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DECISIONS

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- Kentucky appellate court recognizes cause of action for a hospital's negligent credentialing of physicians

COLORADO'S HIGHEST COURT REFUSES TO EXTEND PREJUDICE REQUIREMENT TO ENFORCEMENT OF VOLUNTARY PAYMENTS PROVISION

On April 25, 2016, the Colorado Supreme Court ruled that policyholders that settle claims pre-suit without first obtaining an insurance carrier's consent are not entitled to coverage under the insurance policy. In *Travelers Property Cas. Co. v. Stresscon Co.,* 2016 WL 1639565 (Colo. Apr. 25, 2016), the insured (a concrete company) entered into a settlement agreement with its general contractor relating to claims arising from a serious construction accident that involved injuries to a crane operator who had a subcontract with the insured. The settlement agreement, which was entered into without consulting with Travelers, included the payment of money associated with the crane accident and other unrelated and uncovered claims. The insured sought coverage for the settlement. A coverage action was subsequently filed and Travelers moved for summary judgment based upon the voluntary payments provision contained in the insurance policy. The provision stated that the insured will not, except at the insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without the insurer's consent. The district court denied the motion, finding by analogy that the "notice-prejudice" rule adopted by the Colorado Supreme Court in *Friedland v. Travelers Indemnity Co.*, 105 P.3d 639 (Colo. 2005) applied such that Travelers would only be relieved of its indemnification obligations if it suffered prejudice from the settlement. The trial court denied Travelers' motion on the grounds that the issue of prejudice involved disputed matters of fact which could not be resolved through summary judgment. The court of appeals affirmed the trial court rulings based upon the notice-prejudice rule adopted in *Friedland*. The Colorado Supreme Court disagreed. Writing for the majority, Justice Nathan Coast held that "[t]his so-called 'no voluntary payments' clause clearly excluded from coverage any payments voluntarily made or obligations voluntarily assumed by the insured without consent, for anything other than first aid." "The insurance policy emphatically stated that any such obligations or payments would be made or assumed at the insured's own cost rather than by the insurer." In distinguishing the case from *Friedland*, the Court noted that the *Friedland* case dealt with the policyholder's failure to give timely notice of a claim and that decision does not implicitly extend the notice-prejudice rule to no-voluntary-payments or similar "consent to settle" provisions. The Court further noted that the voluntary payments provision is "far from a mere technicality" but, rather, it defines the limits and extent of coverage under the policy. If the court accepted the insured's argument, the Court reasoned, insurers would effectively be denied the ability to have a say in defending their policyholders against third-party claims or negotiating settlements of those claims. Because the court declined to extend the notice-prejudice rule to the voluntary payments provision, the insured's settlement was not covered under the Travelers' policy. In her dissent, Justice Monica Marquez disagreed and noted that the insured should be afforded an opportunity to rebut a presumption that the insurer suffered actual prejudice.

"Travelers' efforts to parse alternative dictionary definitions do not absolve it of the duty to defend."

Fourth Circuit Court of Appeals Holds That Data Breach Is Covered Under Liability Policy

On April 11, 2016, the United States Court of Appeals for the Fourth Circuit concluded that a general liability insurer was obligated to defend a medical records company against a class action claim that its failure to secure a server caused records to be accessed by unauthorized users. *Travelers Indemnity Co. of America v. Portal Healthcare Solutions, LLC*, 2016 WL 1399517 (4th Cir. Apr. 11, 2016). The coverage action stemmed from an underlying putative class action lawsuit filed in New York state court in 2013 claiming that Portal negligently failed to secure a server containing confidential medical records at a hospital located in Glenn Falls, New York. The data breach allowed anyone to view patient records online and two patients had discovered the public nature of the records when searching for themselves on Google. Travelers issued two general liability policies to Portal that provided coverage for electronic publication of material under the personal and advertising coverage section of the policy. In an August, 2014 decision, Judge Gerald Bruce Lee of the United States District Court for the Eastern District of Virginia held that Travelers had a duty to defend Portal because the claimants alleged that the insured had published the confidential patient data thereby triggering coverage under the personal and advertising injury coverage under the policies. Travelers had denied coverage and argued that the coverage grant was not triggered because the insured did not intend to publish the material and there was no evidence that any third parties viewed the information. Judge Lee disagreed and held that "[p]ublication occurs when information 'is placed before the public,' not when a member of the public reads the information placed before it." In the unpublished decision, a panel of the Fourth Circuit endorsed the rationale employed by Judge Lee and held that the Judge correctly applied the eight-corners rule in determining Travelers' duty to defend and noted that Judge Lee properly recognized that if Travelers did not intend to provide coverage for the data breach, it must use language clear enough to avoid ambiguity. The panel held that "[g]iven the eight corners of the pertinent documents, Travelers' efforts to parse alternative dictionary definitions of 'publication' do not absolve it of the duty to defend."

Georgia Supreme Court Clarifies Rules on Spoliation of Evidence

In a June, 2015 decision issued by the Supreme Court of Georgia, the Court addressed a party's duty to preserve evidence in a case involving a hospital's inability to locate and produce paper fetal monitoring strips in a case involving a child born with severe neurological injuries. *Phillips v. Hermon*, 774 S.E.2d 596 (Ga. 2015). In *Phillips*, the plaintiff claimed that the hospital's negligence caused her child to suffer oxygen deprivation shortly before birth resulting in severe and permanent neurological injuries. The jury returned a verdict in favor of the hospital and others in the malpractice lawsuit. The plaintiff filed a motion for a new trial based upon the judge's failure to give her requested instruction on spoliation of evidence but the motion was denied. Plaintiff argued that the hospital destroyed the printed fetal monitoring strips (which also contained nursing notes) sometime after delivery of the child when the defendant was aware of the potential for litigation and was therefore entitled to a presumption that the strips would have been prejudicial to the defendants. The trial court denied the instruction on the grounds that the defendant "had no knowledge or notice of potential litigation." The intermediate appellate court agreed but the Supreme Court reversed the rulings. The Court noted that the holding of the lower courts rested on the incorrect premise that a defendant's duty to preserve evidence required notice of a claim or litigation from a plaintiff without regard to other circumstances—such as the type and extent of the injuries, the high damages that could flow from the injuries, the frequency of litigation in these circumstances, and the defendant's internal investigation and notification to its counsel or insurer. The court concluded that a spoliation claim and instruction could proceed.

Sixth Circuit Court of Appeals Holds That Notice-Prejudice Rule Does Not Apply to Excess Claims Made Policy

In a decision issued on February 29, 2016, the United States Court of Appeals for the Sixth Circuit upheld the dismissal of a hospital's lawsuit against its excess insurer seeking coverage for the hospital's $41 million settlement with the government because the hospital notified the insurer too late. *Ashland Hospital Corporation v. RLI Insurance Company*, 2016 WL 787774 (6th Cir. Feb. 29, 2016). The underlying claim stemmed from the federal government's claims that the hospital billed heath care programs for unnecessary heart procedures. The insured settled the claim in May, 2014 for nearly $41 million. The insured notified its primary directors and officers liability insurer of the claim in December, 2011 (the last day permitted under the policy) and recovered the $15 million in coverage available under that policy. The hospital also sought coverage under a $10 million excess policy issued by RLI. RLI issued a claims-made policy that provided coverage for claims made during the policy period of October, 2010 to October, 2011. The insured, however, did not provide RLI with notice of the government's investigation until June, 2012. RLI denied coverage for the settlement on the grounds that the hospital failed to provide it with timely notice. The insured subsequently filed suit against RLI for breach of contract, bad faith, and declaratory relief. The district court granted summary judgment in favor of RLI on all counts and reused to grant declaratory relief. On appeal, the insured conceded that notice was provided late to RLI but that it was still entitled to coverage because RLI failed to show that it was prejudiced by the late notice pursuant to "notice-prejudice" rule adopted by the Supreme Court of Kentucky n 1991. The panel of the Court of Appeals rejected the

hospital's arguments and upheld the district court's ruling that the prejudice requirement does not apply to claims-made policies. In so ruling, the Court noted that "[w]e agree with the district court's prediction that the Supreme Court of Kentucky would not extend the notice-prejudice rule to a claims-made policy like the excess policy here, which contains the unambiguous notice requirements precedent to collecting under the policy." Because the Court did not detect any errors in the district court's ruling, it concluded that neither certification to the Kentucky Supreme Court or a reasoned opinion would serve any useful purpose.

"We agree with the district court's prediction that the Supreme Court of Kentucky would not extend the notice-prejudice rule to a claims made policy like the excess policy here."

Massachusetts Federal Court Rules That An Insurer Was Not Estopped to Raise Coverage Defenses By Not Issuing A Second Reservation of Rights Letter

In an unpublished decision issued on April 4, 2016, the United States District Court for the District of Massachusetts held that a professional liability insurer was not estopped to raise coverage issues by failing to issue a second reservation of rights letter. *American Guarantee & Liability Ins. Co. v. Lamond*, 2016 WL 1312008 (D. Mass. Apr. 4, 2016). The underlying lawsuit involved an attorney malpractice claim arising out of the insured's alleged malpractice in falsely opining that a parcel of property was free from an encumbrances when, in fact, it was not. In *Lamond*, the insurer issued a reservation of rights letter concerning the plaintiff's claim but never issued a supplemental or subsequent position letter discussing the cross-claim filed by a co-defendant later in the case. The insured argued that the insurer was estopped from denying coverage for the cross-claim because the insurer never reserved rights on the cross-claim. Judge Stearns held that the initial reservation of rights letter put the insured on notice with respect to the fact that there was no coverage for the underlying conduct that gave rise to both claims, even though the cross-claim included a cause of action not included in the plaintiff's original complaint. The Court held that if the insured was uncertain as to coverage for the cross-claim, it should have contacted its insurer to clarify whether the claim was covered or not. The Court further refused to hold the insurer liable for the alleged failure to appoint defense counsel to zealously argue on its behalf for settlement, holding that insurers are not vicariously liable for the actions of defense counsel.

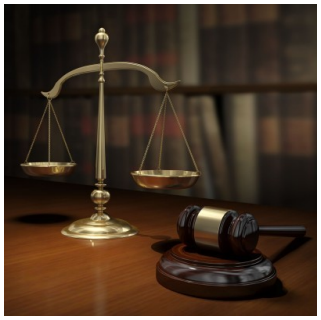
Massachusetts federal court holds that insurer not estopped to raise coverage defenses

Pennsylvania Federal Court Refuses to Apply Interrelated Wrongful Acts Exclusion

"The acts alleged in the 2013 amended complaint do not share a sufficient connection or link, causal or otherwise, with those alleged … in the 2009 action to preclude coverage under the policy ."

In a decision issued by the United States District Court for the Eastern District of Pennsylvania on March 31, 2016, the Court refused to apply an interrelated wrongful act exclusion to preclude coverage for a trademark infringement lawsuit filed against a medical alert response company. *Connect America Holdings, LLC v. Arch Insurance Co.*, 2016 WL 1254073 (E.D. Pa. Mar. 31, 2016). The coverage litigation stemmed from several lawsuits filed against the insured – one in 2009 and another in 2013. The plaintiff was the company who advertised with the "I've fallen and can't get up" commercials. In both lawsuits, the same plaintiff alleged that the insured violated federal trademark and federal and state unfair competition laws. The initial lawsuit was settled in 2011. In the 2013 lawsuit, the plaintiff alleged trademark infringement but also alleged that the insured engaged in fraudulent telemarketing and alleged infringement on a trademark on mobile technology that did not exist in 2009. The D&O policy contained an exclusion that precluded coverage for "Interrelated Wrongful Acts" that took place prior to 2012. The policy defined "Interrelated Wrongful Acts" as "Wrongful Acts that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of causally connected facts, circumstances, situations, events, transactions or causes." The insurer who issued the D&O policy denied coverage for the second lawsuit contending that the interrelated wrongful act exclusion barred coverage. The insured filed a coverage action and subsequently filed a motion for summary judgment. In denying the summary judgment motion, the Court concluded that the lawsuit filed against the insured in 2013 by the plaintiff was not sufficiently similar to a lawsuit filed by the same company against the insured in 2009 because each suit alleged the insured's violated plaintiff's trademark by different schemes. "We conclude that the wrongful acts alleged in the two lawsuits are not related within the meaning of the policy," wrote Judge Timothy Savage. In concluding that the insured's actions were not sufficiently related or similar for the exclusion to apply, Judge Savage noted that the initial suit alleged infringement through Internet activities while the second lawsuit alleged infringement through a telemarketing campaign. The Judge, however, left the door open for the application of other policy provisions that may preclude or limit coverage.

Alaska Supreme Court Rules That Independent Counsel Statute Precludes Policy Language Granting An Insurer the Right to Recoup Defense Costs



On a certified question from the United States Court of Appeals for the Ninth Circuit, the Alaska Supreme Court ruled that the state's independent counsel statute precludes enforcement of a policy provision contained in a professional liability policy providing the insurer with a right to recoup defense costs in the event a determination is later made that the insurer did not owe coverage for the claim. *Attorney's Liability Protection Society, Inc. v. Ingaldson Fitzgerald, P.C.*, 2016 WL 1171299 (Alaska Mar. 25, 2016). At issue was Alaska Statute 21.96.100, which provides insureds with an objectively reasonable expectation that insurers will not attempt to claw back defense costs they have paid when a lawsuit obligates them to provide independent counsel to their insureds when a conflict of interest arises and the insurer reserves its right to deny coverage under the policy. The Court held that recoupment clauses are inconsistent with the section of the statute that provides that insureds only give up their right to independent counsel fees if they sign a written agreement waiving independent counsel. "A review of the statutory text indicates that reimbursement is prohibited, and because there is no evidence of contrary legislative purpose or intent, we conclude that the statute prohibits reimbursement provisions." The Court further noted that the determining event giving rise to an insurer's duty to pay independent counsel fees under the statute was not whether the insurer actually had a duty to defend, but "the objective act of the insurer taken when reserving its position as to coverage."

Kentucky Appeals Court Approves Cause of Action Against Hospital for Negligent Credentialing of Physicians

In a decision issued by the Kentucky Court of Appeals on March 11, 2016, the Court concluded that hospitals may be liable for failing to properly investigate doctors before extending medical privileges to them. *Spalding v. Spring View Hosp., LLC*, 2016 WL 929507 (Ky. Ct. App. Mar. 11, 2016). The decision arises from five appeals taken in three consolidated cases. The trial courts in all three cases held that the claims of negligent credentialing were unsustainable and unrecognized under current law. In analyzing the issue, the Court noted that hospitals traditionally were treated as mere forums where physicians acted as independent contractors. Because the physicians were not employees, the hospitals were generally immune from lawsuits alleging negligence by physicians practicing at the hospital. The Court noted, however, that the legal protection has eroded and now twenty-eight states recognize a claim for negligent credentialing of independent physicians by hospitals. Plaintiffs asserting such cause of actions must demonstrate that the hospital owed the patient a duty to ensure it had a competent medical staff, that the hospital breached its duty by giving privileges to an incompetent or unqualified physician and that the physician caused harm to the patient. In opposition to recognizing such a cause of action, the hospital defendant raised several policy arguments—including that it could lead to an increase in the "already exorbitant cost" of care and would effectively make hospitals the insurers of independent contractor physicians. The Court rejected these policy reasons and noted that it is not a "novel or irrational concept" to impose liability on a hospital for its own decision to credential a physician that it knew or should have known was incompetent. In so ruling, the Court noted that "our decision today lends legal credence to a patient's reasonable belief that the hospital she enters has taken adequate steps to ensure compliance with an objective standard of patient care. This is neither bad policy nor is it unheard of in Kentucky law. Within the bounds we have set out in this opinion, this must extend to the selection and credentialing of even independent contractor physicians."

"There has been a progressive expansion of liability evidenced by the recognition of torts such as negligent hiring, negligent supervision, and corporate negligence, all three of which are recognized in Kentucky."

Three Courts Address the Scope of a "Claim" Under Claims-Made Policies

California— In a decision issued on February 23, 2016, a California federal district court ruled that seven lawsuits pending against the insured constituted a single claim for purposes of the per-claim limit in the policy. *Liberty Ins. Underwriters, Inc. v. Davies Lemmis Raphaely Law Corp.*, 2016 WL 741837 (C.D. Cal. Feb. 23, 2016). The policies at issue contained a provision stating that claims based upon the same or related wrongful acts shall be treated as a single claim and shall be considered first made during the policy period in which the earliest claim arising out of such wrongful acts were made. Although Liberty issued three consecutive policies, the court held that the lawsuits triggered only the first policy and only one "per claim" limit was available for all suits.

Arizona— In a decision issued on March 3, 2016, an Arizona appellate court denied coverage under a D&O policy based upon the application of an "Interrelated Wrongful Acts" exclusion contained in the policy. *SP Syntax LLC v. Federal Ins. Co.*, 2016 WL 831532 (Ariz. Ct. App. Mar. 3, 2016). At issue were two separate lawsuits, the second of which was filed during the policy period of the policy at issue. The second lawsuit involved all three categories of financial misrepresentations as the first. The appellate court affirmed the trial court's ruling that the allegations arose out of and were similar to those in the first action. The inclusion of "new" allegations did not take the claim out of the exclusion.

New York—In a decision issued on March 7, 2016, the United States Court of Appeals for the Second Circuit, applying New York law, held that an insurer was not obligated to defend an action because it was related to a claim first made prior to the policy's effective date. *Weaver v. Axis Surplus Ins. Co.*, 2016 WL 860363 (2d Cir. Mar. 7, 2016). At issue was an exclusion that precluded coverage, in part, for demands pending against an insured before the issuance of the policy. The insured sought coverage for a DOJ securities investigation. The insured, however, was subject to a similar state securities investigation prior to the issuance of the policy. The court concluded that the state letter constituted a "demand" such that the exclusion unambiguously excluded coverage for the DOJ action.

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Recent Notable Defense Verdicts

Notable Verdicts/Settlements

San Diego, CA –April, 2016. A San Diego family reached a $20 million settlement with a Southern California hospital in a medical malpractice case involving a newborn baby left with brain damage as a result of the hospital's alleged negligence. The family alleged that the hospital nursing staff failed to properly monitor a feeding tube, resulting in brain damage to the child. The settlement was reached after three years of litigation.

Bronx, NY –April, 2016. A 38-year old Bronx woman was awarded $50 million in damages ($40 million for future pain and suffering and $10 million for past pain and suffering) after a month long trial. The woman was wounded during delivery of her daughter in 2009 after her physician performed an unnecessary episiotomy during delivery.

Cook County, IL–March 2016. A Chicago family of a six-year old boy left permanently disabled and brain damaged as a result of twenty-five experimental procedures on the young boy have reached a $30 million settlement with the boy's physician and several hospitals. As an update to this case as referenced in the March edition of *Decisions*, it has been reported that the University of Illinois will pay $10 million of the settlement and Rush University Medical Center will pay $20 million of the settlement.

Schenectady County, New York –March, 2016. A Schenectady County jury has awarded $1.52 million in damages to a 51-year old woman in a medical malpractice case. The jury found her doctor liable for malpractice when he failed to repair a bowel injury caused while performing a hysterectomy. The woman was forced to have a colostomy and undergo additional abdominal surgeries as a result of the failure to repair cuts he made.

Charleston County, SC–January, 2015. A Charleston County jury awarded a 47-year old woman a $6.9 million verdict against a defendant radiologist who improperly read her screening mammogram and failed to advise plaintiff that she required further testing. The woman later developed Stage III breast cancer and her prognosis is terminal. The award included $4.8 in economic damages and $2.1 million in non-economic damages.

Notable Defense Verdicts

New Britain County, CT – March, 2016 A New Britain County jury found for the defendants in a case in which the plaintiff alleged that the defendants' failure to timely diagnose and treat his wife's cardiac condition led to her untimely death from a heart attack. The lawsuit was brought against the woman's primary care physician and an emergency medicine physician. Defendants argued that the decedent failed to follow their advice, failed to stop smoking, and failed to take aspirin as directed. The case was tried against the emergency room physician and the jury returned a verdict in favor of the physician.

Collier County, FL– August, 2015. The wife of a 67-year old patient who suffered brain injuries after falling from a bicycle filed suit against a hospital for failing to order a VQ scan which plaintiff contended would have shown a risk of pulmonary embolism and prompt the installation of a filter. As a result, the patient developed a fatal pulmonary embolism and died. The defendant argued that the VQ scan would have been negative for any indication of pulmonary embolism. After trial, the jury found for the hospital.

Bristol County, MA – July, 2015. A female plaintiff filed suit against the defendant's nurse practitioner alleging that she suffered liver damage that required a liver transplant after the practitioner prescribed a medication that plaintiff was allergic to. Plaintiff alleged that the defendant physician failed to properly supervise or oversee her. Defendant contended that her condition was caused by acute hepatitis, not the medication. The jury found for the defendant.

Westchester County, NY–June, 2015. A Westchester County jury found for the defendant hospital in a case involving alleged negligence in failing to turn and reposition a 17 month old infant treated in an emergency room for necrotizing pneumonia, deep tissue injury and pressure sore to the back of his skull. The defendant maintained that it adhered to appropriate pressure ulcer prevention protocols and, despite efforts, the pressure wound formed nevertheless.