construct the plaintiffs' house, that Pine Oak alone "constructed columns that provided inadequate support," "failed to properly seal seams," "negligently attempted to correct" a problem with the balcony, failed "to perform the work in a good and workmanlike manner," and failed "to make [**10] the repairs described [*655] above." These claims of faulty workmanship by Pine Oak are excluded from coverage under the "your work" exclusion. Faulty workmanship by a subcontractor that might fall under the subcontractor exception to the "your work" exclusion is not mentioned in the petition. [HN4]"If the petition only alleges facts excluded by the policy, the insurer is not required to defend." [24]

24 *Fid. & Guar. Ins. Underwriters, Inc. v. McManus*, 633 S.W.2d 787, 788 (Tex. 1982).

Pine Oak urges that the references in the Glass petition to Pine Oak as the culpable party can be read as either Pine Oak or one of its subcontractors. Unlike the petitions in the other four suits, the petition in the Glass case does not accuse any subcontractor--a separate legal entity--of defective work or other legally actionable conduct, nor does it allege that Pine Oak is liable under any theory for the conduct or work of a subcontractor. It does not allege negligent supervision of a subcontractor or any other third party. It alleges that Pine Oak alone is liable for its own actionable conduct. [HN5]"We will not read facts into the pleadings. . . . Nor will we look outside the pleadings, or imagine factual scenarios [**11] which might trigger coverage." [25] Instead, "an insurer is entitled to rely solely on the factual allegations contained in the petition in conjunction with the terms of the policy to determine whether it has a duty to defend." [26]

25 *Nat'l Union Fire Ins. Co. of Pittsburgh, PA, v. Merchs. Fast Motor Lines, Inc.*, 939 S.W.2d 139, 142 (Tex. 1997).
26 *Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 829 (Tex. 1997).

Pine Oak views *GuideOne Elite* as distinguishable because in that case the insurer was attempting to introduce extrinsic evidence to *limit* its duty to defend, whereas here Pine Oak, the insured, offered extrinsic evidence to *trigger* the duty to defend. This distinction is not legally significant.

[HN6]In deciding the duty to defend, the court should not consider extrinsic evidence from either the insurer or the insured that contradicts the allegations of the underlying petition. The duty to defend depends on the language of the policy setting out the contractual agreement between insurer and insured. [27] A defense of third-party claims provided by the insurer is a valuable benefit granted to the insured by the policy, separate from the duty to indemnify. [28] But the insurer's duty to [**12] defend is limited to those claims actually asserted in an underlying suit. Great American's policy provides that it shall "have the right and duty to defend any 'suit' seeking" damages for bodily injury or property damage covered by the policy. "Suit" is defined as "a civil proceeding in which damages because of [property damage

or other injuries] to which this insurance applies are alleged." The policy imposes no duty to defend a claim that might have been alleged but was not, or a claim that more closely tracks the true factual [*656] circumstances surrounding the third-party claimant's injuries but which, for whatever reason, has not been asserted. To hold otherwise would impose a duty on the insurer that is not found in the language of the policy. Such a construction would subject an insurer to common-law and statutory liability for failing to defend the insured against a third-party claim that has not been alleged, despite policy language limiting the duty to defend to claims that have been alleged.

27 *See* *Forbau v. Aetna Life Ins. Co.*, 876 S.W.2d 132, 133 (Tex. 1994) ("[HN7]Interpretation of insurance contracts in Texas is governed by the same rules as interpretation of other contracts. When [**13] construing a contract, the court's primary concern is to give effect to the written expression of the parties' intent." (citations omitted)).

28 *See* *Cowan*, 945 S.W.2d at 821-22 (noting that [HN8]"the duty to defend and the duty to indemnify by an insurer are distinct and separate duties."); *Heyden Newport Chem. Corp. v. S. Gen. Ins. Co.*, 387 S.W.2d 22, 25 (Tex. 1965) (noting that duty to indemnify protects insureds "from payment of damages they may be found legally obligated to pay," while duty to defend "protects the same parties against the expense of any suit seeking damages" covered by the policy).

Such a construction would also "conflate the insurer's defense and indemnity duties," since [HN9]the duty to defend turns on the "factual allegations that potentially support a covered claim," while "the facts actually established in the underlying suit control the duty to indemnify." [29] The duty to defend protects the insured by requiring a legal defense to allegations without regard to whether they are true, [30] but it does not extend to allegations, true or false, that have not been made. Great American's duty to defend was not triggered by the Glass petition in the record before us.

29 *GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church*, 197 S.W.3d 305, 310 (Tex. 2006).

30 *See* [**14] *Heyden Newport Chem. Corp.*, 387 S.W.2d at 24 ("We think that in determining the duty of a liability insurance company to defend a lawsuit the allegations of the complainant should be considered in the light of the policy provisions without reference to the truth or falsity of such allegations and without reference to what the parties know or believe the true facts to be, or without reference to a legal determination thereof.").

III. Conclusion

We affirm in part and reverse in part the court of appeals' judgment, and remand the case to the trial court for further proceedings consistent with this opinion.

Don R. Willett

Justice

OPINION DELIVERED: February 13, 2009

POTOMAC INSURANCE COMPANY OF ILLINOIS, Plaintiff-Counter Defendant-Appellant, v. JAYHAWK MEDICAL ACCEPTANCE CORPORATION; ET AL., Defendants, JAYHAWK MEDICAL ACCEPTANCE CORPORATION, Defendant-Counter Claimant-Appellee.

No. 99-10560 Summary Calendar

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

198 F.3d 548; 2000 U.S. App. LEXIS 28

January 4, 2000, Decided

PRIOR HISTORY: [**1] Appeal from the United States District Court for the Northern District of Texas, Dallas Division.

CASE SUMMARY:

PROCEDURAL POSTURE: Appellant challenged the ruling on summary judgment by the United States District Court for the Northern District of Texas, Dallas Division, which ruled that appellant had a duty to defend appellee, in three lawsuits under the terms of a comprehensive general liability insurance policy.

OVERVIEW: Appellee provided financing for elective surgeries and referred clients to doctors who performed such surgeries. Appellee was insured by appellant under a comprehensive general liability policy. Claims related to the rendition of professional services were specifically excluded from coverage. Appellee was sued by three persons who were dissatisfied with the results of their breast augmentation surgeries. After appellee submitted these claims to appellant for a defense, appellant filed a declaratory judgment action in federal court. The district court ruled that appellant had a duty to defend appellee in the lawsuits. On appeal, the court affirmed, because the act of referring patients to doctors to perform elective surgeries was not a "professional service" so as to be excluded from coverage under the general liability policy.

OUTCOME: Ruling was affirmed, because appellee's mere act of referring the patients to a doctor, without more, did not constitute a professional service and, therefore, the insurance policy's "professional services" exclusion did not apply to relieve appellant of its duty to defend.

CORE TERMS: professional services, doctor, referral, duty to defend, surgery, lawsuit, patient, ambiguity, insured, insurance contract, elective, coverage, insurer, summary judgment, insurance policy, specialized knowledge, writ denied, qualifications, specialized, susceptible, liability policy, counterclaim, policy definition, contract interpretation, reasonable construction, cause of action, citations omitted, profession, ambiguous, vocation

LexisNexis(R) Headnotes

Civil Procedure > Summary Judgment > Appellate Review > Standards of Review
Civil Procedure > Appeals > Standards of Review > De Novo Review
[HN1]The appellate court's review of a grant of summary judgment is de novo.

Civil Procedure > Appeals > Standards of Review > De Novo Review
Contracts Law > Contract Interpretation > General Overview
Insurance Law > Claims & Contracts > Policy Interpretation > Appellate Review
[HN2]The district court's interpretation of an insurance contract is reviewed de novo.

Contracts Law > Contract Interpretation > General Overview
Insurance Law > Claims & Contracts > Policy Interpretation > General Overview
[HN3]Texas courts interpret insurance contracts under the same rules that apply to contracts generally.

Contracts Law > Contract Interpretation > General Overview
Contracts Law > Defenses > General Overview
Contracts Law > Formation > Ambiguity & Mistake > General Overview

[HN4]In examining a summary judgment ruling relating to the construction of an insurance contract, the appellate court must first determine whether the applicable policy terms are ambiguous. If the terms of a contract are reasonably susceptible to two differing interpretations, then that contract is ambiguous.

Contracts Law > Defenses > Ambiguity & Mistake > General Overview
Contracts Law > Formation > Ambiguity & Mistake > General Overview
Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > General Overview
[HN5]Any ambiguity in a contract is resolved in favor of the insured.

Contracts Law > Defenses > Ambiguity & Mistake > General Overview
Contracts Law > Formation > Ambiguity & Mistake > General Overview
Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > Construction Against Insurers
[HN6]Under Texas law, an insurance contract will not be construed neutrally unless it is susceptible of only one reasonable construction. If multiple interpretations are reasonable, the court must construe the contract against the insurer, and this applies with special force when exceptions to liability are examined. These special rules favoring the insured, however, are applicable only when there is an ambiguity in the policy; if the exclusions in question are susceptible to only one reasonable construction, these rules do not apply.

Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > General Overview
[HN7]Not every difference in the interpretation of an insurance policy amounts to an ambiguity.

Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > General Overview
[HN8]Mere absence of a policy definition does not give rise to a finding of ambiguity.

Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Duty to Defend
Insurance Law > General Liability Insurance > Obligations > Defense
[HN9]Texas courts use the "eight corners" or "complaint allegation" rule when determining whether an insurer has a duty to defend.

Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Duty to Defend
Insurance Law > General Liability Insurance > Obligations > Defense
[HN10]To determine whether an insurer has a duty to defend its insured in a lawsuit, the allegations in the underlying suit must be considered in light of the provisions of the insurance policy.

Insurance Law > General Liability Insurance > Obligations > Defense
[HN11]The court's decision regarding the duty to defend is not influenced by facts ascertained before the suit, developed in the process of litigation, or by the ultimate outcome of the suit.

Insurance Law > Claims & Contracts > Good Faith & Fair Dealing > Duty to Defend
Insurance Law > General Liability Insurance > Obligations > Defense
[HN12]An insurer must defend an insured only when facts alleged in the complaint, if taken as true, potentially state a cause of action within the terms of the policy. As long as the complaint states at least one cause of action within the policy's coverage, the duty to defend attaches.

Insurance Law > General Liability Insurance > Obligations > Defense
[HN13]The mere act of referring a person to a doctor does not constitute a "professional service" as the phrase is defined in Texas.

Insurance Law > General Liability Insurance > Obligations > Defense
[HN14]It is clear that a professional must perform more than an ordinary task to perform a professional service. To qualify as a professional service, the task must arise out of the acts particular to the individual's specialized vocation. The court does not deem an act a professional service merely because it is performed by a professional. Rather, it must be necessary for the professional to use his specialized knowledge or training.

Insurance Law > General Liability Insurance > Obligations > Defense

[HN15]It is clear that the mere act of referring a patient to a doctor, without more, does not constitute a professional service.

Insurance Law > General Liability Insurance > Obligations > Defense

[HN16]To qualify as a professional service, the task must arise out of the acts particular to the individual's specialized vocation. It must be necessary for the professional to use his specialized knowledge or training.

COUNSEL: For POTOMAC INSURANCE COMPANY OF ILLINOIS, Plaintiff - Counter, Defendant - Appellant: Michael Anthony Hummert, Alexander Nelson Beard, Bishop & Hummert, Dallas, TX.

For JAYHAWK MEDICAL ACCEPTANCE CORPORATION, Defendant - Counter, Claimant - Appellee: Robert D Allen, Linda Marie Dedman, Baker Botts, Dallas, TX.

JUDGES: Before SMITH, BARKSDALE and PARKER, Circuit Judges.

OPINION BY: ROBERT M. PARKER

OPINION

[*549] Robert M. Parker, Circuit Judge:

Appellant, Potomac Insurance Company of Illinois ("Potomac"), appeals the district court's ruling on summary judgment that Potomac had a duty to defend Appellee, Jayhawk Medical Acceptance Corporation ("Jayhawk") in three lawsuits under the terms of a comprehensive general liability insurance policy. The specific issue on appeal is the district court's holding that a "professional services" exclusion in the policy did not apply to relieve Potomac of its duty to defend. Because we find that the services performed by Jayhawk were not "professional services," we AFFIRM.

FACTS AND PROCEEDINGS BELOW

Jayhawk provides financing for elective surgeries and refers clients to doctors who perform such surgeries. At all pertinent times referred to herein, Jayhawk was insured by Potomac under a comprehensive general liability policy. The policy provided coverage for "bodily injury" and "property damage" caused by an occurrence during the period covered by the policy. Claims [**2] related to the rendition of professional services are specifically excluded from coverage. The applicable exclusion reads:

> With respect to any professional services shown in the Schedule, this insurance does not apply to "bodily injury," "property damage," "personal injury," or "advertising injury" due to the rendering or failure to render any professional service.

In 1998, Jayhawk was sued by three persons who were dissatisfied with the results of their breast augmentation surgeries. [1] After Jayhawk submitted these [*550] claims to Potomac for a defense, Potomac filed a declaratory judgment action in federal court. [2] The district court ruled that the act of referring patients to doctors to perform elective surgeries is not a "professional service" so as to be excluded from coverage under this general liability policy and that Potomac had a duty to defend Jayhawk in the lawsuits.

> The question thus becomes whether referring patients to doctors and verifying their qualifications to perform elective surgery are inherent to the specialized knowledge Jayhawk brings to its business. Jayhawk argues that it simply arranges financing for patients and contracts with physicians. Of [**3] course, the point of making these contracts is to put doctors on a referral list; however, no specialized knowledge or skill particular to the business is required once these financial arrangements are made. Potomac has failed to prove that referrals themselves involve anything more than merely finding a local doctor who has arranged to participate in the program. The Court therefore concludes that the act of referring patients to doctors for elective surgery is not a "professional service" in the context of this particular case.

1 Two of the cases were filed against Jayhawk and the doctors who performed the surgeries. *See Lasoya v. Al-Marashi, M.D., et al.*, No. DV98-1835 (116th Dist. Ct., Dallas County, Texas); *Juarez v. Jayhawk Medical Acceptance Corp., et al.*, No. 798281 (Dist. Ct., Orange County, California). One case was initiated by Jayhawk, but the patient filed a counterclaim. *See Jayhawk Medical Acceptance Corp. v. Sarmiento*, No.

CV198-423AC (7th Dist. Ct., Clay County, Missouri).

2 Jayhawk asserted counterclaims for breach of contract, unfair claims settlement practices, breach of the duty of good faith and fair dealing and violations of the Texas Insurance Code. Neither party sought summary judgment regarding these claims.

[**4] Based on the general allegations of negligent referrals in each of the three complaints against Jayhawk and the fact that the mere act of referral does not constitute a "professional service," the Court held that Potomac had a duty to defend Jayhawk in the lawsuits.

STANDARD OF REVIEW

[HN1]Our review of a grant of summary judgment is *de novo*. *See Canutillo v. Indep. School Dist. v. National Union Fire Ins. Co.*, 99 F.3d 695, 700 (5th Cir. 1996). [HN2]In addition, the district court's interpretation of an insurance contract is reviewed *de novo*. *See id.*; *Principal Health Care v. Lewer Agency, Inc.*, 38 F.3d 240, 242 (5th Cir. 1994).

INSURANCE CONTRACT INTERPRETATION

In this case, Texas rules of contract interpretation control. *See Amica Mut. Ins. Co. v. Moak*, 55 F.3d 1093, 1095 (5th Cir. 1995). [HN3]Texas courts interpret insurance contracts under the same rules that apply to contracts generally. *See Barnett v. Aetna Life Ins. Co.*, 723 S.W.2d 663, 665 (Tex. 1987).

[HN4]In examining a summary judgment ruling relating to the construction of an insurance contract, we must first determine whether the applicable policy [**5] terms are ambiguous. *See Canutillo*, 99 F.3d at 700 (citing *Yancey v. Floyd West & Co.*, 755 S.W.2d 914, 917 (Tex. App.--Fort Worth 1988, writ denied)). If the terms of a contract are reasonably susceptible to two differing interpretations, then that contract is ambiguous. *See Coker v. Coker*, 650 S.W.2d 391, 393 (Tex. 1983). [HN5]Any ambiguity in a contract is resolved in favor of the insured. *See National Union Fire Ins. Co. v. Hudson Energy Co.*, 811 S.W.2d 552, 554 (Tex. 1991). This Circuit recently spoke on the effect that a contract's ambiguousness has on a court's construction of that contract.

> [HN6]Under Texas law, an insurance contract will be [*sic*] not be construed neutrally unless it is susceptible of only one reasonable construction. If multiple interpretations are reasonable, the court must construe the contract against the insurer, and this applies with special [*551] force when exceptions to liability are examined.

Travelers Indemnity Co. v. CITGO Petroleum Corp., 166 F.3d 761, 769 (5th Cir. 1999) (citing *Western Heritage Ins. Co. v. Magic Years Learning Centers and Child Care, Inc.*, 45 F.3d 85, 88 (5th Cir. 1988)). [**6] "These special rules favoring the insured, however, are applicable only when there is an ambiguity in the policy; if the exclusions in question are susceptible to only one reasonable construction, these rules do not apply." *Canutillo*, 99 F.3d at 701. [3]

3 [HN7]"Not every difference in the interpretation of an insurance policy amounts to an ambiguity." *Maryland Casualty Co. v. Texas Commerce Bancshares, Inc.*, 878 F. Supp. 939, 941 (N.D. Tex. 1995). Although the insured and the insurer take conflicting views of coverage, neither conflicting expectations nor dialectics are sufficient to create ambiguity. *Id.* (citing *Forbau v. Aetna Life Ins. Co.*, 876 S.W.2d 132, 134 (Tex. 1994)). [HN8]In addition, mere absence of a policy definition does not give rise to a finding of ambiguity. *See Harris Methodist Health Sys. v. Employers Reinsurance Corp.*, 1997 U.S. Dist. LEXIS 23660, No. 3:96- CV-0054, 1997 WL 446459, at *5 (N.D. Tex. July 25, 1997) (noting that "Texas courts have previously given meaning to the phrase 'professional services' where it has not been specifically defined in an insurance contract, reinforcing the idea that the absence of a policy definition does not create an ambiguity") (footnote omitted).

[HN9]

[**7] Texas courts use the "eight corners" or "complaint allegation" rule when determining whether an insurer has a duty to defend. *See Canutillo*, 99 F.3d at 701; *Duncanville Diagnostic Ctr., Inc. v. Atlantic Lloyd's Ins. Co.*, 875 S.W.2d 788, 789 (Tex. App.--Eastland 1994, writ denied) ("To [HN10]determine whether an insurer has a duty to defend its insured in a lawsuit, the allegations in the underlying suit must be considered in light of the provisions of the insurance policy."). [HN11]Our decision regarding the duty to defend is not influenced by "facts ascertained before the suit, developed in the process of litigation, or by the ultimate outcome of the suit." *Gulf Chem. & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, 1 F.3d 365, 369 (5th Cir. 1993) (quoting *American Alliance Ins. Co. v. Frito-Lay, Inc.*, 788 S.W.2d 152, 153-54 (Tex. App.--Dallas 1990, writ dism'd)).

[HN12]An insurer must defend an insured only when facts alleged in the complaint, if taken as true, "potentially state a cause of action within the terms of the policy." *Canutillo*, 99 F.3d at 701 (quoting *Gulf Chem.*, 1 F.3d at 369). [**8] As long as the complaint states at least one cause of action within the policy's coverage, the duty to defend attaches. *See* *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116, 119 (5th Cir. 1983).

DISCUSSION

Pursuant to the "eight corners rule" we will examine each of the three complaints in the underlying lawsuits involving Jayhawk in light of the general liability policy and the "professional services" exclusion contained therein to determine whether Potomac is obligated to defend Jayhawk. As the district court noted, the patients all generally alleged negligent referrals on the part of Jayhawk; however, only two plaintiffs allege that Jayhawk made specific representations as to the competency of the doctors who performed the surgeries.

The Sarmiento Case.

Julia Sarmiento alleged negligent referral and negligent investigation of Dr. John Baeke's qualifications against Jayhawk in a counterclaim. In her negligent referral allegation, Ms. Sarmiento fails to allege that Jayhawk did anything beyond merely referring her to Dr. Baeke. Because mere referrals are administrative, or ministerial tasks that do not fall within the exclusion for "professional services," [**9] we affirm the district court's ruling the Potomac must defend Jayhawk in the lawsuit brought by Ms. Sarmiento.

[HN13]The mere act of referring a person to a doctor does not constitute a "professional service" as the phrase is defined in Texas. Recently, the Texas Court of Appeals held that an attorney's solicitation letter sent to [*552] a prospective client, which does not include any legal advice, did not fall within an insurance policy exclusion exempting "designated professional services." *See* *Atlantic Lloyd's Ins. Co. v. Susman Godfrey*, 982 S.W.2d 472, 478 (Tex. App. 1998--Dallas, writ denied). The Court of Appeals gave the following statement regarding "professional service":

> [HN14]It is clear that a professional must perform more than an ordinary task to perform a professional service. To qualify as a professional service, the task must arise out of the acts particular to the individual's specialized vocation. We do not deem an act a professional service merely because it is performed by a professional. Rather, it must be necessary for the professional to use his specialized knowledge or training.

Susman Godfrey, 982 S.W.2d at 476-77 (citations [**10] omitted). *See also* *Duncanville*, 875 S.W.2d at 790 ("In some sense, of course, a profession involves labor, skill, education, special knowledge and compensation or profit."). [HN15]It is clear that the mere act of referring a patient to a doctor, without more, does not constitute a professional service. Therefore, we affirm the district court's ruling with respect to Ms. Sarmiento. Potomac must defend Jayhawk in this suit.

The Lasoya and Juarez Cases

The remaining two complaints against Jayhawk, allege more than mere referrals in their negligent referral claims. The Lasoya complaint and the Juarez complaint allege that Jayhawk made specific statements regarding the competency of the doctors to whom Ms. Lasoya and Ms. Juarez were referred. Although an allegation that Jayhawk represented that these doctors were competent goes beyond a mere referral, such an allegation does not constitute the performance of a "professional service" as defined by Texas courts.

[HN16]"To qualify as a professional service, the task must arise out of the acts particular to the individual's specialized vocation. . . . It must be necessary for the professional to use his specialized knowledge or [**11] training." *Susman Godfrey*, 982 S.W.2d at 476-77 (citations omitted). Jayhawk is not in a profession. It provides financial assistance to persons seeking elective operations not otherwise covered by insurance. In addition, Jayhawk's knowledge relates to financial matters, not to doctor qualifications. Therefore, a referral that represents that a particular doctor is qualified does not constitute a "professional service" under the facts of this case. Potomac has a duty to defend Jayhawk in these two cases as well.

CONCLUSION

For the above-stated reasons, we AFFIRM the district court's ruling that Potomac has a duty to defend Jayhawk in the three lawsuits filed by Ms. Sarmiento, Ms. Lasoya and Ms. Juarez.

ST. PAUL FIRE & MARINE INSURANCE COMPANY, Plaintiff, v. HONG HUN CHONG, SUN HO CHANG, and SANG YONG KIM, Defendants.

CIVIL ACTION NO. 91-2141-O

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF KANSAS

787 F. Supp. 183; 1992 U.S. Dist. LEXIS 5589

March 2, 1992, Decided
March 2, 1992, Filed

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff insurer filed an action for declaratory relief to determine the policy limits of a professional liability insurance policy.

OVERVIEW: The court found that the constitutional rights to effective assistance of counsel of defendants, resident aliens, had been denied by attorney's representation in their criminal matter. Their convictions were declared void. Thereafter, each of the aliens filed separate legal malpractice actions against the attorney. The attorney, his insurer, and the aliens each reached separate agreements allowing each of them to secure a judgement against the attorney for $ 100,000. The insurer brought an action for declaratory relief to determine the policy limits. It argued that the amount of coverage provided was limited to a total of $ 100,000 for the claims of all three aliens. The aliens, in opposition, claimed that they were each entitled to recover $ 100,000. The district court found that the phrase "series of related wrongful acts" was ambiguous. Therefore the term "related" as used in the policy at issue was defined solely in terms of causation. Hence, the court found that the damages arose out of negligent acts and omissions in the separate and distinct professional services provided. Therefore, the aliens were each entitled to recover $ 100,000.00 under the terms of the policy.

OUTCOME: The district court held that the aliens were each entitled to recover $ 100,000 under the terms of the professional liability insurance policy.

CORE TERMS: wrongful act, omission, negligent acts, habeas corpus petitions, ambiguous, interpreter, ambiguity, insured, logical, guilty plea, withdraw, coverage, limits of liability, pro se, assistance of counsel, malpractice, favorable, plead guilty, proximate result, erroneously, rules of construction, insurance policies, professional services, liability policy, criminal convictions, rights to recover, entitled to recover, causal connections, per occurrence, recommendation

LexisNexis(R) Headnotes

Insurance Law > Claims & Contracts > Policy Interpretation > General Overview
[HN1]If a dispute arises as to the meaning of the terms chosen by the parties, courts will attempt to determine what the parties intended. To determine this intent, courts will consider the policy as a whole and will examine the language used by the parties, taking into account the situation of the parties, the nature of the subject matter, and the purpose to be accomplished.

Insurance Law > Claims & Contracts > Policy Interpretation > Plain Language
[HN2]If there is no uncertainty about the meaning of the insurance policy, it will be enforced as written.

Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > General Overview
[HN3]If there is uncertainty about the meaning of the insurance policy, courts determine the meaning by applying rules of construction. These rules do not apply unless the court first determines that the policy is ambiguous. A policy is not ambiguous unless, viewing it as a whole, there is genuine uncertainty as to which one of two or more possible meanings is the proper meaning. Ambiguity may not be created by viewing the policy in fragmentary segments. And the rules of construction do not authorize a perversion of the language, or the exercise of inventive powers for the purpose of creating an ambiguity where none exists.

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FOR SAG YONG KIM, a citizen of the Republic of Korea, defendant, Veronica Jongenelen, Benson & McKay, 1000 Walnut, Suite 1125, Kansas City, MO 64106, 816-842-7603. Rayborn C Johnson, Jr, Bartley & Johnson, 14825 St Mary's Lane - Ste. 280, Houston, TX 77079, 713-531-0501.

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JUDGES: O'CONNOR

OPINION BY: EARL E. O'CONNOR

OPINION

[*184] MEMORANDUM AND ORDER

This matter is before the court on plaintiff St. Paul Fire & Marine Insurance Company, Inc.'s ("St. Paul's") motion for discharge and enjoinment (Doc. #21). St. Paul filed this action for declaratory relief to determine the policy limits of a professional liability insurance policy. Having reviewed St. Paul's motion, the court is now prepared to rule.

Factual Background

The relevant facts are undisputed: [1]

1 St. Paul has entered into factual stipulations with each of the defendants. Because the stipulations are nearly identical, the court will rely heavily on them for purposes of setting forth the factual background of this case.

1. Defendants Hong Hun Chong ("Chong"), Sun Ho Chang ("Chang"), and Sang Yong Kim ("Kim") are citizens of the Republic of Korea and are lawful resident aliens.

2. Kent Owen Docking ("Docking") is a Kansas [**3] attorney licensed to practice before the Supreme Court of the State of Kansas and the United States District Court for the District of Kansas. Docking was admitted to practice on September 20, 1985.

3. On May 24, 1986, Chong, Chang, and Kim were arrested. Each was subsequently charged in the District Court of Leavenworth County, Kansas, with two counts of aggravated kidnapping.

4. At the time of their respective arrests, the three defendants understood little, if any, English.

5. The factual allegations supporting the criminal charges all occurred at or about the same time. Further, the complaining witnesses were the same against all three defendants.

6. Shortly after the arrests, Docking agreed to provide legal representation to each of the three defendants. [2] In turn, each of the defendants paid Docking a retainer of $ 5,000. Docking assumed legal representation of the three defendants in spite of his lack of felony jury trial experience, lack of experience in representing non-English speaking persons, lack of experience on immigration law consequences that might arise from criminal proceedings, and with knowledge that Chong had given a written statement to law enforcement officers [**4] possibly implicating Kim and Chang.

2 The record is not clear how Docking came into contact with each of the defendants.

7. Proceedings before the District Court of Leavenworth County, Kansas, were not simultaneously, properly, and/or adequately translated for the three defendants from English into Korean because Docking only secured one interpreter to be shared by the three defendants, and this retained interpreter did not simultaneously and/or properly during court proceedings translate from English into Korean and vice versa. Further, Docking failed to inquire into and establish the qualifications [*185] of the retained interpreter on the court record as required by Kansas law.

8. After little, if any, investigation or research, Docking recommended to each defendant, without adequate and complete explanation, that each should plead guilty to the counts charged. In so doing, Docking informed each defendant that each would receive proba-

tion, rather than a prison sentence, if the court-ordered pre-sentence investigations [**5] were favorable. If such investigations were not favorable, Docking advised, the trial judge would then allow each defendant to withdraw his "guilty" plea and to proceed to trial. In advising the three defendants in this manner, Docking failed to explain to them the consequences of pleading guilty. Further, Docking failed to understand that the word "plea," as commonly used in the legal system, did not have the same meaning as that word is usually and commonly understood in the Korean language and as was understood by each of the three defendants.

9. On September 5, 1986, in reliance on Docking's recommendations, each of the three defendants plead guilty to the charges against them.

10. On October 6, 1986, four days before the scheduled sentencing hearings, Docking filed with the District Court of Leavenworth County separate motions on behalf of each defendant requesting that each be allowed to withdraw the guilty pleas previously entered. The basis for each motion was that there had been mistakes in translations by both the court's interpreter and the interpreter retained by Docking and that each of the defendants had accordingly failed to understand the terms and conditions of their [**6] guilty pleas.

11. On October 10, 1986, the trial judge heard the motions to withdraw guilty pleas. Docking called no witnesses in support of the motions. The trial judge denied each of the motions and sentenced each defendant to the custody of the Secretary of Corrections of the State of Kansas.

12. Subsequent to the sentencings, Docking erroneously informed each of the defendants that they could not appeal the trial judge's rulings on the motions to withdraw guilty pleas.

13. Subsequently, the Attorney General of the United States, through the Immigration and Naturalization Service, issued separate orders to each of the defendants to show cause why, because of their criminal convictions, they should not be deported from the United States pursuant to 8 U.S.C. § 1251. At no time during Docking's representation of the three defendants had he advised any of them that they could be deported from the United States upon being convicted of the charges against them. Further, Docking failed to advise each of the defendants that they had a right to request from the District Court of Leavenworth County a recommendation against deportation pursuant to 8 U.S.C. § 1251(b)(2). Finally, although [**7] each of the defendants had informed Docking that they wanted to become American citizens, Docking failed to inform them that criminal convictions might make each of them ineligible for such citizenship pursuant to 8 U.S.C. § 1427.

14. Following the convictions, Docking informed each of the defendants of their right to file habeas corpus petitions. However, Docking erroneously informed each defendant that, because of their confinement, they would have to file pro se petitions. Further, Docking erroneously advised each defendant that such petitions could only be filed in federal court.

15. On December 23, 1987, Chong, with assistance from a so-called "jail-house lawyer" at the Kansas State Penitentiary and without any assistance from Docking, filed a pro se habeas corpus application pursuant to K.S.A. 60-1507 with the District Court of Leavenworth County, seeking release on the grounds of ineffective assistance of counsel.

16. On November 18, 1988, Chang and Kim each filed similar pro se habeas corpus petitions with the District Court of Leavenworth County alleging ineffective assistance of counsel.

17. On December 6, 1988, the District Court of Leavenworth County held a hearing on the [**8] habeas corpus petitions. After [*186] hearing testimony and receiving a variety of exhibits, the court found that each of the defendants' federal and state constitutional rights to effective assistance of counsel had been denied. Accordingly, the court sustained each of the petitions and declared each of the convictions to be void.

18. The parties have stipulated to the negligent acts and omissions of Docking. With respect to Docking's representation of Chong, the parties have listed 25 separate negligent acts and omissions on the part of Docking. With respect to Docking's representation of Chang, the parties have also listed 25 separate negligent acts and omissions on the part of Docking. Finally, with respect to Docking's representation of Kim, the parties have listed 26 separate negligent acts and omissions on the part of Docking. Although Docking's actions and omissions are similar with respect to each defendant, they are not identical.

19. As a direct and proximate result of Docking's negligence, each of the defendants was incarcerated.

20. As a direct and proximate result of Docking's negligence, each of the defendants was unable to work for approximately 30 months and suffered resulting [**9] losses of wages, benefits, and social security contributions.

21. As a direct and proximate result of Docking's negligence, each of the defendants has suffered severe mental anguish, humiliation, pain and suffering, loss of freedom, and emotional distress. Further, each defendant has incurred legal and translation expenses in successfully prosecuting their habeas corpus petitions and in seeking dismissal of their deportation proceedings.

22. At all material times, Docking was an insured of St. Paul under a professional liability insurance policy. The policy provides coverage limits of $ 100,000 for "each wrongful act." Further, the policy provides, in pertinent part, as follows:

Limits of Coverage

The limits shown in the Coverage Summary and the information contained in this section fix the most we'll pay regardless of the number of:

* protected persons;

* claims made or suits brought; or

* persons or organizations making claims or bringing suits.

Each wrongful act limit. This is the most we'll pay for all claims that result from a single wrongful act or a series of related wrongful acts.

The policy provides that the term "wrongful acts" shall include "error[s], omission(s) [**10] or negligent act(s) committed in the performance of legal or notary services." However, the policy does not define the phrase "series of related wrongful acts."

23. Subsequent to their release from confinement, each of the defendants filed separate legal malpractice actions against Docking. Docking, St. Paul, and the defendants each reached separate agreements allowing each of the defendants to "secure a judgement against Docking for $ 100,000.00 in return for a Covenant Not To Execute against any assets other than those provided Docking under the terms of his liability policy."

Discussion

St. Paul argues that the amount of coverage provided under the policy at issue is limited to a total of $ 100,000.00 for the claims of all three defendants. In support of its argument, St. Paul argues that the negligent acts and omissions committed by Docking with respect to all defendants constitute a "series of related wrongful acts." Stated differently, St. Paul asserts that the claims made by Chong, Chang and Kim all resulted from a "series of related wrongful acts."

Defendants, in opposition to St. Paul's argument, claim that they are each entitled to recover $ 100,000.00 under the terms [**11] of the policy. In support of this argument, defendants assert that Docking owed each of them a separate duty of care and that his negligence constituted a separate series of wrongful acts as to each defendant.

As the parties' arguments suggest, the critical issue in this case is the interpretation of the phrase "series of related wrongful acts" as contained in Docking's policy [*187] of insurance. Before analyzing this phrase, however, the court first turns to the general rules for construction of insurance policies.

In Penalosa Co-op v. Farmland Mut. Ins. Co., 14 Kan. App.2d 321, 789 P.2d 1196 (1990), the Kansas Court of Appeals noted:

[HN1]If a dispute arises as to the meaning of the terms chosen by the parties, courts will attempt to determine what the parties intended. To determine this intent, courts will consider the policy as a whole and will examine the language used by the parties, taking into account the situation of the parties, the nature of the subject matter, and the purpose to be accomplished. (Citations omitted.)

[HN2]If there is no uncertainty about the meaning of the policy, it will be enforced as written. (Citations omitted.)

[HN3]If there is uncertainty [**12] about the meaning of the policy, courts determine the meaning by applying rules of construction. These rules do not apply unless the court first determines that the policy is ambiguous. A policy is not ambiguous unless, viewing it as a whole, there is genuine uncertainty as to which one of two or more possible meanings is the proper meaning. (Citation omitted.) Ambiguity may not be created by viewing the policy in fragmentary segments. (Citations omitted.) And the rules of construction do not "'authorize a perversion of the language, or the exercise of inventive powers for the purpose of creating an ambiguity where none exists.'" (Citation omitted.)

Id. at 323-24.

Turning now to the policy at issue, the court finds that the phrase "series of related wrongful acts" is ambiguous. In particular, the use of the term "related," which itself has no accepted legal definition, allows the entire phrase to be construed in many different ways. [3] Notably, a review of the few cases interpreting similar policy language demonstrates that there is a general lack of agreement among the courts on the meaning and clarity of the term "related." See Gregory v. Home Ins. Co., 876 F.2d 602, 605-06 (7th Cir. 1989) [**13] (court in dicta suggested that the word "related" would include "a very broad range of connections, both causal and logical."); Arizona Property & Casualty Ins. Guar. Fund v. Helme, 153 Ariz. 129, 735 P.2d 451, 456-57 (1987) (holding that the term "related," as used in a professional liability policy, referred only to causal connections); Bay Cities Paving & Grading, Inc. v. Lawyers' Mutual Ins. Co., 233 Cal.App.3d 1184, 285 Cal. Rptr. 174 (1991) (holding that failure to define term "related" as used in

"limits of liability" clause of professional malpractice policy created ambiguity in policy that would be construed in favor of insured); see also Penalosa, 14 Kan.App.2d at 327-28 (holding that provision of employee dishonesty policy that defined "occurrence" as related acts during policy period was ambiguous). A finding of ambiguity is further supported by a review of Docking's answers to interrogatories in the malpractice actions filed against him by the defendants. Specifically, Docking responded in an initial set of interrogatories that the limits of liability under the policy were [**14] "$ 100,000.00 per person, $ 300,000.00 per occurrence." Docking later filed a supplemental answer in which he stated that he had been informed by St. Paul that under the policy the limits of liability were "$ 100,000.00 for each wrongful act and $ 300,000.00 total limit for all wrongful acts reported in a policy year." Although such responses are not controlling, they certainly suggest that the insured himself was unsure of the meaning of the policy limitations.

3 In its reply memorandum, St. Paul recites definitions of the term "related" as found in Black's Law Dictionary and Webster's Ninth New Collegiate Dictionary. A review of these definitions indicates that the term covers an incredibly broad, and certainly subjective, range of connections.

Because the court finds that the term "related" and the phrase "series of related wrongful acts" are ambiguous, the court will construe the policy in the way most favorable to the insured. Farm Bureau Mut. Ins. Co. v. Old Hickory Casualty Ins. Co., 248 Kan. 657, 659, 810 P.2d 283 [*188] (1991). [**15] The court therefore finds that the term "related" as used in the policy at issue should be defined solely in terms of causation. See Hermes, 735 P.2d at 456; Bay Cities, 285 Cal. Rptr. at 177. Further, the court finds that the phrase "series of related wrongful acts" refers only to "multiple, causally connected" negligent acts or omissions. [4] Hermes, 735 P.2d at 457.

4 As noted by the Hermes court, this construction is consistent with cases that have defined "per occurrence" clauses in terms of causative acts. 735 P.2d at 457.

Interpreting the facts of this case in light of the policy provisions, the court finds that the claims of the defendants did not arise out of a "series of related wrongful acts." Rather, the court finds that there were multiple discrete omissions and actions on the part of Docking which resulted in discrete losses to each of the three defendants. [5] See Continental Casualty Co. v. First Arlington Investment Corp., 497 So.2d 726 (Fla. Dist. Ct. App. 1986) [**16] (holding that the damages to two clients of the same attorney arose from attorney's acts or omissions in separate and distinct professional services that should have been provided to each client). Without engaging in a lengthy review of an attorney's obligations to his clients, the court notes, as have the defendants, that Docking owed separate duties to each of the three defendants. In order to protect the individual interests of Chang, Chong and Kim, "it was necessary for [Docking] to render separate services which were distinct to each of them." [6] Continental, 497 So.2d at 728. Accordingly, the court finds that defendants' damages arose out of negligent acts and omissions "in separate and distinct professional services [Docking] provided, or should have provided. . . ." Id. The court therefore finds that the defendants are each entitled to recover $ 100,000.00 under the terms of the policy.

5 For example, Docking's wrongful acts with respect to defendant Chang had no causal connection to Docking's wrongful acts with respect to defendant Kim.

6 Even focusing solely on Docking's advice to each defendant to plead guilty, the court finds that such acts are separate wrongful acts. Although the criminal charges may have arisen out of the same set of events, each defendant clearly was in a different position and arguably had his own set of defenses. Further, each defendant was arguably at a different level with respect to his ability to speak and understand English. In short, each defendant brought a unique set of circumstances with him which should have been considered by Docking in deciding how to advise each defendant.

[**17] Even if the court were to accept a broader definition of the term "related,", the court would nonetheless reach the same conclusions with respect to the defendants' rights to recover under the policy. In Gregory, a case heavily relied upon by St. Paul, the court suggested that the term "related" would cover "a very broad range of connections, both causal and logical." [7] 876 F.2d at 606. Accepting this definition, for purposes of argument, the court finds no "logical" connection between the errors and omissions Docking committed with respect to each of the three defendants. Although the errors and omissions grew out of highly similar factual situations, Docking had a separate duty to each client and was rendering separate services to each. Accordingly, the court finds no "logical" connection between such services for purposes of Docking's insurance policy.

7 The court notes that the facts of the instant case make it clearly distinguishable from Gregory.

As a final matter, the court notes that [**18] defendant Chang has filed a motion entitled "Motion for Garnishment" (Doc. #26). In light of the court's finding with respect to the policy and the defendants' rights to recover thereunder, the court finds it unnecessary to grant Chang's motion.

IT IS THEREFORE ORDERED that plaintiff's motion for discharge and enjoinment (Doc. #21) is denied.

IT IS FURTHER ORDERED that defendant Chang's motion for garnishment (Doc. #26) is denied.

IT IS FURTHER ORDERED that the motions for summary judgment on the cross claims (Doc. #32, #34, and #39) are denied as moot.

[*189] IT IS FURTHER ORDERED that this action is hereby dismissed.

Dated this 2nd day of March, 1992, at Kansas City, Kansas.

EARL E. O'CONNOR

United States District Judge