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908 Are You Covered? Part 2: Basic Strategies to Compel Your Insurer to Pay Your Claim

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Faculty Biographies

John A. O'Neil

John A. O'Neil is an assistant vice president/counsel and director of insurance risk management at Massachusetts Mutual Life Insurance Company (MassMutual) in Springfield, Massachusetts where he is responsible for overall enterprise insurance coverage and insurance risk management issues.

Mr. O'Neil joined MassMutual as assistant vice president/counsel in the litigation section of the law division advising on issues such as insurance defense litigation, risk management, as well as both state and federal regulatory issues. Later, he took a position as assistant vice president and head of global sourcing at MassMutual, a position he held until he entered his current role. Prior to joining MassMutual, Mr. O'Neil served in the litigation departments of Monarch Life Insurance Company and Unum Provident Companies. He began his law career as an assistant district attorney in Hampden County, Massachusetts.

Mr. O'Neil received a BS from Western New England College, and a JD from Western New England College School of Law.

David H. Paige

David H. Paige is a managing director and the general counsel of Sterling & Sterling, Inc., a privately owned insurance, risk consulting and brokerage firm with location in New York, New Jersey, Connecticut and California. His responsibilities include providing legal counsel to the company, as well as risk management consulting services, legal fee auditing and insurance coverage advocacy to Sterling's clients.

Prior to joining Sterling, Mr. Paige was chief operating officer of the DeWitt Stern Group, a national insurance brokerage, where he was responsible for national operations. Prior to his tenure at DeWitt, he was a partner in his own law firms, concentrating in the litigation of insurance coverage disputes on a national basis.

He provides pro bono volunteer services to the New York Court system, counseling pro se defendants in credit disputes.

Mr. Paige received a BA from Syracuse University, an MA from Michigan State University, and is a magna cum laude graduate of the Syracuse University College of Law.

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Robert M. Reeves

Robert M. Reeves is a partner in Ernst & Young's Fraud Investigation & Dispute Services (FIDS) practice in Dallas, Texas. His practice focuses on complex insurance claims and dispute-related services as a member of the insurance claims services (ICS) team within FIDS. His experience includes assisting policyholders to reach settlement on insurance claims, including property, business interruption, fidelity and liability, along with working for insurance and reinsurance companies in arbitration and litigation matters.

Mr. Reeves began his career with Campos & Stratis, where he audited claims for insurance companies. While at Campos & Stratis, he worked closely with both adjusters and policyholders to resolve complex claims accounting issues. This experience working for insurance companies provided insight into the methods used to evaluate business interruption and property damage claims.

He currently serves as co-chair for Ernst & Young's Dallas office March of Dimes Campaign. He is a licensed Certified Public Accountant from the state of Texas and a member of the Texas Society of Certified Public Accountants. He is a member of the American Institute of Certified Public and Associate Member of the Risk and Insurance Management Society (RIMS).

Mr. Reeves received his BBA from Texas Christian University.

John Schryber

John Schryber is a partner with Patton Boggs, LLP in Washington, DC. Representing a wide range of major corporate and individual policyholders in every region of the country, Mr. Schryber has won precedent-setting decisions against insurance companies in multiple federal and state appellate courts, as well as at the trial court level. Mr. Schryber has prosecuted the rights of policyholders and beneficiaries of private indemnity agreements in connection with coverage disputes of every kind, including disputes over coverage for claims of trademark infringement, CERCLA liability, breach of corporate fiduciary duty, violations of securities laws, Ponzi-scheme conversion, predatory subprime mortgage lending, forgery, defective building construction, racial discrimination, and products liability.

Mr. Schryber has lectured here and abroad on the subject of the applicability of liability insurance policies to various subprime claims. In July 2008, Mr. Schryber was a presenter at "The Explosion in U.S. Subprime Litigation & Regulatory Initiatives: Implications for European Market Participants" in London. The topic on which Mr. Schryber presented was Mining Liability Insurance Policies to Cover Subprime Losses. He also is a contributing author to a treatise on subprime litigation (and related insurance-coverage issues), entitled Mortgage and Asset Backed Securities Litigation Handbook.

Mr. Schryber graduated from New York Law School, JD, magna cum laude.

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Are You Covered?

Part 2: Basic Strategies to Compel Your Insurer to Pay Your Claim

Synopsis

- Basic issues involving insurer denial of insurance claims
- Hypothetical Scenario: A Corp's Predicament
- Lessons to be learned from two major claims
- Ten Strategies

Insurance Cost

- Begin by assessing risk, independent of insurance solutions
- Four step analysis of risks:
  - Identify threats
  - Estimate probability of threat's occurrence
  - Quantify cost: probability X cost of threat
  - Manage risk: most cost-effective solutions?

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The Case of A Corp

- Ultimate Questions for A Corp.'s new GC re A Corp.'s risk management and insurance team:
- In Part 1 we asked:
  - How can A Corp. best manage its liabilities to minimize litigation potential and costs?
  - How can we best use our resources to minimize our exposure through insurance and contractual risk transfer?
  - How can we best stay on top of the liabilities presented by everything that A Corp. and its subsidiaries are doing?

The Case of A Corp

- Is A Corp ready for an adverse claims response from its insurers?
- What strategies should A Corp have in place in advance of a claim denial in order to cope with an unfavorable response?

A D&O and Employment Claim

- Aconstruction, in response to Hurricane Katrina, decided to participate in the rebuilding of New Orleans.
- The A Corp Board decided to leave most local planning to "Katrina Kares". A Corp employees were housed in badly secured motels.
- Two were assaulted, and one employee was harassed.
- The Katrina Kares supervisor had a criminal record for stalking.
- A Corp's leader, Sam Ash, on CNN, stated that the employees' injuries "were not so bad," and about "a few complainers in a group."
- The assaults and statement drew national headlines, seriously damaging A Corp's image, and its stock price.
- The injured employees brought actions against A Corp, and Sam for their assaults and harassment. Shareholders threatened action against the Board.
- A Corp's insurer, NoPay, issued a reservation of rights letter, offering some indemnity for defense costs, but reserving its right to disclaim coverage. The insurer declined to use A Corp's long trusted law firm as defense counsel, as they were not on NoPay's panel.

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A D&O and Employment Claim

- How should A Corp respond to the claim?
- What potential resources should A Corp have in place for response to this type of situation?
- What legal principles apply to assess the strength of the insurer's position?
- How can counsel best prepare a reliable strategy for management?

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A Property and Business Interruption Claim

- A Corp produces extracts through a partnership with ThaiCorp. A Corp and ThaiCorp own and run the plant on a 50/50 basis.
- The extraction facility is located on the coast of Thailand, allowing for easy transshipment of extracts and other natural materials to the US for processing.
- In 2006, a Tsunami flooded the Thai plant, knocking it out of commission for 12 months. During that period, A Corp was compelled to purchase extracts from other suppliers. The closing of the Thai facility also caused three other US A Corp plants to sit idle.
- A Corp had to settle disputes with retailers who had contracts with A Corp to supply a steady stream of product. Further, A Corp had to cut back on standing advertising contracts.
- A Corp's insurer, NoPay, investigated the claim for 9 months before taking any position on coverage. The insurer disputed all of A Corp's asserted damages. They ultimately declined payment, stating that A Corp had not paid the proper premium based on the actual scope of its operations. NoPay also took the position that it was not informed that the Thai plant was on the coast, and that it would not have written the coverage if it had known the true location and purpose of the Thai plant.

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A Property and Business Interruption Claim

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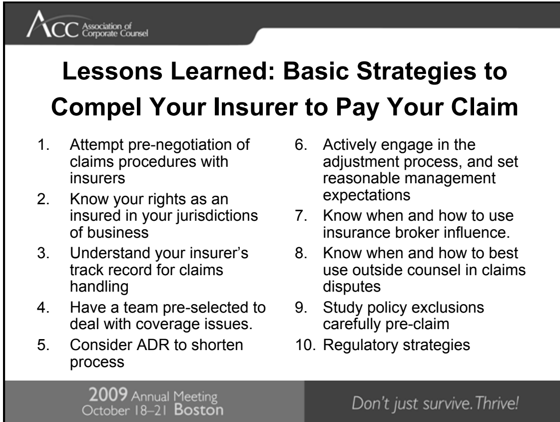

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PART ONE:
"MINING" LIABILITY INSURANCE POLICIES IN COMMERCIAL CONTRACT DISPUTES

I. When is an uncovered "Contract-Related Claim" a Covered Tort Claim?
   A. Breach of Contract/Tortious Inducement to Contract
      1. Was the contract induced by any material false statements?
      2. Were those misrepresentations made?
      3. Is the individual officer who made the misrepresentation an insured under policy?
      4. Were "out-of-pocket" or "reliance" damages sustained in reliance on the misrepresentation?

A. Breach of Contract/Tortious Inducement to Contract (Continued)
   5. Does the complaint allege facts that, if proved:
   A. Would establish a tort claim and
   B. Would not trigger any contract exclusion
      1. The policy's "contract" exclusion
         a. "existence *or* breach" of contract, and
         b. "breach" of a contract only
      2. Tortious inducement
         a. Avoids "breach" exclusion
         b. Negligent Misrepresentation
      • "Special Relationship" condition
      3. Fraudulent Inducement

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B. Breach of Contract/Trademark Infringement
1. Scope of consent to trademark use
2. "Advertising injury" coverage
3. Exclusion's applicability?
4. Damages

C. Breach of Contract/"Securities Claim" (Repo Claim)
1. Mortgage lender contracts to sell loans to securitizing purchaser
2. Securitized or "to-be-securitized" lending agreements
3. Right to demand that seller repurchase the loans
4. Securities claims if *owned by* the insured company
5. No reported judicial decision (yet)

II. Non-Recourse Settlements When Contra-Insurer Erroneously Denies Coverage

A. What is a Non-Recourse Settlement?

B. Partial or Full Risk

C. Enforceability

III. Maximizing Insurance Recovery, Net of Legal Fees

A. Mediate, and Mediate Early
1. Coverage disputes are often legal "winner-take-all" issues
2. Keeps legal fees to a minimum
3. Can salvage insured-insurer business relationship
4. Is it ever too early?

B. Recovering Litigation Costs in Coverage Actions
1. There is no "general rule" as to fee-shifting
2. Is this a forum-selection issue?

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PART TWO:

MAXIMIZING
THE INSURER-PROVIDED DEFENSE
WHERE
THE INSURER
“RESERVES RIGHTS”
BASED ON
AN “UNDERLYING” GROUND

I. Shifting the “Right to Select Defense Counsel” to the Insured
   A. Duty-to-Defend clause
   B. The Insured’s right is to a “*conflict-free defense*” by competent counsel
      1. The triggering “conflict”
      2. The “substituted performance”
         a. Majority View: Majority of states provide the Insured with an absolute right to choose counsel if a conflict exists
         b. Minority View: The Insurer has veto power over insured’s selection of independent counsel.

II. Shifting the “Right to Control the Defense” to the Insured
   A. Conflict/reserved-rights situation
   B. *In re Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures,* 2 P.3d 806 (Mont. 2000)

III. Minimizing the Burden of the “Duty to Cooperate”
   A. Non-Privileged Documents and Information Relating to Underlying Action
   B. Non-Privileged Documents and Information Relating to Coverage Issues
   C. Privileged Communications Relating to Coverage Issues

D. Privileged Communications Relating to Underlying Action

1. "Sole Client" Jurisdictions: Insured is the only client (Majority rule & common trend)
   a. *No* "Common Interest" Jurisdictions
   b. "Common Interest" Jurisdictions
   c. "Implied Limited Waiver" Jurisdictions

2. "Dual Client/Common Interest" Jurisdictions

E. Risk of waiver in tripartite context

IV. Avoiding Liability for "Reimbursement" of Defense Costs (Varies by Jurisdiction)

A. Insured is insulated from "reimbursement" liability as a matter of law

B. Contingent liability for reimbursement of defense costs

C. Manner by which the Insured responds to a demand is determinative

PART THREE:

AVOIDING THE D&O TRAPS
OF
UNTIMELY NOTICE
AND
UNDER-INSURANCE

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I. The “Untimely Notice” Trap

A. D&O policies are written on a claims-made basis

B. Insureds who report claims late tend to do so for two reasons:

1. Fail to recognize what constitutes a claim; or
2. Decide not to report a claim

C. Recognizing claims:

1. Claims are not limited to lawsuits!

D. What “Claim-Catching” Systems are in Place?

E. Fallacious Reasoning for Not Reporting Claims

F. When Late Notice May Not be Late Notice

II. The “Under-Insurance” Trap

A. Typical D&O Policy

1. Traditional D&O policy will typically offer three main types of protection
2. Side A, Side B, and Side C
3. Bankruptcy considerations

B. The New “Dedicated Limit” Policy Maximizes Coverage for the D & O’s

1. Advantages generally
2. Customized advantages

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Hypothetical Factual Scenario

A Corp is a manufacturer and distributor of unique peanut-flavored drinks that have swept the nation, and are beginning to gain traction in world wide markets. The unique combination of cheap, low-fat protein, together with an injection of caffeine makes the drink popular with dieters, and young people who need a jolt to stay up throughout the night.

A Corp has taken to naming its products, using its distinctive "A" as a prefix: "Acola", "Agingerdrink" and "Awater". A Corp. has manufacturing plants in three states, but maintains its headquarters in Georgia. A Corp. is distinctive in that it insists that it closely supervise the building of all of its properties so that they are "green", convey the latest design, and comfort for employees. To accomplish this, A Corp. has created its own construction company, "Aconstruction" that supervises the building process.

Aconstruction also has a charitable arm: "The A Foundation", building low-cost "green" housing for victims of hurricane and tornado damage. Volunteers from across the US participate in building these homes.

A Corp. has regional distributors throughout the US. The charismatic 28 year old owner, Sam "A" Ash, has built a campus for his headquarters near Atlanta, incorporating a gym, sauna, hot tubs, and 24 hour cafeteria. His product line is growing to include refrigerated drinks, as well as codes with each purchase for free music downloads.

A Corp. has also built its business through innovation: purchasing heavily on radio advertising, sponsoring an Acola alternative music festival, and selling its drinks from refrigerated carts near college campuses.

Sam wishes to expand to Asia, Africa and Europe, and wishes to be sure that his risks are covered as he expands. His board is advocating that A Corp. consider an IPO once the stock market settles down.

Questions for A Corp.'s new GC re A Corp.'s risk management and insurance:

1. How can A Corp. best manage its liabilities to minimize litigation potential and costs? How can we best use our resources to minimize our exposure through insurance and contractual risk transfer?
2. How can we best stay on top of the liabilities presented by everything that A Corp. and its subsidiaries are doing?

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PURSUING A CLAIM - DEALING WITH INSURER CLAIM DENIALS

1. **Notify the insurance company of the claim promptly.** Most insurance policies require a policyholder to timely notify the insurance company that a claim has been made against the policyholder. A failure to do so may result in the policyholder forfeiting coverage. Under many policies, an insurer cannot deny coverage based on late notice unless it has been prejudiced by the delay. *Johnson Controls, Inc. v. Bowes,* 381 Mass. 278 (1980). Under claims-made-and-reported insurance policies a different rule often applies. In many states, under this type of policy, the policyholder must notify the insurer of a claim during the policy period. *Burns v. International Ins. Co.,* 929 F.2d 1422 (9th Cir. 1991).

2. **If the insurer has the duty to defend, insist on the insurer promptly issuing any reservation of rights and promptly retaining defense counsel.** If the insurer reserves rights on certain grounds, the policyholder may have the right to independent counsel of its choosing. *E.g., San Diego Navy Federal Credit Union v. Cumis Insurance Company,* 208 Cal. Rptr. 494 (Cal. App, 1984)(partially superseded by Cal. Cir. Code § 2860). It will assist in the defense of the case if the policyholder learns of the situation promptly.

3. **If the policyholder has the duty to defend, inform the insurer of the policyholder's choice of defense counsel promptly.** Most policies that impose the duty to defend on the policyholder require the insurer to reimburse defense costs. If this is the case, the insurer's consent to the policyholder's choice of counsel may be required before the policyholder incurs defense costs. To avoid a dispute on the issue, the policyholder should promptly notify the insurer of a claim being made and of the policyholder's intentions with respect to defense counsel.

4. **Fulfill the duty to cooperate.** Many insurance policies require the policyholder to cooperate and to provide information to the insurance company to assist the insurance company in its coverage determination and in defending the ease. In many states, an insurance company cannot deny coverage based on lack of cooperation unless it can show that it has been substantially prejudiced by a lack of cooperation. *Darcy v. Hartford lns. Co.,* 407 Mass. 481, 488-91 (1990). Nevertheless, this obligation should be taken seriously; efforts should be made to comply with reasonable requests for information. Consider, however, whether supplying information risks the defense of any underlying case. In some circumstances, a policyholder has been held to have waived the work product protection because it supplied information to an insurer that had reserved its rights to deny coverage. *In re Imperial Corp. of America,* 167 F.R.D. 447 (S.D. Cal. 1995).

5. **Do not settle without informing the insurance company.** Most insurance policies require the insurance company's consent for a policyholder to settle a claim. While the insurance company cannot unreasonably withhold consent, the policyholder must at least seek the insurer's consent. Otherwise, the policyholder risks forfeiting coverage. *E.g., Vigilant Ins. Co. v. The Bear Sterns Co.,* 10N.Y.3d 170 (2008).

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6. **<u>If the insurer denies the claim or refuses to pay promptly.</u>**

a. **<u>The insurance relationship.</u>** In some circumstances, an insurer may be open to coverage arguments because of its longstanding relationship with the policyholder and the hope for a continuing business relationship. This may not lead an insurer to pay a claim that it believes is not covered, but it may give the policyholder the ability to work with the insurer to find an appropriate solution or, in the alternative, an appropriate forum to resolve the dispute. Depending upon the size of the dispute, a scaled-down arbitration may be preferred to full-scale litigation or arbitration. While the policy may not require the insurer to agree to a scaled-down arbitration of a coverage dispute, the insurer may see this as a good option to put the problem behind the patties and to allow them to "get on" with their relationship.

b. **<u>Negotiation and Mediation.</u>** Some insurance disputes may be resolved more quickly through negotiation between the parties with or without the assistance of a mediator. It is important to explore the best way to resolve an insurance dispute. If a dispute can be resolved through negotiation or mediation, the parties may save considerable expense by doing so.

c. **<u>Consider regulatory remedies.</u>** Some states have active insurance departments that will investigate an inappropriate denial of coverage by an insurance company. Informing regulators of an insurance company's behavior' may place pressure on the insurance company to pay a claim in which valid arguments for coverage exist.

d. **<u>Carefully consider where to resolve the dispute.</u>** In seeking coverage for a wrongfully denied claim, one size may not fit all circumstances. Negotiation alone may be appropriate in some circumstances, Arbitration in others, and litigation in certain circumstances. Choice of law may play a role in deciding where to resolve a dispute. The insurance policy may limit or enhance the policyholder's ability to choose a forum.

i. **<u>Litigation vs. Arbitration.</u>** If it is not possible to resolve the dispute without the intervention of third parties, other alternatives should be considered. Some disputes are better resolved in litigation; some are better resolved in arbitration. Confidentiality concerns may lead a policyholder to prefer arbitration over litigation. Under appropriate procedures, arbitration may be a less expensive, more expeditious way to resolve a dispute. For other disputes, litigation may be the preferred course. A judge or jury may be more likely than an arbitrator to resolve the dispute entirely in the policyholder's favor. Appellate rights may be important with respect to some high-value cases.

ii. **<u>Alternative Dispute Resolution ("ADR') Provisions.</u>** Some policies require the parties to resolve a dispute by arbitration or require the parties

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to mediate a dispute before going to court. Depending on the language of the policy and the conduct of the insurer, ADR provisions may not be binding. (e.g. repudiation).

iii. **Service of Suit Clauses.** Some policies require the insurer to consent to service of process and, in some instances, even to consent to the policyholder's chosen forum.

iv. **Choice of Law Clauses.** Though relatively rare, some insurance policies require disputes to be resolved according to the law of a particular jurisdiction. Other insurance policies are silent on this issue. Before deciding where to resolve a dispute, it is important to know how that decision will impact the choice of the law under which the dispute will be resolved.

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Basic Strategies to Compel Your Insurer to Pay Your Claim

1. Attempt pre-negotiation of claims procedures with insurers
    a. To Do:
        i. Determine most likely claim scenarios in advance of policy purchase;
        ii. Attempt pre-negotiation of claims procedures
    b. To Avoid:
        i. Acceptance of insurer assertion that claims procedures cannot be discussed in advance of an actual claim
2. Know your rights as an insured in your jurisdictions of business
    a. To Do:
        i. Obtain a realistic picture of insured vulnerabilities in jurisdictions of greatest exposure;
    b. To Avoid:
        i. Lack of familiarity with crucial peculiarities of certain jurisdictions and their track record on insurance claims
3. Understand your insurer's track record for claims handling
    a. To Do:
        i. Require broker and risk manager to obtain comparative claims track records of insurers by line of coverage;
        ii. Independent research of case precedent concerning certain insurers' denials of coverage.
4. Have a team pre-selected to deal with coverage issues.
    a. To Do:
        i. Engage insurance coverage counsel in advance of a claim so that it will be possible to move quickly when an insurance dispute arises;
        ii. Make certain that your insurance broker has an active, experienced claims professional at your disposal in the event of a claim
    b. To Avoid:
        i. Do not assume that a generalist law firm has the expertise to handle complex coverage matters;
        ii. Determine if your regular counsel generally represents insurers in disputes;
        iii. Do not assume that you insurance broker has a strong claims dimension unless you interview them for yourself, and question them regarding the types of claims you are most concerned with.
5. Consider ADR to shorten process
    a. To Do:
        i. Make certain that you understand mandatory ADR provisions written into insurance agreements;
        ii. Consider alteration to such provisions to your advantage through the policy negotiation phase;

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            iii. Pursue ADR as an alternative to insurance coverage litigation
    b. To Avoid:
        i. Lengthy negotiations regarding ADR that stalls resolution;
        ii. Unproductive ADR when there is clarity that insurer is not motivated to negotiate.
6. Actively engage in the adjustment process, and set reasonable management expectations
    a. To Do:
        i. Do not delay in reporting and engaging insurer in the adjustment process;
        ii. Create an agreed timeline early, so that a road to recovery becomes focused from early stages
    b. To Avoid:
        i. Delay in providing information or access to information reasonably needed for insurer to adjust the claim;
        ii. Engaging in heightened rhetoric before it is necessary
7. Know when and how to use insurance broker influence.
8. Know when and how to best use outside counsel in claims disputes
9. Study policy exclusions carefully pre-claim
10. Regulatory strategies

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BUSINESS INTERRUPTION AND COMPLEX PROPERTY CLAIMS

Description of the adjustment process.
The adjustment of a claim and measurement of a property damage and business interruption loss is not solely an accounting or legal function. The tenor and timing of the adjustment process can be influenced by many factors that can include the policy language, interpretation of the policy, the circumstances of the loss, the people involved in the adjustment of the claim, the documentation available to support the loss, and a host of other factors. One of the most significant factors that impacts the adjustment process is the amount of the claim.

Decisions made regarding property damage have an impact on the time element claim and vice versa. Successful insureds develop claim strategies that seamlessly mold together the many variables of the claim including cause & origin, coverage, production, engineering, construction, sales & marketing, finance, accounting, and negotiation. The insurance company's adjustment team and the insured's claimant team should contain the needed expertise to address the complex issues that arise. Depending on the amount of damage, the period of indemnity, the application of policy coverages and the claims strategy employed, settlement of complex property damage and business interruption claim can take from several months to several years.

The role of different professionals in the claims process
The insurance company will hire various consultants during the claims process, including adjusters, accountants, engineers, coverage counsel and contractors. These insurance company representatives have years of experience in evaluating claims on behalf of the insurance industry and are responsible for protecting the interest of the insurer. They will often interpret complex issues in a manner that advances their clients' perspective.

- The adjuster: Serves on behalf of the insurers as a liaison between the policyholder and the insurance carrier(s). Responsible for gathering information regarding the cause of the loss, sometimes interpreting the policy language (some insurance companies rely on the underwriter to interpret coverage), mitigating the loss, leading the adjustment team (see below), gathering the information and documentation to support a claim, and providing periodic reports to the insurance carrier(s). He also represents insurers in settling the claim with the insured, typically based on parameters provided by the insurance carrier(s). Depending on the complexity of the loss the adjustment team might include any of the following:

    - Engineering, equipment or construction experts to assist with cause & origin, extent of damage, or quantum of loss issues.
    - Claims Auditors to review financial documentation and provide advice regarding claim documentation and quantum.
    - Coverage attorney to advise on the application of coverage.

- The risk manager: Serves on behalf of the insured as the liaison with the insurance carrier(s). Responsible for leading the claimant team, notifying insurers and brokers of a loss incident, providing insurers with a well documented claim, ensuring that the adjuster's questions are responded to appropriately, communicating the insured's position on complex issues, and. They are also responsible for building a claims team that has the appropriate expertise to fully prepare and support the claim. Depending on the complexity of the loss and the issues being raised by the insurance company the claimants team might include any of the following:

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- CEO/CFO to comment on the impact to the corporation.
- Legal representation to address liability, policy or other legal issues.
- Accounting, operations, sales & marketing people to provide input on operational and business impacts.
- Engineering, equipment or construction consultants to assist with cause & origin, extent of damage, or the development of loss estimates.
- Forensic accountants to assist with the measurement and documentation of the loss.

Communication in the claims process

Communication internal to the corporation and external with the insurance company should begin early and continue often throughout the process to alleviate concerns and minimize issues. Internal communication would include such things as: educating management and the appropriate operations personnel about the claims process, managing expectations of management regarding the anticipated timing of payments, discussing potential adjustment and measurement issues, communicating loss exposures and recovery potentials, etc. External communication would include: educating insurance company representatives about the affected business and how it will be impacted by the loss, detailing mitigation strategies and their impact on the claim, notifying parties about potential loss exposures, developing agendas for upcoming meetings, communicating the timing for delivery of documentation, requesting advances, and pushing for the timely resolution of issues.

Depending on the nature of the claim, much of the necessary daily communication may take place verbally. However, regardless of the tone, substantive agreements should be documented in writing so that early decisions are not discounted later in the adjustment process.

Common claim documentation needs

Each loss and the documentation needed to support the claim is different and should be evaluated on a loss by loss basis. For instance, replacement of a multi-million dollar radio tower by a single contractor might require one invoice, but the repair of a $100,000 water damaged medical office might require 30-40 invoices covering water extraction, wall board drying, carpet removal, plumbing repairs, etc.. There are however, several documentation categories consistent with complex claims and they include:

- Written estimates and purchase order for property repairs.
- Invoices for property repairs.
- Lease contracts for equipment, buildings or property.
- Historical production, inventory and sales information.
- Forecasted production, inventory and sales information.
- Financial documentation like Profit & Loss statements, etc.

During the adjustment of a claim insurance adjuster's will often request vast amounts of data and information from a claimant. To the extent that this information is pertinent to the claim then it should be provided. Before this information is provided however, an insured would be well advised to understand why the data is being requested, how it might be used, it's applicability to the loss, and how it relates to the claim being presented. The insured should also provide the data with an explanation of the proper context, so chances of the information being misinterpreted are reduced.

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The insurance company may also require that insured's complete a proof of loss in order to receive payment. A proof of loss is a legal document that provides particulars of the loss, swears to the amount being claimed, and is typically signed by an officer of the company.

Common Issues

Adjustment and measurement of a loss is dependent on the loss scenario and an interpretation of the policy responding to it. And, as with most loss scenarios, there is often more than one way to interpret the scenario and policy so issues often result. Some of the more common disputes that arise during the adjustment and measurement of a claim are addressed briefly below.

- Period of indemnity: This most often relates to the time between when the loss occurred until repairs are complete and operations are restored. However, if the insured decides to make design changes, or if the insurance company feels that all due haste was not employed, then disputes can arise.
- Scope of rebuild: If the insured and insurance company do not agree on the extent of damage and need for repairs early in the adjustment process, then scope of rebuild concerns can affect both the property claim and the business interruption (period of indemnity).
- Rebuilding elsewhere or process changes: Losses often present an insured with an opportunity to move or change their operations to increase efficiencies. To the extent that these changes can be incorporated into the needed repair and do not affect the period of indemnity then they should be considered in the normal measurement of the loss. However, significant changes and/or delays may cause issues in the adjustment process requiring the development of "theoretical timelines" based on the application of engineering judgements.
- Sales projections: The anticipated introduction of new products after the date of loss or the implementation of cost savings initiatives can result in projected margin increases that maybe questioned and cause issues.
- Makeup and offsets: An insurance company might question an insured's ability to increase production after the loss or make sales from inventory to offset a loss of sales. Also, increased sales after the period of indemnity that the insured may consider normal sales levels based on changed market conditions, may be perceived by insurers as make up sales that were delayed from the indemnity period.
- Extra expense vs. business decision: Extra expenses or additional costs incurred to operate the business like normal might be interpreted as business decisions and not recoverable if the costs extend outside of the period of indemnity.

From the discovery of a loss to the recovery of insurance proceeds, the process of measuring and settling of a property damage and business interruption claims can involve complex issues. The appropriate claims people should be involved, communication should be stressed, information and documentation should be exchanged, and issues should be addressed expeditiously. If this can be done, then prompt claim settlements that are viewed as equitable by all parties can be achieved.

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Supreme Judicial Court of Massachusetts, Middlesex.
JOHNSON CONTROLS, INC.
v.
John T. BOWES et al.[FN1]

FN1. St. Paul Fire and Marine Insurance Company.

Argued April 9, 1980.
Decided Aug. 5, 1980.

Company brought an action to reach and apply the proceeds of legal malpractice insurance policies to the judgment awarded company against insured attorney, who was found to have been negligent. The Superior Court, Middlesex County, Ronan, J., granted insurer's motion for summary judgment and dismissed company's claim, and the appeal was transferred. The Supreme Judicial Court, Hennessey, C. J., held that where an insurance company attempts to be relieved of its obligations under a nonmotor vehicle liability insurance policy on the ground of untimely notice by insured, insurance company will be required to prove both that notice provision was in fact breached and that the breach resulted in prejudice to its position, but such change in the law is to be applied wholly prospectively, and thus dismissal of company's claim was correct, in that insured attorney failed to give written notification of the claim and to forward the suit papers to insurer in violation of provisions of the insurance contract.

Affirmed.

West Headnotes

Courts 106 ⚷100(1)

106 Courts
106II Establishment, Organization, and Procedure
106II(H) Effect of Reversal or Overruling
106k100 In General
106k100(1) k. In General; Retroactive or Prospective Operation. Most Cited Cases

Insurance 217 ⚷3170

217 Insurance
217XXVII Claims and Settlement Practices
217XXVII(B) Claim Procedures
217XXVII(B)2 Notice and Proof of Loss
217k3170 k. Forwarding Demands and Papers; Summons and Pleadings. Most Cited Cases
(Formerly 217k539.8)

Where an insurance company attempts to be relieved of its obligations under a liability policy not covered by statute applicable only to motor vehicle liability coverage, on the ground of untimely notice, the insurance company will be required to prove both that the notice provision was in fact breached and that the breach resulted in prejudice to its position; however, such change in the law is to be applied wholly prospectively, and thus plaintiff's action to apply proceeds of legal malpractice policies was correctly dismissed, in that insured attorney failed to give written notification of the claim and to forward suit papers to insurer in violation of provisions of his insurance contract. M.G.L.A. c. 175, § 112.

*278 **185 Evan T. Lawson, Boston (Howard J. Wayne, Boston, with him), for plaintiff.

Stephen A. Moore, Boston (Jean F. Farrington, Boston, with him), for St. Paul Fire & Marine Ins. Co.

**186 Before HENNESSEY, C. J., and QUIRICO, WILKINS and ABRAMS, JJ.

HENNESSEY, Chief Justice.

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This is an action by Johnson Controls, Inc. (Johnson), to reach and apply the proceeds of legal malpractice insurance policies issued by St. Paul Fire and Marine Insurance Company (St. Paul) to attorney John T. Bowes (Bowes). See G.L. c. 214, s 3(6). A judge of the Superior Court in Middlesex County granted St. Paul's motion for summary judgment and entered a judgment dismissing*279 Johnson's claim. The appeal was transferred to this court on our own motion.

Between 1960 and 1972 Bowes, then a member of the Massachusetts bar, was retained by Johnson to perform legal services in its behalf. St. Paul issued Bowes legal malpractice insurance policies, which were in effect from July, 1962, to July, 1968, and had a $1,000,000 an occurrence limit of liability.

On June 4, 1973, Johnson brought an action against Bowes in the Superior Court in Norfolk County charging six counts of negligence in his performance of legal services. On January 10, 1974, counsel for Johnson notified St. Paul of the malpractice action against Bowes. Counsel also provided St. Paul with copies of the declaration and writ and rescheduled a deposition of Bowes from January 30 to February 13, 1974, at the request of St. Paul's representative. On February 7, 1974, St. Paul notified Bowes that it disclaimed coverage and would not honor the claim or provide a defense. St. Paul based its disclaimer on Bowes's failures to give written notification of the claim and to forward suit papers to the company in violation of the provisions of his insurance contract. [FN2] A copy of St. Paul's letter to Bowes was sent to attorneys for Johnson.

FN2. The insurance contract between Bowes and St. Paul provided, in part: (1) "In the event of an occurrence, written notice containing particulars sufficient to identify the Insured and also reasonably obtainable information with respect to the time, place or circumstances thereof, and the names and address (sic) of the injured and of available witnesses shall be given by or for the Insured to the Company or any of its authorized agents as soon as practicable." (2) "If claim is made or suit is brought against the Insured, the Insured shall immediately forward to the Company every demand, notice, summons or other process received by him or his representative."

Subsequently, Johnson's action in Norfolk County against Bowes was referred to a master, who found that Bowes had been negligent in all six instances claimed by Johnson. The master's report was confirmed, and Johnson was awarded judgment against Bowes in the amount of $31,698.28 plus $27.50 for costs. The judgment has not been satisfied.

*280 Johnson raises several issues in this appeal, but we reach only the first wherein Johnson urges this court to reexamine the present rule, applicable to some liability insurance, that the failure of an insured to comply with the notice requirements of a policy, in the absence of estoppel or waiver and regardless of lack of prejudice to the insurer, bars recovery. See Spooner v. General Accident Fire & Life Assur. Corp., -- Mass. --, -- [FNa], 397 N.E.2d 1290 (1979), and cases cited. In Spooner v. General Accident Fire & Life Assur. Corp., supra at -- [FNb], 397 N.E.2d at 1291, we noted that the notice requirement was "an aspect of contract law that we (had) not previously questioned." In sharp contrast to the case at bar, however, Spooner involved a motor vehicle liability insurance policy, one of the types of policies affected by a prospective legislative amendment of the notice requirement. [FN3] Id. at -- - -- [FNc], 397 N.E.2d 1290. This court deferred to the Legislature's determination that the change in **187 common law should be prospective only and refused the plaintiff's request that we "depart retroactively from the meaning and import that we have given for at least two generations to a significant condition of contracts of insurance."

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Id. at -- [FNd], 397 N.E.2d at 1291. The policy in the instant case does not come within the confines of the legislative amendment. Consequently, it presents a more appropriate vehicle for reconsideration of our common law.

FNa. Mass.Adv.Sh. (1979) 2657, 2658.

FNb. Mass.Adv.Sh. (1979) at 2659.

FN3. The Legislature's passage of St. 1977, c. 437, amending G.L. c. 175, s 112, prohibits an insurer from denying coverage on a motor vehicle insurance policy or other policy compensating for bodily injury, death, or property damage because of failure of the insured to give seasonable notice, unless the insurer has been prejudiced thereby.

FNc. Mass.Adv.Sh. (1979) at 2659-2660.

FNd. Mass.Adv.Sh. (1979) at 2659.

Although a majority of courts adhere to a strict contractual interpretation of notice provisions as a condition precedent to an insurer's liability, there is a recent trend to eschew such technical forfeitures of insurance coverage unless the insurer has been materially prejudiced by virtue of late notification. See generally 8 J.A. Appleman, Insurance Law and Practice s 4732 (1962); 13 G. Couch, Insurance s 49:88 (2d ed. 1965); Comment, The Materiality of Prejudice to the Insurer as a Result of the Insured's *281 Failure to Give Timely Notice, 74 Dick.L.Rev. 260 (1970). In rejecting the strict contractual approach, the Supreme Court of Pennsylvania stated: "The rationale underlying the strict contractual approach reflected in our past decisions is that courts should not presume to interfere with the freedom of private contracts and redraft insurance policy provisions where the intent of the parties is expressed by clear and unambiguous language. We are of the opinion, however, that this argument, based on the view that insurance policies are private contracts in the traditional sense, is no longer persuasive. Such a position fails to recognize the true nature of the relationship between insurance companies and their insureds. An insurance contract is not a negotiated agreement; rather its conditions are by and large dictated by the insurance company to the insured. The only aspect of the contract over which the insured can 'bargain' is the monetary amount of coverage." Brakeman v. Potomac Ins. Co., 472 Pa. 66, 72, 371 A.2d 193, 196 (1977). Courts have also been influenced to adopt a more liberal approach to the notice question because the classic contractual approach involves a forfeiture. In Cooper v. Government Employees Ins. Co., 51 N.J. 86, 93-94, 237 A.2d 870, 873-74 (1968), the court commented: "(A)lthough the policy may speak of the notice provision in terms of 'condition precedent,' . . . nonetheless what is involved is a forfeiture, for the carrier seeks, on account of a breach of that provision, to deny the insured the very thing paid for. This is not to belittle the need for notice of an accident, but rather to put the subject in perspective. Thus viewed, it becomes unreasonable to read the provision unrealistically or to find that the carrier may forfeit the coverage, even though there is no likelihood that it was prejudiced by the breach. To do so would be unfair to insureds." See Miller v. Marcantel, 221 So.2d 557, 559 (La.App. 1969); Restatement (Second) of Contracts s 255 (Tent.Draft No. 7, 1972).

The basic purpose of a strict interpretation of a notice clause is to enable an insurer to make "seasonable investigation of the facts relating to liability." *282Bayer & Mingolla Constr. Co. v. Deschenes, 348 Mass. 594, 600, 205 N.E.2d 208, 212 (1965). "Such a requirement protects the insurance company from fraudulent claims, as well as invalid claims made in good faith, by allowing the insurance company to gain early control of the proceedings. . . . (A) reasonable notice clause is de-

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signed to protect the insurance company from being placed in a substantially less favorable position than it would have been in had timely notice been provided, e.g., being forced to pay a claim against which it has not had an opportunity to defend effectively. In short, the function of a notice requirement is to protect the insurance company's interest from being prejudiced. Where the insurance company's interests have not been harmed by a late notice, even in the absence of extenuating circumstances to excuse the tardiness, the reason behind the notice condition in the policy is lacking, and it follows neither logic nor fairness to relieve the insurance company of its obligations under **188 the policy in such a situation." Brakeman v. Potomac Ins. Co., supra 472 Pa. at 74-75, 371 A.2d at 197. See Miller v. Marcantel, supra at 559.

In light of the foregoing reasoning, we are of the opinion that our prior decisions relative to the delayed notice of an accident and the delayed notice of the institution of a suit have been too restrictive and should be changed. Accordingly, we hold that where an insurance company attempts to be relieved of its obligations under a liability insurance policy not covered by G.L. c. 175, s 112, on the ground of untimely notice, the insurance company will be required to prove both that the notice provision was in fact breached and that the breach resulted in prejudice to its position. See, e.g., Lindus v. Northern Ins. Co., 103 Ariz. 160, 438 P.2d 311 (1968); Miller v. Marcantel, supra; Cooper v. Government Employees Ins. Co., supra; Fox v. National Sav. Ins. Co., 424 P.2d 19 (Okl. 1967); Lusch v. Aetna Cas. & Sur. Co., 272 Or. 593, 538 P.2d 902 (1975); Pickering v. American Employers Ins. Co., 109 R.I. 143, 282 A.2d 584 (1971); Factory Mut. Liab. Ins. Co. v. Kennedy, 256 S.C. 376, 182 S.E.2d 727 (1971); Oregon Auto. Ins. Co. v. Salzberg, 85 Wash.2d 372, 535 P.2d 816 (1975). However, because our reform of the notice requirement constitutes "a drastic or *283 radical incursion upon existing law," which would disturb retroactively the contractual arrangements of the insurer and the insured, we confine our decision to claims arising after the date of this opinion.[FN4] Diaz v. Eli Lilly & Co., 364 Mass. 153, 167, 302 N.E.2d 555 (1973). R. E. Keeton, Venturing to do Justice 25-53 (1969). It follows that the Superior Court's order dismissing Johnson's claim is affirmed.

FN4. We note that an alternative to our wholly prospective overruling would be a limited retroactive application to the claim before us. Such selective retroactive application has been justified, in part, because it encourages socially beneficial attacks on outmoded doctrines. E.g., Molitor v. Kaneland Community Unit Dist. No. 302, 18 Ill.2d 11, 28, 163 N.E.2d 89 (1959), cert. denied, 362 U.S. 968, 80 S.Ct. 955, 4 L.Ed.2d 900 (1960) (charitable immunity); Kojis v. Doctors Hosp., 12 Wis.2d 367, 374, 107 N.W.2d 131 (1961) (charitable immunity). However, the unevenness of such a change in doctrine has been criticized: "This combination of partly prospective and partly retroactive overruling offers only a little more encouragement to attacks on outmoded doctrine than the inducement a claimant and his attorney would find in the hope of persuading the court to overrule retroactively. The advantage from this added degree of encouragement, such as it may be, probably is outweighed by the disadvantage of uneven treatment . . . . It is true that some unevenness is an inevitable consequence of any change in doctrine, regardless of the choice among methods of change. But it seems preferable that a court reduce the element of unevenness more than is possible under decisions applying a new rule retroactively only to the case before the court, or to that and closely related cases."

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R. E. Keeton, Venturing to do Justice 36 (1969). As we have stated, the change of existing law involves a previously unquestioned aspect of contract law, in which reliance interests exert a strong influence. We conclude, therefore, that a wholly prospective overruling is more appropriate in the instant case. We are cognizant of the fact that in spite of our prospective limitation there will be a period of adjustment in which insurers may be exposed to increased liability, but we do not think such a limited impact justifies a strict adherence to precedent.

So ordered.

Mass., 1980.
Johnson Controls, Inc. v. Bowes
381 Mass. 278, 409 N.E.2d 185

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United States Court of Appeals,
Ninth Circuit.
James K. BURNS; Patricia Ross; Walter H. Ratcliff, Plaintiffs-Appellants,
v.
INTERNATIONAL INSURANCE CO.; Crum & Forster, Defendants-Appellees.
No. 89-15473.

Argued and Submitted March 15, 1990.
Decided April 2, 1991.

After they were sued, officers and directors of savings and loan brought action seeking declaration that they were owed coverage under professional liability policy. The United States District Court for the Northern District of California, Fern M. Smith, J., 709 F.Supp. 187, entered summary judgment against officers and directors, and they appealed. The Court of Appeals, Beezer, Circuit Judge, held that California Supreme Court would conclude that "notice-prejudice rule" did not apply to claims-made policies.

Affirmed.

West Headnotes

[1] Insurance 217 ⚷2266

217 Insurance
217XVII Coverage--Liability Insurance
217XVII(A) In General
217k2263 Commencement and Duration of Coverage
217k2266 k. Claims Made Policies. Most Cited Cases
(Formerly 217k178.6)
California Supreme Court would conclude that "notice-prejudice rule," under which breach of policy provision by insured cannot provide valid defense to insurer unless insurer was substantially prejudiced by breach, did not apply to claims-made policies.

[2] Federal Courts 170B ⚷383

170B Federal Courts
170BVI State Laws as Rules of Decision
170BVI(B) Decisions of State Courts as Authority
170Bk382 Court Rendering Decision
170Bk383 k. Inferior State Courts. Most Cited Cases

Federal Courts 170B ⚷391

170B Federal Courts
170BVI State Laws as Rules of Decision
170BVI(B) Decisions of State Courts as Authority
170Bk388 Federal Decision Prior to State Decision
170Bk391 k. Sources of Authority; Assumptions Permissible. Most Cited Cases
In absence of state Supreme Court decision on issue of state law, federal Court of Appeals looks to other state-court decisions, well-reasoned decisions from other jurisdictions, and any other available authority to determine applicable state law; decisions by state Courts of Appeals provide guidance and instruction and are not to be disregarded in absence of convincing indications that state Supreme Court would hold otherwise.
***1422** Timothy F. Perry, Khourie, Crew & Jaeger, San Francisco, Cal., John Banker, Tiburon, Cal., and Patricia Nichols, Oakland, Cal., for plaintiffs-appellants.

Harry W.R. Chamberlain, II, Musick, Peeler & Garrett, Los Angeles, Cal., and Louis G. Corsi, Siff, Rosen & Parker, New York City, for defendants-appellees.

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Appeal from the United States District Court for the Northern District of California.

Before TANG and BEEZER, Circuit Judges, and STEPHENS, District Judge.

BEEZER, Circuit Judge:

Plaintiffs, officers and directors of Centennial Savings and Loan Association, were sued in state and federal court for alleged *1423 professional misconduct. Defendants, International Insurance Company and Crum and Forster, refused to cover plaintiffs in these actions under a professional liability policy between them. In the present action, plaintiffs sought a judgment declaring that defendants owed them coverage under the policy. The district court granted summary judgment in favor of defendants. We affirm.

I

Plaintiffs James K. Burns, Patricia Ross, and Walter H. Ratcliff are former officers and directors of Centennial Savings and Loan Association ("Centennial"), a now bankrupt California corporation. Defendant International Insurance Company ("International") is an Illinois insurance corporation. Defendant Crum and Forster is an underwriting corporation, not a party to this appeal.

Plaintiffs purchased professional liability insurance from International for the period March 3, 1982 through March 3, 1985. Under this agreement the insurer agreed to pay, up to the policy limits,

on behalf of the insureds all loss which the insureds shall become legally obligated to pay for any claim or claims made against the insureds during the policy period because of a wrongful act, notice of which claim is received by the company within sixty days following the termination of the policy period. [FN1]

FN1. This requires that notice be provided to the insurer on or before May 2, 1985.

This policy provides that the insurer's duties arise

[i]f during the policy period:

(i) the insureds or any of them shall receive written or oral notice from any party that it is the intention of such party to hold the insureds responsible for the results of any specified wrongful act done or alleged to have been done by the insureds while acting in an insured capacity, and shall during the policy period give notice in writing to the [insurance] company of such oral or written notice received, ...;

(ii) the insureds or any of them shall become aware of any event or circumstance which may subsequently give rise to a claim being made against the insureds in respect of such alleged wrongful act, and shall during the policy period give written notice to the company....

This notice provision is a "condition precedent to the insured's right of coverage under the policy."

Centennial and its officers and directors came under the examination of the Federal Home Loan Bank Board ("FHLBB") beginning in 1983 because of various banking regulation violations. The FHLBB gave Centennial notice of the practices that caused concern. However, in a 1984 examination, the operations of the bank were still found to be in violation. In particular, Centennial was found to be overlending in general, overlending to individual borrowers, and lending to interested borrowers.

On August 30, 1984, the Federal Savings and Loan Insurance Corporation ("FSLIC") and Centennial came to an agreement under which FSLIC would not begin formal proceedings against the bank in exchange for the cooperation of the bank in desisting such practices. As part of this agreement, the officers and directors admitted the above-men-

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tioned violations. Centennial did not notify International of these investigations, or of this agreement. According to the record, the defendants' first notice came in a letter from FHLBB to defendants, dated August 20, 1985.

In September, 1985, FHLBB declared Centennial bankrupt. In response, a number of shareholder derivative lawsuits were filed against Centennial and its officers. In September, 1987, FSLIC filed suit against Centennial and its officers. Plaintiffs notified defendants promptly of each action, but defendants refused coverage.

Plaintiffs brought this action against International and Crum and Forster seeking a declaration that defendants owed Centennial coverage under the policy. The district court, in an opinion reported at 709 F.Supp. 187 (N.D.Cal.1989), granted summary*1424 judgment for International.[FN2] The court held that even though events and circumstances that could have led to a claim against the plaintiffs occurred during the policy period, plaintiffs had not given International timely notice, as required by the terms of the policy.

> FN2. In addition, the district court dismissed all claims against Crum and Forster. Plaintiffs have not appealed the dismissal of those claims.

II

We review a grant of summary judgment de novo. *Darring v. Kincheloe,* 783 F.2d 874, 876 (9th Cir.1986). Where a federal court has jurisdiction by virtue of diversity of citizenship of the parties, the court must follow state law. *Erie R.R. Co. v. Tompkins,* 304 U.S. 64, 78, 58 S.Ct. 817, 822, 82 L.Ed. 1188 (1938). The parties agree that California law is the governing substantive law. Questions of state law are reviewed de novo. *Churchill v. F/V Fjord (Matter of McLinn),* 739 F.2d 1395, 1397 (9th Cir.1984) (en banc).

In the present case, the parties agree that the policy at issue is a claims-made policy,[FN3] and that the insurer is only responsible for claims made during the term of the policy or resulting from events or circumstances that could lead to a claim, concerning which the insurer is notified within the term of the policy plus sixty days.[FN4] The parties also agree that the insured did not provide notice to the insurer within the described notice period.

> FN3. Under a "claims-made policy," an insurer is responsible for any loss resulting from claims made during the policy period. Under the traditional "occurrence policy," an insurer is responsible for any loss resulting from acts that occur during the policy period. The insurer and the insured clearly may limit policy coverage in this way. *See National Ins. Underwriters v. Carter,* 17 Cal.3d 380, 386, 131 Cal.Rptr. 42, 46, 551 P.2d 362, 366 (1976) (insurance company has right to limit coverage of policies it issues).

> FN4. The district court found that the Supervisory Agreement between Centennial and FHLBB and the correspondence represented a circumstance that might subsequently give rise to a claim that would lead to coverage under the policy under section VII(A)(ii). Appellees do not dispute this analysis. Appellants argue that these events themselves constitute a claim. We reserve comment because this argument does not affect the outcome on ap- peal.

[1] Plaintiffs argue that the district court erred in its determination that they were precluded from coverage under the insurance policy. They claim that, despite the fact that they did not comply with the notice provisions of the policy, they should nonetheless receive coverage because, as a matter of public policy, California has adopted the notice-

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prejudice rule. The notice-prejudice rule provides that the breach of a policy provision by an insured cannot provide a valid defense to the insurer unless the insurer substantially was prejudiced by the breach.

The California Supreme Court has not decided whether the notice-prejudice rule applies to claims-made insurance policies in California. In the absence of California Supreme Court precedent, we must resort to other authority and exercise our own best judgment in determining how that court would resolve the issue. *Dimidowich v. Bell & Howell,* 803 F.2d 1473, 1482 (9th Cir.1986).

The district court held that the notice-prejudice rule should not apply to claims-made policies. In doing so, the court relied upon policy arguments, jurisprudence from outside California, and *Brown-Spaulding & Assocs. v. International Surplus Lines Ins. Co.,* 206 Cal.App.3d 1441, 254 Cal.Rptr. 192 (1988), *rev. denied and op. withdrawn,* (Cal.S.Ct., March 16, 1989).

[2] In the absence of a supreme court decision on the subject in question, we look to other state-court decisions, well-reasoned decisions from other jurisdictions, and any other available authority to determine the applicable state law. *Dimidowich,* 803 F.2d at 1482. Decisions by the state courts of appeals provide guidance and instruction and are not to be disregarded in the absence of convincing indications that the state supreme court would hold otherwise. *Id.*

In California, it is clear that the notice-prejudice rule applies to occurrence policies. *See, e.g.,* ***1425***Campbell v. Allstate Ins. Co.,* 60 Cal.2d 303, 305-06, 32 Cal.Rptr. 827, 828, 384 P.2d 155, 156 (1963). Authorities in California are split, however, as to whether the notice-prejudice rule applies to claims-made policies. In *Northwestern Title Security Co. v. Flack,* 6 Cal.App.3d 134, 85 Cal.Rptr. 693 (1970), the California Court of Appeal for the First District held that the notice-prejudice rule applies to claims-made policies. More recently, the Court of Appeal for the Second District reached the opposite conclusion. *See Pacific Employers Ins. Co. v. Superior Ct.,* 221 Cal.App.3d 1348, 1358-59, 270 Cal.Rptr. 779, 784 (1990). Because these are decisions from different districts of the Court of Appeal, neither is binding on the other. 9 B. Witkin, *California Procedure,* Appeal § 772 (3d ed. 1985); *see, e.g., Bridges v. Bridges,* 82 Cal.App.3d 976, 977-78, 147 Cal.Rptr. 471, 472 (1978).

For two reasons, however, we believe the California Supreme Court would agree with the Second District that the notice-prejudice rule does not apply to claims-made policies.

First, the California Supreme Court denied a request to review *Pacific Employers* on October 17, 1990. Although denial of review "is not to be regarded as expressing approval of the propositions set forth in an opinion of the District Court of Appeal or as having the same authoritative effect as an earlier decision of [the California Supreme Court, ...] it does not follow that such a denial is without significance as to [the] views [of that court]." *Di Genova v. State Bd. of Educ.,* 57 Cal.2d 167, 178, 18 Cal.Rptr. 369, 375, 367 P.2d 865, 871 (1962) (citations omitted). Thus, the denial provides some indication that *Pacific Employers* was decided correctly. *Id.*

Second, we note, as did the Court of Appeal in *Pacific Employers,* that the distinction between the two kinds of policies is critical. A claims-made policy reduces the potential exposure of the insurer and is therefore less expensive to the insured. To apply the notice-prejudice rule to a claims-made policy would be to rewrite the policy, extending the policy's coverage at no cost to the insured.

The district court held that the notice-prejudice rule does not apply to a claims-made policy in California. We believe the California Supreme Court

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would reach the same conclusion. Therefore, we affirm.

AFFIRMED.

C.A.9 (Cal.),1991.
Burns v. International Ins. Co.
929 F.2d 1422

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162 Cal.App.3d 358, 208 Cal.Rptr. 494, 50 A.L.R.4th 913
(Cite as: 162 Cal.App.3d 358, 208 Cal.Rptr. 494)

Court of Appeal, Fourth District, Division 1, California.
SAN DIEGO NAVY FEDERAL CREDIT UNION, et al., Plaintiffs and Respondents,
v.
CUMIS INSURANCE SOCIETY, INC., Defendant and Appellant.
D000911.
Civ. 31043.

Dec. 3, 1984.
Hearing Denied Feb. 21, 1985.

Insurer appealed a judgment of the Superior Court, San Diego County, G. Dennis Adams, J., requiring it to pay its insureds all reasonable past and future expenses of their independent counsel retained for defense of a law suit filed against them. The Court of Appeal, Gamer, J., assigned, held that where insurer retained counsel to defend the third-party lawsuit but reserved its right to assert noncoverage at a later date, a conflict of interest existed between the insurer and insureds, and thus, insureds had right to independent counsel paid for by the insurer.

Judgment affirmed.

West Headnotes

[1] Attorney and Client 45 ⚿20.1

45 Attorney and Client
45I The Office of Attorney
45I(B) Privileges, Disabilities, and Liabilities
45k20 Representing Adverse Interests
45k20.1 k. In General. Most Cited Cases
(Formerly 45k20)
An attorney who has dual agency status is subject to the rule that a conflict of interest between jointly represented clients occurs whenever their common lawyer's representation of the one is rendered less effective by reason of his representation of the other.

[2] Attorney and Client 45 ⚿21.10

45 Attorney and Client
45I The Office of Attorney
45I(B) Privileges, Disabilities, and Liabilities
45k20 Representing Adverse Interests
45k21.10 k. Disclosure, Waiver, or Consent. Most Cited Cases
While an insurance policy provision requiring an insured to permit insurer to employ an attorney to defend a third party suit may amount to a consent in advance to a conflict of interest, where the insured affirmatively withdraws that consent by hiring independent counsel, no doubt motivated by the insurer's reservation of rights, any such consent may be deemed withdrawn.

[3] Attorney and Client 45 ⚿21.5(5)

45 Attorney and Client
45I The Office of Attorney
45I(B) Privileges, Disabilities, and Liabilities
45k20 Representing Adverse Interests
45k21.5 Particular Cases and Problems
45k21.5(5) k. Insurance. Most Cited Cases
Law firm hired by insurance company to defend action brought against its insureds represented clients with conflicting interests on the advisability of settlement, where it was uncontested that basis for liability, if any, might rest on conduct excluded by terms of the insurance policy.

[4] Insurance 217 ⚿2929

217 Insurance
217XXIII Duty to Defend
217k2925 Fulfillment of Duty and Conduct of Defense

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162 Cal.App.3d 358, 208 Cal.Rptr. 494, 50 A.L.R.4th 913
(Cite as: 162 Cal.App.3d 358, 208 Cal.Rptr. 494)

217k2929 k. Conflicts of Interest; Independent Counsel. Most Cited Cases
(Formerly 217k514.15)
An insurer has to pay for an insured's independent counsel where a conflict of interest exists in that multiple theories of recovery are alleged and some theories involve uncovered conduct under the policy, since if an insurer must pay for cost of defense and, when a conflict exists, the insurer may have control of the defense if he wishes, it follows the insurer must pay for such defense conducted by independent counsel.

[5] Attorney and Client 45 ⚿21.5(5)

45 Attorney and Client
45I The Office of Attorney
45I(B) Privileges, Disabilities, and Liabilities
45k20 Representing Adverse Interests
45k21.5 Particular Cases and Problems
45k21.5(5) k. Insurance. Most Cited Cases
A conflict of interest arises when an attorney represents both an insurer and the insured in a third-party action once the insurer takes the view a coverage issue is present.

[6] Attorney and Client 45 ⚿21.5(5)

45 Attorney and Client
45I The Office of Attorney
45I(B) Privileges, Disabilities, and Liabilities
45k20 Representing Adverse Interests
45k21.5 Particular Cases and Problems
45k21.5(5) k. Insurance. Most Cited Cases
A serious conflict of interest occurs between an insurer and an insured when an insurer's retained counsel obtains information bearing directly on issue of coverage during course of preparation of a third-party suit.

[7] Attorney and Client 45 ⚿21.5(5)

45 Attorney and Client
45I The Office of Attorney
45I(B) Privileges, Disabilities, and Liabilities
45k20 Representing Adverse Interests
45k21.5 Particular Cases and Problems
45k21.5(5) k. Insurance. Most Cited Cases
When an insurer's retained counsel represents both the insurer and the insured in a third-party action, recognition of a conflict in interest cannot wait until moment a tactical decision must be made during trial, but rather, existence of such a conflict of interest should be identified early in the proceeding so it can be treated effectively before prejudice has occurred to either party.

[8] Insurance 217 ⚿2929

217 Insurance
217XXIII Duty to Defend
217k2925 Fulfillment of Duty and Conduct of Defense
217k2929 k. Conflicts of Interest; Independent Counsel. Most Cited Cases
(Formerly 217k514.15)
Where insurer retained counsel to defend a third-party suit against insureds in which punitive damages were sought, with a potential result that there would be no coverage under the policy, a plain conflict of interest existed in attorney's representation of both the insurer and the insureds, for purposes of determining whether insurer was liable to pay attorney fees for independent counsel hired by insureds; disagreeing with *Zieman Mfg. Co. v. St. Paul Fire & Marine Ins. Co.*, 724 F.2d 1343.

[9] Attorney and Client 45 ⚿107

45 Attorney and Client
45III Duties and Liabilities of Attorney to Client
45k107 k. Skill and Care Required. Most Cited Cases
Counsel representing an insurer and the insured owes both a high duty of care and unswerving allegiance.

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[10] Attorney and Client 45 21.10

45 Attorney and Client
 45I The Office of Attorney
  45I(B) Privileges, Disabilities, and Liabilities
   45k20 Representing Adverse Interests
    45k21.10 k. Disclosure, Waiver, or Consent. Most Cited Cases

When two clients have diverging interests, counsel who represents both must disclose all facts and circumstances to both clients to enable them to make intelligent decisions regarding continuing representation. ABA Code of Prof.Resp., EC5-14 to EC5-17.

[11] Attorney and Client 45 21.10

45 Attorney and Client
 45I The Office of Attorney
  45I(B) Privileges, Disabilities, and Liabilities
   45k20 Representing Adverse Interests
    45k21.10 k. Disclosure, Waiver, or Consent. Most Cited Cases

Canons of Ethics impose upon lawyers hired by an insurer an obligation to explain to the insured and the insurer the full implications of joint representation in situations where the insurer has reserved its rights to deny coverage. Prof.Conduct Rule 5-102(B); ABA Code of Prof.Resp., EC5-14 to EC5-17.

[12] Attorney and Client 45 21.5(5)

45 Attorney and Client
 45I The Office of Attorney
  45I(B) Privileges, Disabilities, and Liabilities
   45k20 Representing Adverse Interests
    45k21.5 Particular Cases and Problems
     45k21.5(5) k. Insurance. Most Cited Cases

If an insured does not give an informed consent to an attorney's continued joint representation of insurer and the insured in situations where the insurer has reserved its rights to deny coverage, counsel must cease to represent both. Prof.Conduct Rule 5-102(B); ABA Code of Prof.Resp., EC5-14 to EC5-17.

[13] Insurance 217 2929

217 Insurance
 217XXIII Duty to Defend
  217k2925 Fulfillment of Duty and Conduct of Defense
   217k2929 k. Conflicts of Interest; Independent Counsel. Most Cited Cases
 (Formerly 217k514.15)

In the absence of insured's consent to an attorney's joint representation of the insurer and the insured, where there are divergent interests of the insured and the insurer brought about by the insurer's reservation of rights based on possible noncoverage under the insurance policy, the insurer must pay insured's reasonable costs for hiring independent counsel.

[14] Insurance 217 2928

217 Insurance
 217XXIII Duty to Defend
  217k2925 Fulfillment of Duty and Conduct of Defense
   217k2928 k. Right to Control Defense. Most Cited Cases
 (Formerly 217k514.7)

An insurer may not compel an insured to surrender control of litigation where insurer has reserved its rights to deny coverage.

[15] Attorney and Client 45 21.5(5)

45 Attorney and Client
 45I The Office of Attorney
  45I(B) Privileges, Disabilities, and Liabilities
   45k20 Representing Adverse Interests
    45k21.5 Particular Cases and Problems
     45k21.5(5) k. Insurance. Most Cited Cases

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Insurance 217 ⟹2929

217 Insurance
217XXIII Duty to Defend
217k2925 Fulfillment of Duty and Conduct of Defense
217k2929 k. Conflicts of Interest; Independent Counsel. Most Cited Cases
(Formerly 217k514.15)

Disregarding common interest of both insurer and insureds in finding total nonliability in third-party action for tortious wrongful discharge, breach of covenant of good faith and fair dealing, and other claims against insureds, remaining interests of the insurer and the insureds diverged to such an extent as to create an actual, ethical conflict of interest in same attorney representing both the insureds and their insurer, warranting payment by insurer for insureds' independent counsel.

**495 *360 Hardin, Cook, Loper, Engel & Bergez, Gennaro A. Filice III, Oakland, and Roberta E. Nalbandian, Sacramento, for defendant and appellant.

Breidenbach, Swainston, Yokaitis & Crispo, Los Angeles, Bronson, Bronson & McKinnon, San Francisco, W.F. Rylaarsdam, Los Angeles, Jeanne E. Emrich, Long Beach, Ronald E. Mallen, San Francisco, Michael J. Brady, Redwood City, David R. Fuller, Chico, Raoul D. Kennedy, Oakland, Paul H. Cyril and David W. Gordon, San Francisco, as amici curiae on behalf of defendant and appellant.

*361 Saxon, Alt, Brewer & Kincannon and Mark A. Saxon, San Diego, for plaintiffs and respond- ents.

Leonard Sacks, Northridge, Robert E. Cartwright, Harvey R. Levine, San Diego, Wylie A. Aitken, Santa Ana, Harlan Arnold, Beverly Hills, Glen T. Bashore, North Fork, Ray Bourhis, San Francisco, Richard D. Bridgman, Oakland, Edwin Train Caldwell, San Francisco, David S. Casey, Jr., San Diego, Victoria DeGoff, Berkeley, **496 Douglas K. deVries, Sacramento, H. Grieg Fowler, San Francisco, Sanford M. Gage, Beverly Hills, Ian Herzog, Los Angeles, G. Dana Hobart, Marina Del Rey, Stanley K. Jacobs, Los Angeles, John C. McCarthy, Claremont, Timothy W. Peach, San Bernardino, R.H. Sulnick, Los Angeles, Arne Werchick, Sausalito, and Stephen Zetterberg, Claremont, as amici curiae on behalf of plaintiffs and respondents.

GAMER, Associate Justice.[FN*]

FN* Assigned by the Chairperson of the Judicial Council.

Cumis Insurance Society, Inc. (Cumis) appeals a judgment requiring Cumis to pay the San Diego Navy Federal Credit Union, J.W. Jamieson and Larry R. Sharp (insureds) all reasonable past and future expenses of their independent counsel retained for the defense of a lawsuit filed against the insureds by Magdaline S. Eisenmann (Eisenmann action).[FN1]

FN1. *Magdaline S. Eisenmann v. San Diego Navy Federal Credit Union,* et al., San Diego Superior Court case number 469823.

The issue presented to this court by the appeal is whether an insurer is required to pay for independent counsel for an insured when the insurer provides its own counsel but reserves its right to assert noncoverage at a later date. We conclude under these circumstances there is a conflict of interest between the insurer and the insured, and therefore the insured has a right to independent counsel paid for by the insurer.

The Eisenmann action against the insureds seeks $750,000 general and $6.5 million punitive damages for tortious wrongful discharge, breach of the covenant of good faith and fair dealing, wrongful interference with and inducing breach of contract, breach of contract and intentional infliction of emo-

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tional distress. Under insurance policies issued by Cumis, the insureds tendered the defense of the Eisenmann action to Cumis. Cumis associate counsel Willis E. McAllister reviewed the complaint in the Eisenmann action and concluded Cumis had a duty to provide a defense to the insureds. McAllister selected and retained, at Cumis' expense, the San Diego law firm of Goebel & Monaghan to represent the interests of the insureds in the *362 Eisenmann action. McAllister informed Goebel & Monaghan it was to represent the insureds as to all claims in the Eisenmann action, including the punitive damages claim. He also told Goebel & Monaghan Cumis was reserving its right to deny coverage at a later date and the insurance policies did not cover punitive damages.

McAllister sent Goebel & Monaghan copies of the insurance policies in effect and letters accepting the defense and reserving rights which were delivered to the insureds. McAllister never asked Goebel & Monaghan for an opinion whether coverage existed under the insurance policies, nor did Goebel & Monaghan give any coverage advice to either Cumis or the insureds.

McAllister believed if the Eisenmann action resulted in a finding of wilful conduct or an award of punitive damages, the Cumis policies did not provide coverage for those damages. Moreover, his view was if the Eisenmann action resulted in a finding of breach of contract as against any of the insureds, there might be no coverage under the relevant Cumis policies. Accordingly, on behalf of Cumis, McAllister notified each insured by letter Cumis was reserving its rights to disclaim coverage and denying any coverage for punitive damages. FN2

FN2. The reservation of rights letter explained:

"Because of the nature of the case and the present lack of factual information relative to the allegations of the plaintiff, it is necessary for CUMIS Insurance Society, Inc. to reserve its rights to disclaim coverage on the ground that the actions complained of by the plaintiff are not covered under the Directors and Officers Endorsement to the CUMIS Discovery Bond, or any other coverage provided by CUMIS to you. CUMIS specifically denies any coverage for punitive damages in the above-mentioned legal action.

"On behalf of CUMIS Insurance Society, Inc., we will conduct an investigation of this case, and provide the defense to you under a full reservation of the Society's rights. In addition, if CUMIS settles the above-mentioned legal action, CUMIS reserves its right to seek reimbursement from you for such settlement amount if noncoverage by CUMIS is subsequently established. Such investigation, defense or settlement shall not prejudice the rights of CUMIS Insurance Society, Inc. to disclaim coverage at a later date.

"Although CUMIS is not now denying coverage, we are sending this Reservation of Rights letter to you so that we may proceed to investigate the case, defend you or arrange settlement of this suit pending a decision of whether or not the actions complained of by the plaintiff are covered by CUMIS. In the meantime, your rights and interests are being protected as though coverage does extend to the fact situation involved."

**497 The Credit Union retained the San Diego law firm of Saxon, Alt & Brewer (independent counsel) to provide independent representation to protect the insureds' interests. Independent counsel notified Cumis it was retained to act as co-counsel with

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Goebel & Monaghan and presented Cumis a claim for its attorneys' fees and costs. McAllister was persuaded California law required Cumis to pay the fees, and he agreed to pay the fees and costs *363 incurred by independent counsel as co-counsel for the insureds. Cumis paid two separate invoices for legal services of independent counsel but additional invoices were not paid. After independent counsel sent a demand letter to Cumis and further discussed the matter with McAllister, McAllister sought a separate opinion on the question from Cumis' home office and asked Goebel & Monaghan if it felt there was a conflict of interest in representing the insureds such that Cumis would be required to pay the expenses of separate counsel. Goebel & Monaghan told McAllister it did not see a conflict of interest. Cumis' home office came to the same conclusion and McAllister notified independent counsel Cumis would pay no further invoices.

In the Eisenmann action settlement conference, the case did not settle after a demand within the Cumis policy limits. Cumis authorized Goebel & Monaghan to make an offer at the settlement conference but in an amount lower than Eisenmann's demand. Goebel & Monaghan did not contact the Credit Union before or during the settlement conference, but informed the Credit Union about the conference afterward.

In this action, the trial court ruled Cumis is required to pay for the insureds' hiring of independent counsel, rejecting Cumis' argument the court was bound by *Gray v. Zurich Insurance Co.* (1966) 65 Cal.2d 263, 54 Cal.Rptr. 104, 419 P.2d 168, and reasoning:

"1. *Gray* involved a question of the duty to defend in an assault and battery case rather than the extent and scope of that duty. The reasoning thus used to support *Gray* is not controlling, especially if it makes little sense.

"2. The reasoning of *Gray*, '[s]ince ... the court in the third party suit does not adjudicate the issue of coverage the insurer's argument (as to a conflict of interest) collapses,' just does not stand scrutiny. What the defense attorney in the third party case does impacts the coverage case, in that, the questions of coverage depends [sic] on the development of facts in the third party case and their proper development is left to the attorney paid for by the Carrier. *Gray* recognized that a finding in the third party action would effect the issues of coverage in a subsequent case but analyzed the question from the point of view of the carrier. *Gray* recognized a possible conflict from the point of view of the insured in footnote 18, where it stated: 'In rare cases the issue of punitive damages or a special verdict might present a conflict of interest, but such possibility does not outweigh the advantages of the general rule. Even in such cases, however, the insurer will still be bound ethically and legally, to litigate in the interests of the insured.' Additionally, *Gray* was looking for a way to avoid a conflict of interest, to hold that it was excluding all other approaches just does not make common *364 sense."

The court further explained its ruling:

"The Carrier is required to hire independent counsel because an attorney in actual**498 trial would be tempted to develop the facts to help his real client, the Carrier Company, as opposed to the Insured, for whom he will never likely work again. In such a case as this, the Insured is placed in an impossible position; on the one hand the Carrier says it will happily defend him and on the other it says it may dispute paying any judgment, but trust us. The dictum in *Gray* flies in the face of the reality of insurance defense work. Insurance companies hire relatively few lawyers and concentrate their business. A lawyer who does not look out for the Carrier's best interest might soon find himself out of work."

[1][2] In the usual tripartite relationship existing between insurer, insured and counsel, there is a

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single, common interest shared among them. Dual representation by counsel is beneficial since the shared goal of minimizing or eliminating liability to a third party is the same. A different situation is presented, however, when some or all of the allegations in the complaint do not fall within the scope of coverage under the policy. In such a case, the standard practice of an insurer is to defend under a reservation of rights where the insurer promises to defend but states it may not indemnify the insured if liability is found. In this situation, there may be little commonality of interest.[FN3] Opposing poles of interest are represented on the one hand in the insurer's desire to establish in the third party suit the insured's "liability rested on intentional conduct" (*Gray, supra,* 65 Cal.2d 263, 279, 54 Cal.Rptr. 104, 419 P.2d 168), and thus no coverage under the policy, and on the other hand in the insured's desire to "obtain a ruling ... such liability emanated from the nonintentional conduct within his insurance coverage" (*ibid.*). Although issues of coverage under the policy are not actually litigated in the third party suit, this does not detract from the force of these opposing interests as they operate on the attorney selected by the insurer, who has a dual ***365** agency status (see *Tomerlin v. Canadian Indemnity Co.* (1964) 61 Cal.2d 638, 647, 39 Cal.Rptr. 731, 394 P.2d 571).[FN4]

FN3. See *Purdy v. Pacific Automobile Insurance Co.* (1984) 157 Cal.App.3d 59, 76, 203 Cal.Rptr. 524, which states in part:

"[T]he 'triangular' aspect of the representation afforded the insured by the insurer's lawyers is described as a coalition for a common purpose, a favorable disposition of the claim-with the attorney owing duties to both clients. As a practical matter, however, there has been recognition that, in reality, the insurer's attorneys may have closer ties with the insurer and a more compelling interest in protecting the insurer's position, whether or not it coincides with what is best for the insured. [Citation.]

"The problem arises when the attorney knows, or should know, when a conflict has appeared between the insurer and the insured as to the most beneficial course of action indicated by the developing circumstances. It has long been the law in this state that when a conflict develops, the insurer cannot compel the insured to surrender control of the litigation, and must, if necessary, secure independent counsel for the insured, [citations] and, as was explained in *Previews, Inc. v. California Union Ins. Co.* (9th Cir.1981) 640 F.2d 1026, 1028, the insurer's obligation [to defend, after the appearance of a conflict] 'extends to paying the reasonable value of legal services and costs performed by independent counsel selected by the insured.' [Citations.]"

FN4. An attorney having dual agency status is subject to the rule a "[c]onflict of interest between jointly represented clients occurs whenever their common lawyer's representation of the one is rendered less effective by reason of his representation of the other" (*Spindle v. Chubb/Pacific Indemnity Group* (1979) 89 Cal.App.3d 706, 713, 152 Cal.Rptr. 776). While it has been said a policy provision requiring the insured to permit the insurer to employ the attorney to defend the third party suit amounts to a consent in advance to the conflict of interest (see *Lysick v. Walcom* (1968) 258 Cal.App.2d 136, 146, 65 Cal.Rptr. 406), where the insured affirmatively withdraws that consent by hiring independent counsel, no doubt motivated by the insurer's reservation of rights, any such consent may be deemed withdrawn (see *Employers' Fire Insurance Company v.*

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> *Beals* (1968) 103 R.I. 623, 240 A.2d 397, 403).

Here, it is uncontested the basis for liability, if any, might rest on conduct excluded by the terms of the insurance policy. Goebel & Monaghan will have to make certain decisions at the trial of the Eisenmann action which may either benefit or harm the insureds. For example, it will have to seek or oppose special verdicts, the answers to which may benefit the insureds **499 by finding nonexcluded conduct and harm either Cumis' position on coverage or the insureds by finding excluded conduct. These decisions are numerous and varied. Each time one of them must be made, the lawyer is placed in the dilemma of helping one of his clients concerning insurance coverage and harming the other.

The conflict may appear before trial. Goebel & Monaghan represented the insureds in the Eisenmann action settlement conference and the case did not settle although a demand was made within policy limits. Before and during the settlement conference, Goebel & Monaghan was in contact with Cumis but had no contact with the insureds about settlement until after the conference ended. The insureds then wrote a letter to counsel:

"You should know that the Credit Union desires the lawsuit to be settled without trial. Our insurance coverages, duly paid and contracted for, are precisely for such cases and any settlement liability that may arise therefrom. Your confidence in the defensibility of the case is appreciated. Should trial prove you wrong, however, and the jury awards damages, the insurance may no longer cover the Credit Union's possible losses. As you know, such losses would considerably exceed any possible settlement amount. It is clear that trial in lieu of settlement in this case subjects the Credit Union to a considerably additional risk while possibly lowering or eliminating a claim payout by CUMIS. Such is not the basic premise upon which we contracted for insurance with CUMIS.

"I urge you to work for an appropriate settlement before trial in this case so that CUMIS will have provided the risk protection for which the Credit Union has contracted."

[3] *366 On the advisability of settlement, Goebel & Monaghan represented clients with conflicting interests (*Tomerlin v. Canadian Indemnity Co., supra,* 61 Cal.2d 638, 647, 39 Cal.Rptr. 731, 394 P.2d 571). No matter how honest the intentions, counsel cannot discharge inconsistent duties.

The potential problems may develop during pretrial discovery which must go beyond simple preparation for a favorable verdict to develop alternate strategies minimizing exposure. Goebel & Monaghan was bound to investigate all conceivable bases on which liability might attach. These investigations and client communications may provide information relating directly to the coverage issue. Furthermore, counsel may form an opinion about the insureds' credibility. As between counsel's two clients, there is no confidentiality regarding communications intended to promote common goals (Evid.Code, § 962). But confidentiality is essential where communication can affect coverage. Thus, the lawyer is forced to walk an ethical tightrope, and not communicate relevant information which is beneficial to one or the other of his clients.[FN5]

> FN5. The court in *Industrial Indem. Co. v. Great American Ins. Co.* (1977) 73 Cal.App.3d 529 at 536 in footnote 5, 140 Cal.Rptr. 806, cited *E.F. Hutton & Company v. Brown,* 305 F.Supp. 371, 393-394, on a related issue. The *Hutton* court stated:
>
> " '[T]he basis for the rule against representing conflicting interests is broader than the basis for the attorney-client evidentiary privilege [Bus. & Prof.Code, § 6068]. The evidentiary privilege and the ethical duty not to disclose confidences both arise from the need to en-

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162 Cal.App.3d 358, 208 Cal.Rptr. 494, 50 A.L.R.4th 913
(Cite as: 162 Cal.App.3d 358, 208 Cal.Rptr. 494)

courage clients to disclose all possibly pertinent information to their attorneys, and both protect only the confidential information disclosed. The duty not to represent conflicting interests, on the other hand, is an outgrowth of the attorney-client relationship itself, which is confidential, or fiduciary, in a broader sense. Not only do clients at times disclose confidential information to their attorneys; they also repose confidence in them. The privilege is bottomed only on the first of these attributes, the conflicting-interests rule, on both.' (Fns. omitted. *Id.* at p. 394.)" (See also *Parsons v. Continental National American Group* (1976) 113 Ariz. 223, 550 P.2d 94, 98-99.)

The ABA Code Ethical Considerations 5-1 reads:

"The professional judgment of a lawyer should be exercised, within the bounds of the new law, solely for the benefit of his client and free of compromising influences**500 and loyalties. Neither his personal interests, the interests of other clients, nor the desires of third persons should be permitted to dilute his loyalty to his client."

ABA Code Ethical Considerations 5-15 states, in pertinent part:

"If a lawyer is requested to undertake or to continue representation of multiple clients having potentially differing interests, he must weigh carefully the possibility that his judgment may be impaired or his loyalty divided if he accepts or continues the employment. He should resolve all doubts against the propriety of the representation. A lawyer should never represent in litigation*367 multiple clients with differing interests, and there are few situations in which he would be justified in representing in litigation multiple clients with potentially differing interests. If a lawyer accepted such employment and the interests did become actually differing, he would have to withdraw from employment with likelihood of resulting hardship on the clients; and for this reason it is preferable that he refuse the employment initially."

The standard of care expressed in the ABA canons underscores the existing conflict.

Cumis contends *Gray v. Zurich Insurance Co., supra,* 65 Cal.2d 263, 54 Cal.Rptr. 104, 419 P.2d 168, is controlling and asserts Cumis fully met its duty to defend when it retained counsel at its expense and instructed counsel to defend the insureds in the underlying action.

Gray dealt with an insurer's duty to defend in the face of a third party complaint against the insured alleging the insured caused intentional injury which by the policy's terms is not within its coverage. The insured, Gray, was sued on the basis he "wilfully, maliciously, brutally and intentionally assaulted" the third party who prayed for both actual and punitive damages. The insurer refused to defend and the third party action went to judgment against the insured for actual damages. Gray then sued the insurer for breach of its duty to defend. Holding the insurer breached its duty to defend and was liable for the amount of the judgment in the third party suit, plus costs, expenses and attorney's fees for defending that suit, the Supreme Court said, in part, the insurer "bears a duty to defend its insured whenever it ascertains facts which give rise to the potential of liability under the policy" (*Gray, supra,* 65 Cal.2d 263, 276-277, 54 Cal.Rptr. 104, 419 P.2d 168). *Gray* pointed out the third party suit did not necessarily mean a recovery by the third party would be outside the policy's coverage [FN6] and it emphasized this "potential" or "possibility" of coverage in concluding the insurer "should have defended because the loss could have fallen within that liability" (*id.* at p. 277, 54 Cal.Rptr. 104, 419 P.2d 168).

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FN6. "Jones' [third party] complaint clearly presented the possibility that he might obtain damages that were covered by the indemnity provisions of the policy. Even conduct that is traditionally classified as 'intentional' or 'wilful' has been held to fall within indemnification coverage. [Fn. omitted.] Moreover, despite Jones' pleading of intentional and wilful conduct, he could have amended his complaint to allege merely negligent conduct. Further, plaintiff [Gray] might have been able to show that in physically defending himself, even if he exceeded the reasonable bounds of self-defense, he did not commit wilful and intended injury, but engaged only in nonintentional tortious conduct." (*Gray, supra,* 65 Cal.2d 263, 277, 54 Cal.Rptr. 104, 419 P.2d 168.)

The insurer argued it had no duty to defend because its interests and those of its insured were opposed. The insurer asserted, had it defended the third *368 party suit,

"it would have sought to establish either that the insured was free from any liability or that such liability rested on intentional conduct. The insured, of course, would also seek a verdict holding him not liable but, if found liable, would attempt to obtain a ruling that such liability emanated from the nonintentional conduct within his insurance coverage. Thus, defendant contends, an insurer, if obligated to defend in this situation, faces an insoluable**501 ethical problem." (*Gray, supra,* 65 Cal.2d at pp. 278-279, 54 Cal.Rptr. 104, 419 P.2d 168.)

The court rejected the argument.

"Since, however, the court in the third party suit does not adjudicate the issue of coverage, the insurer's argument collapses. The only question there litigated is the insured's *liability.* The alleged victim does not concern himself with the theory of liability; he desires only the largest possible judgment. Similarly, the insured and insurer seek only to avoid, or at least to minimize, the judgment. As we have noted, modern procedural rules focus on whether, on a given set of facts, the plaintiff, regardless of the theory, may recover. Thus the question of whether or not the insured engaged in intentional conduct does not normally formulate an issue which is resolved in that litigation." (*Gray, supra,* 65 Cal.3d at p. 279, 54 Cal.Rptr. 104, 419 P.2d 168; emphasis by the court.)

At the same time, however, the court recognized, in the footnote to this passage, "[i]n rare cases the issue of punitive damages or a special verdict might present a potential conflict of interests, but such a possibility does not outweigh the advantages of the general rule. Even in such cases, however, the insurer will still be bound, ethically and legally, to litigate in the interests of the insured." (*Gray, supra,* 65 Cal.2d at p. 279, fn. 18, 54 Cal.Rptr. 104, 419 P.2d 168.)

Gray found the insurer's contractual duty to defend cannot be avoided by creating a conflict of interest. *Gray* is not controlling here because it does not address whether the scope of the duty to defend includes payment for the insured's independent counsel where a conflict of interest exists.

We find authority for that proposition in an earlier case, *Tomerlin v. Canadian Indemnity Co., supra,* 61 Cal.2d 638, 39 Cal.Rptr. 731, 394 P.2d 571, which involved a coverage problem arising out of a third party complaint alleging conduct partially excluded under the policy. *Tomerlin* stated:

"Similarly, in cases involving multiple claims against the insured, some of which fall within the policy coverage and some of which do not, the insurer may be subject to substantial temptation to shape its defense so as to place the risk of loss

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entirely upon the insured....

"It is true, of course, that defendant's attorney owes to the insured a legal duty to defend in good faith, but as Professor Keeton points out 'On the *369 other hand [the] company has no duty to sacrifice its own interests when they conflict with those of the insured.' (Keeton, *Liability Insurance & Responsibility for Settlement, supra,* 67 Harv.L.Rev. 1136, 1170.)

"Customarily, insurers, in cases involving tort claims in excess of policy limits, notify the insured that he may employ his own attorney to participate in the defense. (*Id.* at p. 1169.) A like duty must arise in the instant case in which potential conflict stemmed not only from the multiple theories of the Villines complaint and the propriety of settlement, but from the total absence in defendant of any economic interest in the outcome of the suit." (*Tomerlin, supra,* 61 Cal.2d at p. 647, 39 Cal.Rptr. 731, 394 P.2d 571.)

[4] Thus, the California Supreme Court recognized where, as here, multiple theories of recovery are alleged and some theories involve uncovered conduct under the policy, a conflict of interest exists. *Tomerlin* concluded: "In actions in which ... the insurer and insured have conflicting interests, the insurer may not compel the insured to surrender control of the litigation. [Citations.]" (*Tomerlin, supra,* 61 Cal.2d at p. 648, 39 Cal.Rptr. 731, 394 P.2d 571.) Although *Tomerlin* did not expressly state the insurer had to pay for the insured's independent counsel under such circumstances, this is necessarily implicit in the decision. If the insurer must pay for the cost of defense and, when a conflict exists, the insured may have control of the defense if he wishes, it follows the insurer **502 must pay for such defense conducted by independent counsel.

Other decisions following *Tomerlin* have developed its reasoning further. For example, *Industrial Indemnity Co. v. Great American Ins. Co., supra,* 73 Cal.App.3d 529, 140 Cal.Rptr. 806, held a coverage dispute between insurer and insured, similar to that here, created a conflict of interest. In *Industrial,* an employee of one of the insured's subcontractors was killed on the job. The employee's heirs sued, among others, the insured, Tomei, and the city which had contracted to have the insured do the work. The insurance policy named the city as an additional insured but coverage applied to the city only if its negligence was secondary, passive and vicarious, i.e., only if it was not actively negligent. Tomei was fully covered under the policy. The insurer retained counsel to defend both Tomei and the city. In December 1970, about two months before trial, counsel acquired knowledge the city was actively negligent and, on the eve of trial, he sent a reservation of rights letter to the city and hired independent counsel to represent it. One day later, the case was settled with the insurer apportioning $100,000 of the liability to the city where coverage was in question, and only $62,000 to the fully insured Tomei. The city was never consulted about the insurer's apportionment. After the insurer paid the settlement, it sued the city and its *370 other insurer in declaratory relief for reimbursement, using the same counsel it had retained to defend the third party suit. The city did not respond directly but filed a cross-complaint alleging breach of the insurer's duty to defend as a result of the insurer's retaining one attorney with conflicting interests in the third party suit.

Industrial spoke of the conflicts of interest in the third party action as follows:

"In the Sanchez [third party] action Runkle [counsel retained by insurer] had three clients: Industrial, Tomei and the City. We assume that there was no conflict between Industrial and Tomei, whose protection under the Industrial policy appears to have been as broad as its exposure to liability in the Sanchez action. There were, however, obvious conflicts between Industrial and the City, as well as between Tomei and the

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City.... The Industrial-City conflict arises from the simple fact that, as Industrial sees it, the City's coverage under the endorsements to the Tomei policy was not as broad as the City's exposure to the Sanchez heirs. Essentially, the less 'vicarious' the City's liability, if any, turned out to be, the less was the danger that the Industrial policy would cover.

'.....................

'That Runkle represented conflicting interests in the Sanchez action is now plain. (See Rules of Prof. Conduct, rule 5-102(b).) As far as the record shows, the consent of the City to Runkle's representation of conflicting interests was never obtained. (See *Lysick v. Walcom,* 258 Cal.App.2d 136, 147 [65 Cal.Rptr. 406] ....) It may well be that the conflict was not apparent when Runkle assumed the defense of the Sanchez action. It must, however, have become obvious sometime before December 1970, when Industrial first asserted its position with respect to the City's coverage under its endorsements. Even then Runkle did not discontinue the relationship. (See *Ishmael v. Millington,* 241 Cal.App.2d 520, 526-527 [50 Cal.Rptr. 592] ....)" (Fns. omitted; *Industrial Indemnity Co. v. Great American Ins. Co., supra,* 73 Cal.App.3d 529, 536-537, 140 Cal.Rptr. 806.)

[5][6][7] Although the issue before the court in *Industrial* pertained to the conflict of interest problem in the later action in which coverage was in issue, the court recognized retained counsel is bound to learn about coverage issues as he prepares the earlier suit (*Industrial, supra,* 73 Cal.App.3d at p. 535, 140 Cal.Rptr. 806). A conflict arises once the insurer takes the view a coverage issue is present. In *Industrial,* the retained counsel's recently acquired knowledge of the City's active negligence, combined with its reservation of rights, made the conflict "obvious sometime**503 before December 1970" (*Industrial, supra,* 73 Cal.App.3d at p. 537, 140 Cal.Rptr. 806). Thus, *Industrial* recognizes a serious conflict of interest occurs when insurer's retained counsel obtains information bearing *371 directly on the issue of coverage during the course of preparation of the third party suit. There is no room under *Industrial* for labeling the conflict there described as merely a "potential" one.[FN7]

FN7. Cumis makes a distinction between "potential" and "actual" conflicts of interest which is invalid and unworkable. Recognition of a conflict cannot wait until the moment a tactical decision must be made during trial. It would be unfair to the insured and generally unworkable to bring in counsel midstream during the course of trial expecting the new counsel to control the litigation. Contrary to Cumis' argument, the existence of a conflict of interest should be identified early in the proceedings so it can be treated effectively before prejudice has occurred to either party. It may well be in a given case special verdicts will not be requested or given, and other indicators of the basis of liability such as punitive damages will not come into play. Nevertheless, this often cannot be known until shortly before the case is submitted to the jury. By that time, it is normally too late to prevent prejudice.

In *Executive Aviation, Inc. v. National Ins. Underwriters* (1971) 16 Cal.App.3d 799, 94 Cal.Rptr. 347, the same insurer-selected attorney represented the insurer in a property coverage action by the insured against the insurer and represented the insured and insurer in a third party suit against the insured. Both actions arose from the same accident, a plane crash during a flight where there was a question whether the plane was being used in "common carriage." If the plane was ultimately found to have been used in common carriage, there would be no coverage under the terms of the policy. The attorney defending the property damage action against the insurer on this basis would be operating directly

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against the insured's interest in obtaining coverage for the third party suit.

The appellate court stated:

"A reasonable solution was proposed by the New York Court of Appeals in *Prashker v. United States Guarantee Company* (1956) 1 N.Y.2d 584 [154 N.Y.S.2d 910, 136 N.E.2d 871] ..., namely, that where a conflict of interest has arisen between an insurer and its insured, the attorney to defend the insured in the tort suit should be selected by the insured and the reasonable value of the professional services rendered assumed by the insurer. If the insured and the insurer are represented by two different attorneys, each of whom is pledged to promote and protect the prime interests of his client, adequate representation is guaranteed and the deleterious effect of the conflict of interest imposed on an attorney who attempts the difficult task of representing both parties is averted." (*Executive Aviation, supra,* 16 Cal.App.3d at p. 809, 94 Cal.Rptr. 347.)

The court concluded:

"We hold, therefore, that in a conflict of interest situation, the insurer's desire to exclusively control the defense must yield to its obligation to defend its policy holder. Accordingly, the insurer's obligation to defend extends to paying the reasonable value of the legal services and costs performed by independent counsel, selected by the insured [citation].... We conclude that the insured here is entitled to the reasonable value of the legal services rendered by its independent counsel*372 and the costs in the Dakin action." (*Executive Aviation, supra,* 16 Cal.App.3d at p. 810, 94 Cal.Rptr. 347.)

The conflict in *Executive Aviation* is no more "real and existing" than the conflict in Cumis' case. In both instances, the interests of insured and insurer diverge and conflict, differing only in degree of immediacy. The result of the existing conflict is the same in each instance.

In *Previews, Inc. v. California Union Ins. Co.* (9th Cir.1981) 640 F.2d 1026, the Court of Appeals decided the insurer was required to pay for independent counsel due in part to a claim for punitive damages. The Court of Appeals said in applying California law:

**504 "This case presents a plain conflict of interest.... [The insurer's] best interests are served by a finding of willful conduct because it thus may not be deemed liable. Previews, on the other hand, could suffer greater loss by a finding of willful conduct because Previews would then be liable for punitive damages. Thus, the district court properly decided that Previews was entitled to engage outside counsel." (*Previews, supra,* 640 F.2d at p. 1028.)

[8] The point *Previews* makes about the insurer's interests being served by a finding of wilful conduct and resultant punitive damages fully applies to this case. Cumis retained counsel for a third party suit, the Eisenmann action, in which punitive damages were sought with a potential result there would be no coverage under the policy. The "plain conflict of interest" language of *Previews,* applies equally to this aspect of the case. Entitlement to independent counsel paid for by the insurer under its duty to defend is an order *Previews* directly supports.[FN8]

FN8. Cumis cites a recent Ninth Circuit case, *Zieman Mfg. Co. v. St. Paul Fire & Marine Ins. Co.* (9th Cir.1983) 724 F.2d 1343, which summarily approved the district court's denial of fees for independent counsel. According to the decision of the district court approved by the Court of Appeals, the insured hired independent counsel after the third party amended his complaint to claim punitive damages and the insurer notified the insured there was no coverage for wilful actions. The insurer

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provided a defense to the third party suit.

Reviewing a summary judgment in favor of the insurer in the insured's action for breach of the duty to defend (and the implied covenant of good faith) the Court of Appeals sought only to determine whether any genuine issues of material fact existed (*Zieman, supra,* 724 F.2d at p. 1344). Doing so, the Court of Appeals gave the following analysis:

"Zieman [insured] alleges that a conflict of interest arose when the punitive damage claim was filed in addition to the damage claim. Zieman characterizes this as a genuine issue of material fact; however, it fails to point to any facts in dispute relating to this issue. Nor does Zieman present any evidence that an actual conflict of interest existed which would prevent St. Paul's retained counsel from defending Zieman. St. Paul (by providing the legal services of Hillsinger and Costanza) fulfilled its contractual duty to defend Zieman on all claims against it." (*Zieman, supra,* 724 F.2d at pp. 1344-1345.)

It is apparent *Zieman's* dominant concern was whether an issue of material fact was present. The court said no to this question. It made no analysis of the presence or absence of a conflict of interest, merely pointing to the absence of any facts in dispute relating to the conflict of interest issue and the absence of evidence of actual conflict of interest. It is apparent the Court of Appeals did not address the merits of the conflict of interest issue. Thus, *Zieman* does not represent a holding on the issue we consider. Moreover, to the extent *Zieman* could be read as deciding the issue we consider, it does not reflect California law.

*373 In *Purdy v. Pacific Automobile Insurance Co., supra,* 157 Cal.App.3d 59, 203 Cal.Rptr. 524, the plaintiff offered to settle his third party action within policy limits under circumstances where counsel retained by the insurer knew an excess verdict was probable. The insurer refused the offer. The court stated retained counsel was in a conflict of interest situation and the insured had a right to independent counsel paid for by the insurer. Further, the court stated:

"[T]he record discloses that Purdy had in fact employed independent counsel as of December 1972, prior to the last offer of settlement; and that counsel strongly urged settlement of the Partin suit. Pacific, however, retained control of the litigation-to Purdy's disadvantage. The fact that Purdy did have independent counsel at a crucial stage of the settlement negotiations undoubtedly explains why the causes of action against the lawyer defending herein were not refined to charges of failing to disclose a conflict between the insurer and the insured." (*Id.* at p. 77.)

Other jurisdictions reach varying conclusions on the issue before us (see *Employers' Fire Insurance Company v. Beals, supra,* 103 R.I. 623, 240 A.2d 397, 404, and works cited).[FN9]

FN9. Among the cases from other jurisdictions which are generally supportive of the view we take are the following:

Alaska *Continental Ins. Co. v. Bayless & Roberts, Inc.* (1980) 608 P.2d 281;

Ariz. *Fulton v. Woodford* (1976) 26 Ariz.App. 17, 545 P.2d 979;

Ill. *Maryland Casualty Co. v. Peppers* (1976) 64 Ill.2d 187, 355 N.E.2d 24, 30;

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Md. *Southern Md. Agr. Ass'n v. Bituminous Cas. Corp.* (D.Md.1982) 539 F.Supp. 1295;

Mass. *Magoun v. Liberty Mutual Insurance Company* (1964) 346 Mass. 677, 195 N.E.2d 514, 519;

N.Y. *Prashker v. United States Guarantee Co.* (1956) 1 N.Y.2d 584, 154 N.Y.S.2d 910, 136 N.E.2d 871; and see *Utica Mutual Insurance Co. v. Cherry* (1974), 38 N.Y.2d 735, 381 N.Y.S.2d 40, 343 N.E.2d 758; *Public Service Mutual Ins. Co. v. Goldfarb* (1981), 53 N.Y.2d 392, 442 N.Y.S.2d 422, 425 N.E.2d 810;

R.I. *Employers' Fire Insurance Company v. Beals, supra,* 103 R.I. 623, 240 A.2d 397;

Tex. *Steel Erection Co., Inc. v. Travelers Indemnity Co.* (Tex.Civ.App.1965) 392 S.W.2d 713; and see *Satterwhite v. Stolz* (1968) 79 N.M. 320, 442 P.2d 810;.

Jurisdictions ruling to the contrary include:

Ohio *Motorists Mutual Insurance Co. v. Trainor* (1973) 33 Ohio St.2d 41, 294 N.E.2d 874;

Va. *Norman v. Insurance Company of North America* (1978) 218 Va. 718, 239 S.E.2d 902.

**505 The lawyer's duties in the conflict of interest situation presented here are correlative to the insurer's contractual duty to pay for an independent lawyer *374 when it reserves its rights to deny coverage under the policy. California Rules of Professional Conduct rule 5-102(B) states: "A member of the State Bar shall not represent conflicting interests, except with the written consent of all parties concerned."

[9][10] Counsel representing the insurer and the insured owes both a high duty of care (*Lysick v. Walcom, supra,* 258 Cal.App.2d 136, 146, 65 Cal.Rptr. 406) and unswerving allegiance (*Betts v. Allstate Ins. Co.* (1984) 154 Cal.App.3d 688, 715-716, 201 Cal.Rptr. 528). When two clients have diverging interests, counsel must disclose all facts and circumstances to both clients to enable them to make intelligent decisions regarding continuing representation (*Ishmael v. Millington* (1966) 241 Cal.App.2d 520, 528, 50 Cal.Rptr. 592). The ABA Model Code EC 5-14, 5-15, 5-16 and 5-17 reinforce these constrictions, EC 5-16 stating in part: "[B]efore a lawyer may represent multiple clients he should explain fully to each client the implications of the common representation and should accept or continue employment only if the clients consent."

One commentator analyzing these Ethical Considerations concluded:

"The emphasis of the ... Rules suggests a functional means of resolving the conflicts which confront counsel hired by an insurer to defend its insured. The best course is for an attorney to beware of the potential for conflict at the outset.... Where a question exists as to whether an occurrence is within coverage, independent counsel representing the insured's interests is required. The insurer is contractually obligated to pay for insured's independent counsel." (Dondaville, 1982, *Defense Counsel Beware: The Perils of Conflicts of Interest,* 26 Trial Lawyer's Guide, 408, 415.)

The Committee on Professional Responsibility of the State Bar of Louisiana reaches the same conclusion.

"Under the circumstances presented, the Committee is of the opinion that it would be improper, with or without the consent of all parties concerned,

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for the same attorney to represent both the insurer and the insured.

"The Committee is compelled to this conclusion based upon its belief that once the insurer decides to assert a coverage defense, the same attorney may not represent both the insured and the insurer. Canon 5 and, to some extent, Canon 7, would militate against such dual representation. EC 5-1 provides that the attorney's professional judgment should be exercised 'solely for the benefit of his client and free of compromising influences and loyalties,' including 'interests of other clients.' EC 5-14 states that an attorney cannot represent two clients with 'conflicting, inconsistent, diverse, *375 or otherwise discordant' interests. And EC 5-15 indicates that counsel 'should resolve all doubts against the propriety of the representation.'

"The Committee feels that when coverage is disputed, the interests of the insured and the insurer are always divergent. The attorney should not be placed **506 in the position of divided loyalties. Such an arrangement would be adverse to the best interests of the insured, the insurer, the attorney, and the profession." (Opn. No. 342, 22 La.Bar J. (July 1974).)

[11][12][13][14][15] We conclude the Canons of Ethics impose upon lawyers hired by the insurer an obligation to explain to the insured and the insurer the full implications of joint representation in situations where the insurer has reserved its rights to deny coverage. If the insured does not give an informed consent to continued representation, counsel must cease to represent both. Moreover, in the absence of such consent, where there are divergent interests of the insured and the insurer brought about by the insurer's reservation of rights based on possible noncoverage under the insurance policy, the insurer must pay the reasonable cost for hiring independent counsel by the insured. The insurer may not compel the insured to surrender control of the litigation (*Tomerlin v. Canadian Indemnity Co., supra,* 61 Cal.2d 638, 648, 39 Cal.Rptr. 731, 394 P.2d 571; and see *Nike, Inc. v. Atlantic Mut. Ins. Co.* (1983) 578 F.Supp. 948, 949). Disregarding the common interests of both insured and insurer in finding total nonliability in the third party action, the remaining interests of the two diverge to such an extent as to create an actual, ethical conflict of interest warranting payment for the insureds' independent counsel.

Judgment affirmed.

GERALD BROWN, P.J., and STANIFORTH, J., concur.
Hearing denied; BROUSSARD AND LUCAS JJ., dissenting.
Cal.App. 4 Dist.,1984.
San Diego Navy Federal Credit Union v. Cumis Ins. Society, Inc.
162 Cal.App.3d 358, 208 Cal.Rptr. 494, 50 A.L.R.4th 913

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Supreme Judicial Court of Massachusetts,
Suffolk.

Lillian DARCY et. al.[FN1]

FN1. Mary Iglesias.

v.

The HARTFORD INSURANCE COMPANY et. al.; [FN2]

FN2. Aladdin Building Maintenance, Inc.

Royal Globe Insurance Company, third-party defendant.
Argued March 8, 1990.
Decided May 22, 1990.

Liability insurer appealed from an order of the Superior Court Department, Suffolk County, John L. Murphy, Jr., J., which refused to allow it to disclaim coverage under policy. The Supreme Judicial Court transferred the appeal on its own motion and Greaney, J., held that: (1) insurer could not disclaim coverage on grounds that insured failed to provide seasonable notice or failed to cooperate, and (2) in the future, insurers would be required to make affirmative showing of actual prejudice resulting from insured's breach of cooperation provision in order to disclaim liability for breach of cooperation provision.

Affirmed.

West Headnotes

[1] Insurance 217 ⚿3168

217 Insurance
217XXVII Claims and Settlement Practices
217XXVII(B) Claim Procedures
217XXVII(B)2 Notice and Proof of Loss
217k3166 Effect of Noncompliance with Requirements
217k3168 k. Prejudice to Insurer. Most Cited Cases
(Formerly 217k539.8)

Liability insurer did not show prejudice from its insured's failure to provide seasonable notice of claim, as was required for insurer to disclaim liability under policy. M.G.L.A. c. 175, § 112.

[2] Insurance 217 ⚿3212

217 Insurance
217XXVII Claims and Settlement Practices
217XXVII(B) Claim Procedures
217XXVII(B)3 Cooperation
217k3210 Effect of Failure to Cooperate
217k3212 k. Prejudice to Insurer. Most Cited Cases
(Formerly 217k514.17(5), 217k514.18(3))

Insurer will be required to demonstrate actual prejudice to its interests due to insured's lack of cooperation before denial of coverage will be permitted for insured's breach of cooperation provision.

[3] Insurance 217 ⚿3191(1)

217 Insurance
217XXVII Claims and Settlement Practices
217XXVII(B) Claim Procedures
217XXVII(B)2 Notice and Proof of Loss
217k3187 Insurer's Waiver or Estoppel
217k3191 Implied Waiver or Estoppel
217k3191(1) k. In General. Most Cited Cases
(Formerly 217k558(1.1))

Liability insurer failed to exercise diligence and good faith in obtaining insured's cooperation and, thus, insurer could not disclaim liability on grounds of insured's lack of cooperation.

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**29 *482 Roger A. Emanuelson (William P. Smith, Boston, with him), for Royal Globe Ins. Co.

Joseph G. Abromovitz, Boston, for plaintiffs.

Peter C. Kober, Boston, for The Hartford Ins. Co., was present but did not argue.

Before *481 LIACOS, C.J., and WILKINS, ABRAMS, LYNCH and GREANEY, JJ.

GREANEY, Justice.

After trial, a judge in the Superior Court concluded that Lillian Darcy and Mary Iglesias (plaintiffs), and third-party plaintiff, The Hartford Insurance Company (Hartford), could recover the proceeds of a liability insurance policy issued by Royal Globe Insurance Company (Royal Globe). Royal Globe has appealed, claiming that the delay in notice of the plaintiffs' claims, and the failure of its insured to cooperate, permitted Royal Globe to disclaim coverage under the policy. We transferred the appeal to this court on our own motion. We agree with the judge that Royal Globe may not avoid coverage on either of its stated grounds. Consequently, we affirm the judgment of the Superior Court.

The facts found by the judge are as follows. In 1979, Aladdin Building Maintenance Company (Aladdin) was awarded a contract to provide janitorial services for the John F. Kennedy Federal Building in Boston. Aladdin subsequently entered into a subcontract assigning those duties to United Building Maintenance, Inc. (United). At all relevant times, Aladdin carried a comprehensive commercial liability insurance policy with personal injury coverage issued by Hartford, while United carried a similar policy issued by Royal Globe. On September 15, 1979, the plaintiffs were working in the Federal building at their desks, which were separated by a free-standing room partition or baffle. The baffle was accidentally knocked over by a United employee who was attempting to clean around it, and it fell on the plaintiffs, injuring them both severely.

The plaintiffs brought suit against United in the Superior Court on February 18, 1981, seeking damages for their personal injuries. United never filed an appearance, nor did it notify its insurer, Royal Globe, of either the accident or the lawsuit. On August 15, 1981, the plaintiffs filed suit against *483 Aladdin, the main contractor, in the United States District Court for Massachusetts. This action was concluded on September 23, 1983, when the plaintiffs won judgments for $582,080.12, and $82,055.35, respectively.

**30 On November 4, 1983, the plaintiffs sought to satisfy their Federal court judgments by suing Hartford in the Superior Court to reach and apply the proceeds of the Hartford policy issued to Aladdin. Hartford responded by filing a third-party complaint against Royal Globe, seeking recovery from Royal Globe as the liability insurer of United, Aladdin's subcontractor. Hartford's complaint, filed on January 8, 1985, reached Royal Globe nine days later, on January 17, 1985. This was the first notice Royal Globe had received of the accident, which had occurred on September 15, 1979.

At the time Royal Globe received notice of the plaintiffs' claims against its insured, the underlying tort action against United in the Superior Court had not been resolved. Accordingly, Royal Globe undertook an investigation of the claim. The claims adjuster assigned to the case examined Royal Globe's records and discovered reference to a previous claim involving United. The records indicated that United had not responded to Royal Globe's correspondence in that case. The claims adjuster thus assumed that any attempt to make contact with United's principals directly would be futile, and he hired an investigation bureau to locate them.

As found by the judge, the investigation authorized

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by Royal Globe was limited to the following efforts: An investigator was assigned to locate United's principals. To this end, the investigator examined the telephone directory and various public records, and wrote to the attorney listed on United's articles of incorporation. The investigator eventually located one Pasquale Verro, who was named as a principal of United. However, upon reaching this man, the investigator discovered that he was not the Pasquale Verro associated with United, but was a relative. The investigation went no further. The Royal Globe claims adjuster responded to this information by sending a letter to the Pasquale Verro located by the investigator, despite actual knowledge that this was ***484** not the right man, informing him that Royal Globe was disclaiming coverage due to lack of notice and cooperation from United. Subsequently, on August 14, 1987, and October 19, 1987, respectively, default judgments entered against United in the pending State court actions. More than two years had elapsed between Royal Globe's first notice of the claim (January 8, 1985) and the eventual entry of the default judgments against United, Royal Globe's insured.

On October 19, 1987, Hartford and the plaintiffs entered into a settlement agreement pursuant to which the plaintiffs agreed to dismiss their claims against Hartford with prejudice in consideration of a $300,000 payment. The plaintiffs, in the meantime, had brought claims directly against Royal Globe. Hartford and the plaintiffs further agreed to pursue their respective claims against Royal Globe, and stipulated that any recovery on those claims would be divided equally between them.

A trial ensued on the issue whether the plaintiffs and Hartford could reach and recover the proceeds of Royal Globe's policy with United. Royal Globe defended on the basis that it had properly disclaimed coverage because United, its insured, had violated its policy obligations to provide seasonable notice of the claims and to cooperate in the defense thereof. The judge rejected both claims. Relying upon G.L. c. 175, § 112, and our decision in *Johnson Controls, Inc. v. Bowes,* 381 Mass. 278, 409 N.E.2d 185 (1980), the judge concluded that Royal Globe had not carried its burden of proving that the delay in giving notice had materially prejudiced its interests. Further, the judge determined that Royal Globe had not fulfilled its duty to exercise diligence and make a good faith effort to obtain United's cooperation. See *Allen v. Atlantic Nat'l Ins. Co.,* 350 Mass. 181, 214 N.E.2d 28 (1966). Accordingly, the judge concluded that neither breach entitled Royal Globe to disclaim liability, and entered a judgment against Royal Globe (divided between the plaintiffs and Hartford) in the total amount of $300,000.

****31** 1. *The duty to provide seasonable notice.* The Royal Globe policy issued to United contains the notice provision ***485** set forth below [FN3]. As Royal Globe concedes, breach of that provision by an insured is not an independently sufficient basis for an insurer to disclaim liability. Rather, the insurer must prove that its interests have been prejudiced by the insured's failure to provide timely notice of the accident. See G.L. c. 175, § 112, as amended by St.1977, c. 437 ("An insurance company shall not deny insurance coverage to an insured because of failure of an insured to seasonably notify an insurance company of an occurrence, incident, claim or of a suit founded upon an occurrence, incident or claim, which may give rise to liability insured against unless the insurance company has been prejudiced thereby."); *Johnson Controls, Inc. v. Bowes, supra,* 381 Mass. at 282, 409 N.E.2d 185 (insurer bears the burden of proving prejudice) [FN4]. See also *MacInnis v. Aetna Life & Casualty Co.,* 403 Mass. 220, 223, 526 N.E.2d 1255 (1988).

FN3. "In the event of an occurrence, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or

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for the insured to the company or any of its authorized agents as soon as practicable."

FN4. While the assignment of the burden of proof in the *Johnson Controls* case was made in connection with a legal malpractice insurance policy not covered by the statutory prejudice requirement of G.L. c. 175, § 112, the holding of the case applies to other types of policies such as the comprehensive commercial liability policy at issue here.

Royal Globe urges that we adopt a rebuttable presumption of prejudice in cases where the delay in notifying an insurer of a claim or possible claim is "extreme." Such a rule, Royal Globe contends, "makes sense in light of the legitimate purposes served by the notice provisions and fairly balances the competing interests of the insurer, insured and third parties." Were we to adopt such a rule, argues Royal Globe, we should find (contrary to the judge) that the more than five-year delay in notifying Royal Globe in this case was "extreme," and thus entitles Royal Globe to the benefit of the presumption. We decline Royal Globe's request to modify existing law in this area.

*486 Adopting the presumption Royal Globe seeks would, in effect, constitute a retreat to a mode of interpretation of insurance policies which invites technical forfeitures, and would conflict sharply with the view, previously expressed by both the Legislature and this court, that forfeitures should occur only upon a showing of actual prejudice to an insurer's interests. See G.L. c. 175, § 112 (1988 ed.); *Johnson Controls, Inc. v. Bowes, supra.* By its very nature, a presumption, in cases in which it applied, would tend to relieve an insurer of its burden to demonstrate actual harm to its interests. Such a rule could permit an insurer to avoid liability on the basis of the possibility, rather than on proof of actual prejudice. The proposed rule would tend to shift unfairly the burden of showing prejudice from the party in the best position, and with the most resources, to ascertain the existence of prejudice to the party who is least capable of investigating the likelihood that a claim, despite a delay in notice, can be adequately defended. In the process, the protections for which insurance was obtained and paid for, could be denied. Additionally, the Legislature's concern that an insurer attempting to disclaim coverage for lack of notice must show prejudice would be frustrated contrary to the directive of G.L. c. 175, § 112.

The length of delay, of course, in notice will always be a relevant factor to be considered in determining whether actual prejudice has been shown by an insurer, and the longer the delay, the more likely that prejudice exists. But, before a denial of coverage by an insurer is justified, the delay in notice must be accompanied by a showing of some other facts or circumstances (such as, for example, the loss of critical evidence, or testimony from material witnesses despite diligent good faith efforts**32 on the part of the insurer to locate them) which demonstrates that the insurer's interests have been actually harmed. See *Thompson v. Grange Ins. Ass'n,* 34 Wash.App. 151, 163-164, 660 P.2d 307 (1983) (refusing to presume prejudice because of five-year delay in notice and requiring a showing of actual prejudice). We see no reason to absolve the *487 insurer of the burden of identifying the precise manner in which its interests have suffered.

[1] Royal Globe next contends that, even without the benefit of a presumption, it has demonstrated actual prejudice to its interests in this case by showing that it has been "placed in a substantially less favorable position than it would have been in had timely notice been provided." In support of his conclusion that actual prejudice had not been demonstrated, the judge relied primarily on the fact that Royal Globe learned of the claim against its insured more than two years before the default judgment entered. The judge also found that the accident had occurred less than one block from Royal Globe's

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offices, and that it was likely to have generated considerable documentation, including reports in connection with workers' compensation claims and Department of Labor records. Further, the judge found that Royal Globe would have had access to the documents compiled for the plaintiffs' Federal court suit against Aladdin, which was based on the same accident. The judge noted that Royal Globe made no meaningful attempt to identify employees of United, or to locate eyewitnesses to the accident. Royal Globe's efforts boil down to a torpid effort at finding United's principal without any corresponding effort to investigate the incident itself. Thus, the judge concluded that Royal Globe had "sufficient opportunity to investigate the circumstances surrounding the plaintiffs' injuries," even after its receipt of admittedly unseasonable notice; and, consequently, Royal Globe had not demonstrated at all that it had been placed in a substantially less favorable position than it would have been had it received earlier notice. Because this conclusion is amply supported by the evidence, we decline to disturb it on appeal [FN5].

FN5. Most of the contrary arguments Royal Globe raises in its brief do not rise beyond the level of speculation. For example, Royal Globe claims that the "memories of any witnesses who might continue to be available can hardly be said to be fresh," that "it is reasonable to assume" that United's principals "may have had" valuable information, and that potential claims against third parties "would likely have been barred" by some unspecified statute of limitations. Royal Globe further claims prejudice resulting from the default judgment entered against United more than two years after Royal Globe received notice of the claim. The argument that Royal Globe was "powerless" to prevent the entry of the default judgment because it could not have drafted a responsive pleading in the case is specious. As the judge found, Royal Globe had ample time and opportunity to uncover sufficient facts to file a pleading which could have responded to the merits of the action. Had Royal Globe actually been unable to ascertain such facts, prejudice would have been shown. Any prejudice which resulted from the entry of the default judgment in this case is directly due to Royal Globe's inaction in its investigation rather than to United's failure to provide prompt notice.

*488 2. *The duty to cooperate.* The Royal Globe policy contains a provision obligating United to cooperate in the event of a lawsuit, including the duties of attending hearings and trials and assisting in the procurement of relevant evidence and witnesses. Royal Globe asserts that United's failure to cooperate justifies a denial of liability under the policy's terms. The plaintiffs, on the other hand, suggest that we extend the prejudice requirement, which we previously have applied in other insurance policy contexts, to the lack of cooperation context as well. If we make this extension, plaintiffs argue, Royal Globe cannot disclaim liability due to lack of cooperation because, as has been decided above, Royal Globe has not demonstrated that its interests have suffered actual prejudice.

[2] Under current law, breach of the duty to cooperate on the part of an insured must be "substantial and material" before it permits an insurer to disclaim liability. See *Morrison v. Lewis,* 351 Mass. 386, 390, 221 N.E.2d 401 (1966). See also 14 G. Couch, Insurance, § 51.107, at 607 (2d ed. **33 1982). A showing of prejudice on the part of the insurer has not previously been expressly required. See *Imperiali v. Pica,* 338 Mass. 494, 498, 156 N.E.2d 44 (1959); *Polito v. Galluzzo,* 337 Mass. 360, 364-365, 149 N.E.2d 375 (1958). The vast majority of jurisdictions which have considered the issue have decided that actual prejudice to an insurer's interests due to lack of an insured's coopera-

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tion must be demonstrated before a denial of coverage will be permitted,*489 and we conclude that that should be the rule here as well.FN6

FN6. The jurisdictions that have adopted this view are as follows:

Clemmer v. Hartford Ins. Co., 22 Cal.3d 865, 881-882, 151 Cal.Rptr. 285, 587 P.2d 1098 (1978); *Rochon v. Preferred Accident Ins. Co.*, 118 Conn. 190, 198, 171 A. 429 (1934); *Brooks Transp. Co. v. Merchants Mut. Casualty Co.*, 36 Del. 40, 55, 171 A. 207 (1933); *American Fire & Casualty Co. v. Vliet*, 148 Fla. 568, 571, 4 So.2d 862 (1941); *Farley v. Farmers Ins. Exch.*, 91 Idaho 37, 40, 415 P.2d 680 (1966); *State Farm Mut. Auto. Ins. Co. v. McSpadden*, 88 Ill.App.3d 1135, 1138, 44 Ill.Dec. 215, 411 N.E.2d 121 (1980); *Miller v. Dilts*, 463 N.E.2d 257, 261 (Ind.1984); *Boone v. Lowry*, 8 Kan.App.2d 293, 299, 657 P.2d 64 (1983); *Metropolitan Casualty Ins. Co. v. Albritton*, 214 Ky. 16, 19, 282 S.W. 187 (1926); *Bourgeois v. Great Am. Ins. Co.*, 222 So.2d 70, 75 (La.Ct.App.1969); *Medico v. Employers Liab. Assurance Corp.* 132 Me. 422, 427, 172 A. 1 (1934); *Harleysville INs. Co. v. Rosenbaum*, 30 Md.App. 74, 83-84, 351 A.2d 197 (1975); *Anderson v. Kemper Ins. Co.*, 128 Mich.App. 249, 340 N.W.2d 87, 90 (1983); *White v. Boulton*, 259 Minn. 325, 328-329, 107 N.W.2d 370 (1961); *MFA Mut. Ins. Co. v. Sailors*, 180 Neb. 201, 203-204, 141 N.W.2d 846 (1966); *Solvents Recovery Serv. of New England v. Midland Ins. Co.*, 218 N.J.Super. 49, 55, 526 A.2d 1112 (1987); *Foundation Reserve Ins. Co. v. Esquibel*, 94 N.M. 132, 134, 607 P.2d 1150 (1980); *Bailey v. Universal Underwriters Ins. Co.*, 258 Or. 201, 219, 474 P.2d 746 (1971); *Cameron v. Berger*, 336 Pa. 229, 233, 7 A.2d 293 (1939); *Evans v. American Home Assurance Co.*, 252 S.C. 417, 420, 166 S.E.2d 811 (1969); *Oberhansly v. Travelers Ins. Co.*, 5 Utah 2d 15, 19-20, 295 P.2d 1093 (1956); *Francis v. London Guar. & Accident Co.*, 100 Vt. 425, 429, 138 A. 780 (1927); *Oregon Auto. Ins. Co. v. Salzberg*, 85 Wash.2d 372, 376-377, 535 P.2d 816 (1975); *Dietz v. Hardware Dealers Mut. Fire Ins. Co.*, 88 Wis.2d 496, 503, 276 N.W.2d 808 (1979).

We have previously modified the common law in this area by adding prejudice requirements in the contexts of notice provisions, see *Johnson Controls, Inc. v. Bowes*, 381 Mass. 278, 409 N.E.2d 185 (1980), and consent-to-settlement provisions, see *MacInnis v. Aetna Life & Casualty Co.*, 403 Mass. 220, 526 N.E.2d 1255 (1988). Our rationale in both of those cases stemmed from a rejection of the strict contractual view of insurance policy interpretation, under which the failure of any policy provision, characterized as a condition precedent, automatically relieved an insurer of any obligation to pay on the policy. See, e.g., *Rose v. Regan*, 344 Mass. 223, 181 N.E.2d 796 (1962). In *Johnson Controls, Inc. v. Bowes, supra*, we expressed the view that this approach was no longer persuasive because it " 'fails to recognize the true nature of the relationship between insurance companies and their insureds. An insurance contract is not a negotiated agreement; rather its conditions are by and large *490 dictated by the insurance company to the insured. The only aspect of the contract over which the insured can "bargain" is the monetary amount of coverage.' " *Id.* 381 Mass. at 281, 409 N.E.2d 185, quoting *Brakeman v. Potomac Ins. Co.*, 472 Pa. 66, 72, 371 A.2d 193 (1977).

The better approach, we decided, was to determine whether the insured's breach of a policy requirement frustrated the underlying purpose of that re-

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quirement. Only in cases in which that question was answered affirmatively would an insurer be permitted to disclaim coverage. Both notice and consent-to-settlement provisions, we reasoned, exist to enable the insurer to protect its interests. See *Johnson Controls, Inc. v. Bowes, supra,* 381 Mass. at 281-282, 409 N.E.2d 185; *MacInnis v. Aetna Life & Casualty Co., supra* 403 Mass. at 223, 526 N.E.2d 1255. Accordingly, we held in those decisions that an insurer would be able to disclaim coverage because of an insured's breach of the notice or consent-to-settlement provisions in a policy only if the insurer could prove that any such breach actually prejudiced its position. *Johnson Controls, Inc. v. Bowes, supra,* 381 Mass. at 282, 409 N.E.2d 185 [FN7]; **34*MacInnis v. Aet Life & Casualty Co., supra* 403 Mass. at 223, 526 N.E.2d 1255.

FN7. Equitable concerns prompted us to grant purely prospective application to the change in law we announced in *Johnson Controls, Inc. v. Bowes,* 381 Mass. 278, 283 n. 4, 409 N.E.2d 185 (1980).

The foregoing reasoning applies with equal force to cooperation provisions. Like notice and consent-to-settlement clauses, cooperation clauses are designed primarily to protect the insurer's interest in avoiding payment on claims which it cannot adequately defend. When that interest has not been jeopardized by the insured's breach, in the sense that the insured's infraction does not seriously impair the insurer's investigation or defense of the action, there is no persuasive reason to permit the insurer to deny coverage under the policy. We now join the considerable authority throughout the country, see note 5, *supra,* which requires a showing of prejudice by the insurer. We do so "to afford to affected members of the public-frequently innocent third persons-the maximum protection possible consonant with fairness to the insurer." *491*Oregon Auto. Ins. Co. v. Salzberg,* 85 Wash. 2d 372, 376-377, 535 P.2d 816 (1975). We hold that an insurer seeking to disclaim liability on the grounds of an insured's breach of a cooperation provision may do so only upon making an affirmative showing of actual prejudice resulting from that breach. However, because our holding constitutes a "drastic or radical incursion upon existing law," which could disturb preexisting contractual arrangements of the insurer and the insured, we limit its application to claims arising after the date of this opinion. *Diaz v. Eli Lilly & Co.,* 364 Mass. 153, 167, 302 N.E.2d 555 (1973) [FN8].

FN8. We need not consider the limited application of this new rule to this case because, as we conclude the judge correctly decided, under existing law, Royal Globe did not make adequate efforts to procure United's cooperation.

[3] In resolving the cooperation issue in this case, we rely, as did the judge, on the rule that an insurer may not disclaim liability due to lack of cooperation unless it has exercised "diligence and good faith" in obtaining that cooperation. *Imperiali v. Pica, supra* 338 Mass. at 498-499, 156 N.E.2d 44. See *DiMarzo v. American Mut. Ins. Co.,* 389 Mass. 85, 100, 449 N.E.2d 1189 (1983); *Peters v. Saulinier,* 351 Mass. 609, 613-614, 222 N.E.2d 871 (1967). The judge concluded, as we have noted above, that Royal Globe's efforts to locate United's principals were inadequate, and that no effort at all was made to investigate the circumstances surrounding the accident, despite nearby sources that might have disclosed useful information. This conclusion is amply supported by the facts found by the judge, and is not clearly erroneous as matter of law [FN9]. Accordingly, the judge correctly concluded that Royal Globe may not disclaim liability in this case due to *492 United's failure to cooperate in the defense of the plaintiff's underlying tort action.

FN9. Royal Globe's arguments to the contrary-that the search for United's principals was adequate, and that the absence of any

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inquiry into the circumstances of the accident is irrelevant-lack both factual and legal support. The fact remains that cooperation was lacking in this case due in large part to Royal Globe's failure to exercise diligence in seeking it out. That being the case, it would be ironic to permit Royal Globe to deny liability based on a situation which resulted from its own inaction.

Judgment affirmed.

Mass.,1990.
Darcy v. Hartford Ins. Co.
407 Mass. 481, 554 N.E.2d 28

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167 F.R.D. 447
(Cite as: 167 F.R.D. 447)

United States District Court,
S.D. California.

In re IMPERIAL CORPORATION OF AMERICA, Related Litigation.
Ronald L. DURKIN, Trustee of the Benchmark Irrevocable Trust, Plaintiff,
v.
Rodney B. SHIELDS, et al., Defendants.
RESOLUTION TRUST CORPORATION, in its corporate capacity and as Receiver for Imperial Federal Savings Association, Plaintiff,
v.
Robert S. ALSHULER, et al., Defendants.
RESOLUTION TRUST CORPORATION, in its corporate capacity and as Receiver for Imperial Federal Savings Association, Plaintiff,
v.
Stuart I. GREENBAUM, Defendant.
Civil Nos. 92-1003-IEG(LSP), 93-0992-IEG(LSP), 93-1256-IEG(LSP).

Feb. 15, 1995.

Director defendants in shareholder liability action filed motion for protective order with regard to letter sent by directors' attorney to claims adjuster and counsel for directors' and officers' liability insurer. The District Court, Papas, United States Magistrate Judge, held that: (1) letters were not protected from disclosure by attorney-client privilege; (2) letters contained "opinion work product," specifically protected from disclosure to opposing counsel under work product doctrine; (3) attorney waived work product protections by sending letter knowing that litigation between directors and insurer was very real possibility; and (4) joint defense privilege did not extend to agreement between party to litigation and nonparty insurer.

Motions denied.

West Headnotes

[1] Privileged Communications and Confidentiality 311H ⚷122

311H Privileged Communications and Confidentiality
311HIII Attorney-Client Privilege
311Hk120 Parties and Interests Represented by Attorney
311Hk122 k. Common Interest Doctrine; Joint Clients or Joint Defense. Most Cited Cases
(Formerly 410k199(2))

Privileged Communications and Confidentiality 311H ⚷124

311H Privileged Communications and Confidentiality
311HIII Attorney-Client Privilege
311Hk120 Parties and Interests Represented by Attorney
311Hk124 k. Insurers and Insureds. Most Cited Cases
(Formerly 410k199(2))

Letter sent by attorney for director defendants in shareholders derivative action to claims adjuster for affiliate of directors' and officers' liability insurer, copies of which were sent to corporation's in-house counsel and outside litigation counsel and to counsel for other directors was not protected from disclosure by attorney-client privilege in derivative action, where attorney representing directors did not have attorney-client relationship with liability insurer, letters were not written by or to clients of attorney and did not reveal any directors' or officers' communications to attorney but were written for purpose of apprising liability of insurer of status of case and were not seeking or imparting legal advice, insurer did not have duty to defend directors

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and did not defend directors nor pay their legal expenses, and insurer and directors did not share common legal representation.

[2] Federal Civil Procedure 170A **1604(1)**

170A Federal Civil Procedure
170AX Depositions and Discovery
170AX(E) Discovery and Production of Documents and Other Tangible Things
170AX(E)3 Particular Subject Matters
170Ak1604 Work Product Privilege; Trial Preparation Materials
170Ak1604(1) k. In General. Most Cited Cases
(Formerly 170Ak1600(3))

Letters written by attorney representing director defendants in shareholders derivative action to claims adjuster for affiliate of officers' and directors' liability insurer, copies of which were sent to corporate defendant's in-house counsel and outside litigation counsel and counsel for other defendant directors, were "opinion work product," specifically protected from disclosure to opposing counsel under work product doctrine, where letters contained attorney's candid analysis of factual circumstances and legal issues arising from shareholders' complaint in underlying action and his understanding of facts supporting shareholders' contentions as well as his opinions, conclusions and mental impressions relating to directors' risk of exposure to liability resulting from attorney's confidential interviews with officers and employees and his research regarding shareholders' claims. Fed.Rules Civ.Proc.Rule 26(b)(3), 28 U.S.C.A.

[3] Federal Civil Procedure 170A **1604(1)**

170A Federal Civil Procedure
170AX Depositions and Discovery
170AX(E) Discovery and Production of Documents and Other Tangible Things
170AX(E)3 Particular Subject Matters
170Ak1604 Work Product Privilege; Trial Preparation Materials
170Ak1604(1) k. In General. Most Cited Cases
(Formerly 170Ak1600(3))

Under work product rule, although trial preparation material may be discoverable upon appropriate showing, materials containing mental impressions, conclusions, opinions and legal theories of attorney are discoverable only in rare and extraordinary circumstances. Fed.Rules Civ.Proc.Rule 26(b)(3), 28 U.S.C.A.

[4] Federal Civil Procedure 170A **1604(1)**

170A Federal Civil Procedure
170AX Depositions and Discovery
170AX(E) Discovery and Production of Documents and Other Tangible Things
170AX(E)3 Particular Subject Matters
170Ak1604 Work Product Privilege; Trial Preparation Materials
170Ak1604(1) k. In General. Most Cited Cases
(Formerly 170Ak1600(3))

One primary function of work product doctrine is to prevent current or potential adversary in litigation from gaining access to fruits of counsel's investigative and analytical effort, and strategies for developing and presenting client's case. Fed.Rules Civ.Proc.Rule 26(b)(3), 28 U.S.C.A.

[5] Federal Civil Procedure 170A **1604(2)**

170A Federal Civil Procedure
170AX Depositions and Discovery
170AX(E) Discovery and Production of Documents and Other Tangible Things
170AX(E)3 Particular Subject Matters
170Ak1604 Work Product Privilege; Trial Preparation Materials
170Ak1604(2) k. Waiver. Most Cited Cases
(Formerly 170Ak1600(5))

Analysis of issues of waiver of work product pro-

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tection must focus on whether disclosures in issue increased likelihood that current or potential opponent in litigation would gain access to disputed documents. Fed.Rules Civ.Proc.Rule 26(b)(3), 28 U.S.C.A.

[6] Federal Civil Procedure 170A 1604(2)

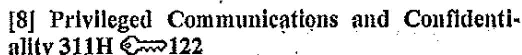
170A Federal Civil Procedure
170AX Depositions and Discovery
170AX(E) Discovery and Production of Documents and Other Tangible Things
170AX(E)3 Particular Subject Matters
170Ak1604 Work Product Privilege; Trial Preparation Materials
170Ak1604(2) k. Waiver. Most Cited Cases
(Formerly 170Ak1600(5))

Any work product protection afforded letter sent by attorney for director defendants in shareholders derivative action to claims adjuster for directors' and officers' liability insurer was waived at time letter was sent to insurer, where although directors and insurer were not adversaries in litigation at time letter was sent, attorney was aware of possibility of future coverage action between his clients and insurer so that transmittal of letter to insurer not only increased likelihood but virtually assured potential opponents in future litigation would gain access to disputed documents, as well as to attorney's opinions and thought process regarding his clients' liability. Fed.Rules Civ.Proc.Rule 26(b)(3), 28 U.S.C.A.

[7] Federal Civil Procedure 170A 1604(1)

170A Federal Civil Procedure
170AX Depositions and Discovery
170AX(E) Discovery and Production of Documents and Other Tangible Things
170AX(E)3 Particular Subject Matters
170Ak1604 Work Product Privilege; Trial Preparation Materials
170Ak1604(1) k. In General. Most Cited Cases
(Formerly 170Ak1600(3))

Work product contained in letter sent by attorney for director defendants in shareholders derivative action to counsel for officers' and directors' liability insurer was not protected by joint defense agreement entered into between insurer and corporate defendant and directors, when letter did not indicate that attorney's communications to insurer were made in course of joint defense effort and instead letter constituted normal business communication keeping insurer informed about insureds' insurance claim and demanded that insurer contribute to settlement of underlying action, so that there was no reasonable expectation that substance of communications in letter would remain confidential.


[8] Privileged Communications and Confidentiality 311H 122

311H Privileged Communications and Confidentiality
311HIII Attorney-Client Privilege
311Hk120 Parties and Interests Represented by Attorney
311Hk122 k. Common Interest Doctrine; Joint Clients or Joint Defense. Most Cited Cases
(Formerly 410k199(2))

Joint defense privilege protects communications between individual and attorney for another when communications are part of ongoing and joint effort to set up common defense strategy.

[9] Privileged Communications and Confidentiality 311H 122

311H Privileged Communications and Confidentiality
311HIII Attorney-Client Privilege
311Hk120 Parties and Interests Represented by Attorney
311Hk122 k. Common Interest Doctrine; Joint Clients or Joint Defense. Most Cited Cases
(Formerly 410k199(2))

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To establish existence of joint defense privilege, party asserting privilege must show that communications to another's attorney were made in course of joint defense effort; statements were designed to further joint defense effort; and privilege has not been waived.

[10] Privileged Communications and Confidentiality 311H 🔑122

311H Privileged Communications and Confidentiality
311HIII Attorney-Client Privilege
311Hk120 Parties and Interests Represented by Attorney
311Hk122 k. Common Interest Doctrine; Joint Clients or Joint Defense. Most Cited Cases
(Formerly 410k199(2))

Joint defense privilege did not extend to agreement between corporation and directors who were defendants in shareholders derivative action and officers' and directors' liability insurer which was nonparty to action.

[11] Federal Civil Procedure 170A 🔑1604(2)

170A Federal Civil Procedure
170AX Depositions and Discovery
170AX(E) Discovery and Production of Documents and Other Tangible Things
170AX(E)3 Particular Subject Matters
170Ak1604 Work Product Privilege; Trial Preparation Materials
170Ak1604(2) k. Waiver. Most Cited Cases
(Formerly 170Ak1600(5))

Any work product protection for letter sent by attorney representing director defendants in shareholder derivative action to counsel for officers' and directors' liability insurer, which contained attorney's opinions, thought processes and analyses regarding his clients' liability, was waived at time letter was sent to insurer, where attorney knew that his clients and insurer were potential adversaries in future litigation due to insurer's position regarding applicable insurance coverage. Fed.Rules Civ.Proc.Rule 26(b)(3), 28 U.S.C.A.

*449 Charles Bird, Robert Steiner, Daniel Lawton, San Diego, CA, for defendants.

Frank Burke, L. Allan Songstad, Irvine, CA, for plaintiffs and R.T.C.

ORDER REGARDING DIRECTOR DEFENDANTS' AND LUCE, FORWARD, HAMILTON AND SCRIPPS' MOTION FOR PROTECTIVE ORDER FOR STEINER LETTERS

PAPAS, United States Magistrate Judge.

On December 1, 1994, counsel for the Director Defendants and counsel for the plaintiffs and the RTC submitted to the court their briefs regarding the use of certain correspondence (hereafter referred to collectively as "the Steiner letters"). On December 15, 1994, counsel for the Director Defendants and counsel for the plaintiffs and the RTC submitted to the court briefs in opposition to the positions taken by each other. On December 20, 1994, the court heard oral argument on the motion. Charles Bird, Robert Steiner and Daniel Lawton appeared on behalf of the Director Defendants. Frank Burke and L. Allan Songstad appeared on behalf of the plaintiffs and the RTC.

The court, having reviewed the moving and opposition papers of counsel, and having heard oral argument, AND GOOD CAUSE APPEARING, HEREBY ORDERS:

I *Factual Background*

In early 1989, shareholders of Imperial Corporation of America (hereafter "ICA") and Imperial Savings Association (hereafter "ISA") filed derivative and class action claims against ICA and its directors,

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officers and third parties alleging, *inter alia,* mismanagement of ICA by its directors and officers. (The 1989 suit is hereafter referred to as the "underlying action"). Shortly after the underlying action was filed, ICA made a demand for settlement on its insurer, American Casualty Company (hereafter "American Casualty"), which had issued primary directors and officers liability insurance coverage.

The directors and officers were represented in the underlying action by Robert Steiner (hereafter "Steiner") and Charles Bird (hereafter "Bird") of the law firm of Luce, Forward,***450** Hamilton & Scripps. In the underlying action, the director defendants, certain officer defendants, and ICA entered into a joint defense agreement dated March 10, 1989. The purpose of the agreement was to share confidential information to facilitate the parties' defense of the underlying action. The agreement barred and bars disclosure of "Common Interest Privileged Information" which the agreement defines as "knowledge (including confidential communications from clients), work product, discovery and strategy." Signatories to the joint defense agreement were ICA and ISA's in-house counsel, ICA's and ISA's outside litigation counsel, and counsel for the directors and officers.

On May 25, 1989, Steiner sent a letter to Roger Novak, a claims adjustor for CNA Insurance Companies, an affiliate of American Casualty. The letter, misdated May 25, 1988, analyzes the allegations contained in the complaint of the underlying action and provides a detailed explanation of the investigation regarding the allegations performed to date. The letter contains Steiner's candid analysis of the risk of exposure presented by the underlying action and further addresses a settlement demand made by plaintiffs in the underlying action. Steiner sent copies of this letter to ICA's in-house counsel, ICA's outside litigation counsel, counsel for directors Thygerson and Villani and Reliance National Insurance Company.

On June 13, 1989, the signatories to the March 10, 1989 joint defense agreement entered into a joint defense agreement with American Casualty. That agreement, similar to that of the March 10, 1989 joint defense agreement, is memorialized in a June 13, 1989 letter from Bird addressed to Michael Tone, of the law firm of Peterson, Ross, Schloerb and Seidel, counsel for CNA Insurance Companies and American Casualty. The letter specifically indicates that the purpose of the agreement is to share confidential information to facilitate defense of the claims in the underlying action. The last page of the letter contains the signature of Michael Tone, indicating CNA's and American Casualty's agreement to be bound by the joint defense agreement.

On September 14, 1989, Steiner sent a letter to Michael Tone, counsel for American Casualty, that further detailed the evidence that had been uncovered. The letter, more detailed than the first Steiner letter of May 25, 1989, again contains Steiner's candid analysis of the risk of exposure presented by the underlying action. The letter additionally alludes to the director defendants' need to settle the case and attempts to persuade American Casualty to contribute to the settlement. Copies of the letter were sent to ICA's in-house counsel and outside litigation counsel.

On November 4, 1994, the directors and officers counsel, represented by Daniel Lawton (hereafter "Lawton"), of Luce, Forward, Hamilton and Scripps, took the deposition of the RTC, pursuant to Fed.R.Civ.Pro. 30(b)(6). The deposition was focused on the RTC's damage allegations. The deposition was attended not only by counsel for the RTC and counsel for the directors and officers, but also by counsel for the Shea & Gould defendants and counsel for the derivative plaintiffs and the derivative plaintiffs' lawyers. During the deposition, the RTC's Rule 30(b)(6) designee, Scott Darling, identified the May 25, 1989 and September 14, 1989 letters ("the Steiner letters") as being among the documents upon which he relied in basing his de-

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position testimony. Lawton questioned Darling about the letters. However, near the end of the deposition, and upon further review of the Steiner letters produced by Darling at the deposition, Lawton realized that the documents were potentially protected from use by the RTC by the joint defense agreement of March 10, 1989. Shortly after the deposition, counsel for the directors and officers learned that the Steiner letters were placed in the document depository to which all counsel in this case have access.

The directors and officers now seek the following:

1. An order requiring the RTC not to divulge the Steiner letters to anyone that is not a party to the joint defense agreements;

2. An order that the Steiner letters be removed from the document depository;

*451 3. An order striking all references to the content of the Steiner letters in the deposition of Scott Darling;

4. An order that any other confidential documents exchanged under the joint defense agreements be maintained as privileged documents and, to the extent any such documents have already been deposited in the document depository, that they be immediately removed; and

5. An award of monetary sanctions against the RTC and its counsel in the amount of $10,000.00 as reimbursement for the fees and costs incurred in pursuing the Motion for Protective Order.

II *Attorney-Client Privilege*

[1] The directors and officers argue that the Steiner letters are protected by the attorney-client privilege. They assert that the letters are replete with confidential communications from clients to their attorneys and were sent to Roger Novak and Michael Tone, representatives of American Casualty, the liability insurance carrier for the director defendants. They further explain that the insured directors and officers and their insurer shared a common interest in the ultimate outcome of the underlying litigation and specifically in opposing the claimants. To that end, they assert that there must be a free flow of information between and among defense counsel, the insureds and the insurer without any waiver of the attorney-client privilege.

The directors and officers concede, however, that the body of law that discusses the "tripartite" relationship of defense counsel, insured and insurer, has developed in the context of liability insurance policies, in which the insurer has a duty to defend the insured and the right to select defense counsel for the insured. They admit that they find no authority which addresses the attorney-client privilege in the context of liability insurance for directors and officers. However, they cite to commentary that suggests that the differences between a directors' and officers' liability policy (which does not contain a duty to defend nor the insurer's right to retain counsel nor directly control the insured's defense) and the "duty to defend" type of policy typical of other liability policies, should not affect the issues pertaining to attorney-client privilege. See W. Borgwest and E. Boyle *Duties of The Insured to The Directors and Officers' Insurer*, Directors and Officers Liability Insurance 1990, at 147, 202-03 (P.L.I.1991).

Plaintiffs and the RTC, on the other hand, argue that the Steiner letters are not protected from disclosure by the attorney-client privilege because their was no privileged relationship between the directors and officers and American Casualty. The letters were not written by or to clients of Steiner and do not reveal any director's or officer's communications to Steiner. Moreover, the letters were not written for the purpose of seeking or imparting legal advice. Rather, they were written for the purpose of apprising American Casualty of the status of the

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litigation and requesting that American Casualty contribute to settlement of the case.

It is undisputed that Steiner and the firm of Luce, Forward, Hamilton & Scripps were retained by the director defendants to represent them in the underlying action. It is also undisputed that Steiner and the Luce firm did not represent American Casualty; rather American Casualty was represented by separate counsel. Further, American Casualty did not pay the director defendants' legal fees, nor did they select or provide counsel to the director defendants. In short, American Casualty's directors and officers policy issued to ICA differs markedly from the type of liability insurance policy to which the directors and officers wish the court to analogize. Unfortunately, the court cannot make such an analogy.

In *Linde Thomson Langworthy Kohn & VanDyke, P.C. v. RTC* 5 F.3d 1508, 1514-1515 (D.C.Cir.1993), the highest court to consider this issue in a similar context, the court flatly rejected an extension of the attorney-client privilege that the director defendants wish this court to adopt. In *Linde*, the RTC issued an administrative subpoena to Linde, et al., a law firm which had contacts to a failed thrift. Linde, et al. refused to comply with parts of the subpoena that requested, *inter alia*, information pertaining to liability insurance coverage and claims. At issue *452 were documents containing communications with Linde's insurer.

The *Linde* court initially noted that "... (f)ederal courts have never recognized an insured-insurer privilege as such." *Id.* at 1514. It then analyzed the purpose of the attorney-client privilege and noted that "the critical factor for purposes of the attorney-client privilege (is) that the communication be made in confidence for the purpose of obtaining legal advice from the lawyer." *Id.* at 1514 [quoting *United States v. Kovel* 296 F.2d 918, 922 (2nd Cir.1961)]. The court further noted that an insurer frequently has its own interests, rather than the insured's interests, foremost in mind and often serves as a primary actor. It then concluded:

> We now firmly reject any sweeping general notion that there is an attorney-client privilege in insured-insurer communications. An insured may communicate with its insurer for a variety of reasons, many of which have little to do with the pursuit of legal representation or the procurement of legal advice. Certainly, where the insured communicates with the insurer for the express purpose of seeking legal advice with respect to a concrete claim, or for the purpose of aiding an insurer-provided attorney in preparing a specific legal case, the law would exalt form over substance if it were to deny application of the attorney-client privilege. However, a statement betraying neither interest in, nor pursuit of, legal counsel bears only the most attenuated nexus to the attorney-client relationship and thus does not come within the ambit of the privilege. To paraphrase the *Kovel* case, *if what is sought is not legal advice, but insurance, no privilege can or should exist.*

Id. at 1515, (Emphasis added) (footnotes omitted).

Other courts analyzing similar issues have reached the same conclusions. See also *Vermont Gas Sys. v. United States Fid. & Guar. Co.* 151 F.R.D. 268, 277 (D.Vt.1993). ("The 'common interest' doctrine does not apply where there is an adversarial relationship between the insured and insurer as to whether coverage exists, the parties have never shared the same counsel or litigation strategy and the documents at issue were prepared in an atmosphere of uncertainty as to the scope of any identity of interest shared by the parties"). *NL Industries, Inc. v. Commercial Union Ins. Co.* 144 F.R.D. 225, 231 (D.N.J.1992) ("The common interest doctrine is applicable only when it has been determined that the ... insurer is obligated to defend the underlying action brought against the insured ... and the parties have employed a lawyer to act for them in common. Employment is not created by the fact that the in-

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sured's actions inure to the ultimate benefit of the insurer.") (citations omitted). *International Insurance Co. v. Newmont Mining Corp.* 800 F.Supp. 1195 (S.D.N.Y.1992) (same); *North River Ins. Co. v. Philadelphia Reinsurance Corp.* 797 F.Supp. 363, 366-367 (D.N.J.1992) (same).

The directors and officers cite *Waste Management, Inc. v. International Surplus Lines, Co.* 144 Ill.2d 178, 161 Ill.Dec. 774, 781, 579 N.E.2d 322, 329 (1991) in support of their position. In *Waste Management,* the court, applying Illinois law, required the insured to produce privileged documents to its insurer in a coverage dispute because the attorney for the insurer was "acting for the mutual benefit of both the insured and the insurer." *Id.* However, the Illinois state court's opinion in *Waste Management* is not binding on this court. Moreover, it has been criticized and rejected by most courts that have had the opportunity to visit the issue presented there, as here. See *North River Ins.* 797 F.Supp. at 367; *Remington Arms Co. v. Liberty Mutual Ins. Co.* 142 F.R.D. 408, 417 (D.Del.1992); *Bituminous Casualty Corp. v. Tonka Corp.* 140 F.R.D. 381, 386-87 (D.Mn.1992); *Rockwell Int'l Corp. v. Sup.Ct.* 26 Cal.App.4th 1255, 1261-1262, 32 Cal.Rptr.2d 153, 156-157 (1994).

Here, as noted above, Steiner and the Luce firm did not have an attorney-client relationship with American Casualty. The Steiner letters were not written by or to clients of Steiner and do not reveal any directors' or officers' communications to Steiner. The letters were written for the purpose of apprising American Casualty of the status of the case, not for seeking or imparting legal advice. American Casualty did not have a *453 duty to defend the directors and officers and did not defend the directors and officers, nor pay their legal expenses. Finally, American Casualty and the directors and officers did not share common legal representation; rather, American Casualty had separate representation. Therefore, based on the case law cited above, this Court finds that the Steiner letters are not protected from disclosure by the attorney-client privilege.

III *Work Product Immunity*

A. *The Work Product Immunity and Application*

[2] Plaintiffs and the RTC argue that the Steiner letters are not entitled to protection from discovery by the work-product immunity. They claim that the letters should be viewed as demand letters sent to American Casualty requesting coverage pursuant to its policy with ICA. Plaintiffs and the RTC suggest that the letters were sent shortly after the plaintiffs in the underlying action made a demand for settlement. They also indicate that the letters contain detailed summaries of the claims against the insureds and evidence uncovered that support those claims. However, they maintain that the letters cannot be entitled to work-product immunity because they do not appear to discuss a joint defense and do not reveal defense strategies or Steiner's mental impressions or opinions regarding the case. Plaintiffs and the RTC further argue that if work-product immunity extends to the Steiner letters, the immunity has been waived by disclosure to adverse parties and/or conduct of the directors' and officers' counsel at the November 4, 1994 deposition of Scott Darling.

The directors and officers argue, on the other hand, that the Steiner letters are entitled to work-product immunity in that they are "opinion work product", which is rarely subject to discovery by a litigation opponent, and enjoy nearly absolute immunity from disclosure. They further argue that a waiver of the work-product immunity did not occur because the initial recipients of the letters were members of the joint defense agreement, for which consent of all signatories to the agreement is required to effectuate a waiver. The directors and officers additionally contend that any conduct of its counsel or co-counsel that might indicate a waiver must be seen as curable inadvertence on their part.

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[3] The work product doctrine is embodied in Rule 26(b)(3) of the Federal Rules of Civil Procedure. Rule 26(b)(3) provides that under certain circumstances, discovery may be had of documents prepared in anticipation of litigation or trial by an attorney. However, the rule also provides that:

> In ordering discovery of such materials (trial preparation materials) when the required showing has been made, the court shall protect against disclosure of the mental impressions, conclusions, opinions or legal theories of an attorney or other representative of a party concerning the litiga- tion.

While trial preparation material may be discoverable upon an appropriate showing, the materials containing mental impressions, conclusions, opinions and legal theories of an attorney are discoverable only in rare and extraordinary circumstances. *Connolly Data Systems v. Victor Technologies, Inc.* 114 F.R.D. 89, 95 (S.D.Cal.1987). See *In re Doe* 662 F.2d 1073 (4th Cir.1981) (holding discovery of opinion work product only in extraordinary circumstances); *In re Murphy* 560 F.2d 326, 336 (8th Cir.1977) ("Opinion work product enjoys a nearly absolute immunity and can be discovered only in rare and extraordinary circumstances"); *Handgards, Inc. v. Johnson and Johnson* 413 F.Supp. 926 (N.D.Cal.1976).

The Supreme Court in *Hickman v. Taylor* 329 U.S. 495, 67 S.Ct. 385, 91 L.Ed. 451 (1947), noted the importance of protecting the thought processes of attorneys.

> Historically, a lawyer is an officer of the court and is bound to work for the advancement of justice while faithfully protecting the rightful interests of his clients. In performing his various duties ... it is essential that a lawyer work with a certain degree of privacy, free from unnecessary intrusion by opposing parties and their counsel. Proper preparation of a client's case demands that he assemble information,*454 sift what he considers to be the relevant from the irrelevant facts, prepare his legal theories and plan his strategy without undue and needless interference. That is the historical and necessary way in which lawyers act within the framework of our system of jurisprudence to promote justice and to protect their client's interests.

The court's review of the Steiner letters indicates that the letters contain Steiner's candid analysis of the factual circumstances and legal issues arising from the plaintiffs' complaint in the underlying action. The letters contain Steiner's understanding of the facts supporting plaintiffs' contentions, as well as his opinions, conclusions and mental impressions relating to the directors' and officers' risks of exposure to liability. Steiner's comments are the result of his (and/or the Luce firm's) confidential interviews with officers and employees of ICA, and research regarding plaintiffs' claims. It is therefore difficult to see how the letters could be characterized as anything other than "opinion work product," specifically protected from disclosure to opposing counsel.

B. *Waiver of Work Product Immunity*

Having decided that the Steiner letters constitute "opinion work product," the court must decide whether the counsel for the directors and officers waived the work product protection that is afforded to the Steiner letters.

[4][5] One of the primary functions of the work-product doctrine is to prevent a current or potential adversary in litigation from gaining access to the fruits of counsel's investigative and analytical effort, and strategies for developing and presenting the client's case. Therefore, analysis of issues of waiver of work product protection must focus on whether the disclosures in issue increased the likelihood that a current or potential opponent in litigation would gain access to the disputed documents.

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Bank of the West v. Valley National Bank 132 F.R.D. 250, 262, (N.D.Cal.1990); *In re Subpoenas Duces Tecum* 738 F.2d 1367, 1374-1375 (D.C.Cir.1984).

The court notes that the circumstances surrounding the transmittal of the Steiner letters to their various recipients differ in important respects: As discussed in greater detail in Part I above, certain director and officer defendants and ICA entered into a joint defense agreement on March 10, 1989. On May 25, 1989, Steiner sent the first "Steiner letter" at issue to Roger Novak, a claims adjustor for CNA Insurance Company, an affiliate of American Casualty. Almost a month later, on June 13, 1989, the signatories to the March 10, 1989 joint defense agreement entered into a similar joint defense agreement with American Casualty. Thereafter, on September 14, 1989, Steiner sent the second "Steiner letter" at issue to Michael Tone, counsel for American Casualty. As can be seen from this chronology, the first "Steiner letter," dated May 25, 1989, was sent to American Casualty after the defendants in the underlying action entered into a joint defense agreement on March 10, 1989, but *before* American Casualty agreed to be bound by terms of the joint defense agreement on June 13, 1989. Consequently, the court must separately examine the issues of waiver of the work product protection for each letter.

C. *The May 25, 1989 Steiner Letter*

[6] As noted in Part I above, Steiner sent the May 25, 1989 letter to Roger Novak, a claims adjustor for CNA Insurance Company, an affiliate of American Casualty. The letter analyzes the allegations contained in the complaint in the underlying action and contains Steiner's candid analysis of the risk of exposure to the directors and officers presented by that complaint. Steiner sent copies of this letter to ICA's in-house and litigation counsel, as well as to Reliance National Insurance Company, the directors' and officers' excess insurer.

At the time Steiner sent the letter to Novak, the directors and officers and American Casualty were not adversaries in litigation. However, there can be no doubt that Steiner was aware that when an insurer has not committed to indemnify its insured after demand has been made to do so, the possibility of a future coverage action pitting the insured*455 against the insurer is a distinct possibility. Therefore, there can be no doubt that Steiner understood that at the time the letter was sent to Novak, and copied to Reliance, litigation between his clients and American Casualty and between his clients and Reliance National was a very real possibility.[FN1] Consequently, Steiner's transmittal of the May 25, 1989 letter to American Casualty and Reliance National not only increased the likelihood, but virtually assured, that potential opponents in future litigation would gain access to the disputed documents as well as to Steiner's opinions and thought process regarding his clients' liability. The circumstances here clearly indicate that Steiner intended to waive any work product protection and did so without objection from any members of the joint defense agreement then in effect. Therefore, the court concludes that any work product protection afforded the May 25, 1989 Steiner letter was waived at the time it was sent to American Casualty and Reliance National.

FN1. In fact, the directors and officers and their insurers are now adverse parties in coverage litigation pending before this court. *American Casualty v. Thygerson* 93-0010-IEG(LSP); *Reliance Insurance Company v. Thygerson* 93-0178-IEG(LSP).

D. *The September 14, 1989 Steiner Letter and the Joint Defense Agreement*

[7] As noted in Part I above, Steiner sent the September 14, 1989 letter to Michael Tone, counsel

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for American Casualty. The letter further details evidence uncovered supporting plaintiffs' allegations in the underlying complaint and again contains Steiner's candid analysis, in more detail, of the risk of exposure to his clients presented in the underlying action. The letter, however, was sent to American Casualty presumably under the guise that Steiner's work product contained in the letter would be protected by the June 13, 1989 joint defense agreement entered into between the defendants in the underlying action and American Casualty.[FN2]

FN2. The September 14, 1989 letter does not indicate anywhere on its face that it was an undiscoverable confidential or privileged communication, unlike the first Steiner letter dated May 25, 1989.

The court's first inquiry regarding the September 14, 1989 Steiner letter must necessarily focus on the joint defense agreement entered into between the defendants and American Casualty on June 13, 1989.

[8][9] The joint defense privilege protects communications between an individual and an attorney for another when the communications are part of an ongoing and joint effort to set up a common defense strategy. To establish the existence of a joint defense privilege, the party asserting the privilege must show that (1) the communications were made in the course of a joint defense effort, (2) the statements were designed to further the joint defense effort, and (3) the privilege has not been waived. *United States v. Bay State Ambulance & Hosp. Rental Serv.* 874 F.2d 20, 28 (1st Cir.1989) citing *In re Bevill, Bresler & Schulman Asset Management Corp.* 805 F.2d 120, 126 (3rd Cir.1986); see also *Waller v. Financial Corp. of America* 828 F.2d 579 (9th Cir.1987). Courts have held that while the joint defense privilege is an extension of the attorney-client privilege, it also applies to the work-product doctrine. *Western Fuels Assn. v. Burlington N.R.R.* 102 F.R.D. 201, 203 (D.Wyo.1984); *Haines v. Liggett Group* 975 F.2d 81 (3rd Cir.1992).

In this case, the September 14, 1989 Steiner letter fails to satisfy the requirements of the joint defense privilege. A fair reading of the September 14, 1989 letter does not indicate that Steiner's communications to American Casualty were made in the course of a joint defense effort. To the contrary, the letter constitutes a normal business communication between an insured and an insurer, with the insured having the contractual obligation to keep the insurer informed about the insured's insurance claim with the insurer. [FN3] The letter must also be characterized as a demand that American Casualty contribute to the settlement of the underlying action. There is simply no indication that Steiner and American Casualty had joined forces to *456 set up a common defense strategy. Therefore, the communications contained in the September 14, 1989 Steiner letter could not possibly be designed to further a joint defense effort.

FN3. The Directors and Officers Liability Policy requires the insureds to give American Casualty any and all information and cooperation it may reasonably require in order to fulfill their obligations under the policy.

Under these circumstances, there could be no reasonable expectation that the substance of communications contained in the September 14, 1989 letter would remain confidential. Any other result would be an overly broad use of the joint defense privilege. Were the court to accept the directors' and officers' interpretation of the joint defense privilege, any time two or more contractually related entities disclosed confidential information to each other during normal business transactions, the privilege would not be waived unless the parties became directly adverse to each other in subsequent litigation. That is, a mere contractual relationship would allow entities to exchange privileged information for any reason, at any time, without third parties ever being

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allowed access to the information. Obviously, this is not a logical result. The bounds of the joint defense privilege are more confined than the directors and officers contend. Accordingly, the court rejects the directors' and officers' portrayal of whether the joint defense privilege applies to the September 14, 1989 Steiner letter.

[10] That the joint defense privilege does not apply to the September 14, 1989 Steiner letter is further supported by another aspect of the law pertaining to the joint defense privilege. Case law discussing and interpreting the joint defense doctrine discuss the doctrine's applicability to *co-parties* to a litigation sharing confidential communications as part of a joint effort to establish a common defense. See for example, *Bay State Ambulance, supra; Waller, supra; USA v. McPartlin* 595 F.2d 1321 (7th Cir.1979); *Continental Oil Co. v. United States* 330 F.2d 347 (9th Cir.1964); *Polycast Tech. Corp. v. Uniroyal, Inc.* 125 F.R.D. 47 (S.D.N.Y.1989); *Ohio-Sealy Mattress Mfg. v. Kaplan* 90 F.R.D. 21 (N.D.Ill.1980); *In re Grand Jury Subpoena* 406 F.Supp. 381 (S.D.N.Y.1975); *Western Fuels Assn. v. Burlington N.R.R.* 102 F.R.D. 201 (D.Wyo.1984).

This court has been unable to find, and counsel for plaintiff and defendants have not cited, any cases in which the joint defense privilege has been extended to an agreement between a party to a litigation and a non-party insurer.[FN4] Accordingly, the court refuses to extend the doctrine as the directors and officers suggest. Consequently, the joint defense privilege cannot, and does not, apply to the September 14, 1989 Steiner letter.

> FN4. Except where the non-party insurer has a duty to defend the insured, has hired counsel for the insured and has the right to control the insured's defense.

[11] Since the joint defense privilege does not apply to the September 14, 1989 Steiner letter, a similar analysis applied to the May 25, 1989 Steiner letter must apply here. As with the May 25, 1989 Steiner letter, Steiner sent the September 14, 1989 letter to American Casualty at a time when his clients and American Casualty were not adversaries in litigation. However, Steiner was aware, at the time the letter was sent, that his clients and American Casualty were potential adversaries in future litigation, due to American Casualty's position regarding applicable insurance coverage.[FN5] Therefore, Steiner's transmittal of the September 14, 1989 letter to American Casualty assured that a potential opponent in future litigation would gain access to the disputed document, as well as Steiner's opinions, thought processes and analyses regarding his clients' liability. Therefore, Steiner waived any work-product protection that was afforded the September 14, 1989 letter when he sent the letter to American Casualty. He did so without objection from any members of the defendants' joint defense agreement then in effect.

> FN5. Correspondence from American Casualty to Steiner specifically stated that American Casualty had reserved its rights regarding coverage pertaining to the plaintiffs' claim in the underlying action. See for example letter of Michael Tone to Robert Steiner, dated June 9, 1989, submitted to the court as Plaintiffs' Sealed Exhibit 7.

Therefore, the court here by DENIES the Director Defendants' Motion for Protective Order, and DENIES the Director Defendants' Motion for Sanctions. The court also *457 admonishes counsel that this ruling applies *only* to the May 25, 1989 and September 14, 1989 Steiner letters. Any other document exchanged under the joint defense agreement(s) to which a privilege or protection is claimed is not currently before the court. Therefore the court declines to rule on any such documents until such documents are properly presented to the court for adjudication.

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IT IS SO ORDERED.

S.D.Cal.,1995.
In re Imperial Corp. of America
167 F.R.D. 447

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Vigilant Ins. Co. v. Bear Stearns Companies, Inc.
10 N.Y.3d 170, 855 N.Y.S.2d 45
NY,2008.

10 N.Y.3d 170884 N.E.2d 1044, 855 N.Y.S.2d 45, 2008 WL 656260, 2008 N.Y. Slip Op. 02080

Vigilant Insurance Company et al., Appellants
v
The Bear Stearns Companies, Inc., Respondent.
Court of Appeals of New York

Argued February 6, 2008
Decided March 13, 2008

CITE TITLE AS: Vigilant Ins. Co. v Bear Stearns Cos., Inc.

SUMMARY

Appeal, by permission of the Appellate Division of the Supreme Court in the First Judicial Department, from an order of that Court, entered November 14, 2006. The Appellate Division modified, on the law, an order of the Supreme Court, New York County (Karla Moskowitz, J.; op 10 Misc 3d 1072[A], 2006 NY Slip Op 50047[U]), which had granted plaintiffs' motion for summary judgment to the extent of declaring that defendant could not recover the $25 million disgorgement payment through its insurance policies with plaintiffs, and otherwise denied the motion. The modification consisted of granting summary judgment to defendant on the investment banking exclusion and the independent research/investor education issue, and denying summary judgment to plaintiffs regarding disgorgement. The following question was certified by the Appellate Division: "Was the order of the Supreme Court, as modified by this Court, properly made?"

Vigilant Ins. Co. v Bear Stearns Cos., Inc., 34 AD3d 300, reversed.

HEADNOTE

Insurance
Disclaimer of Coverage
Failure to Obtain Insurers' Consent before Settling

Defendant insured, having executed a consent agreement in settlement of the underlying federal lawsuit against it providing for the payment of $80 million and certain other relief three days before it notified plaintiff liability carriers and asked for their consent to the settlement, breached a provision in its liability policies with plaintiffs obligating it to obtain plaintiffs' consent before settling claims in excess of $5 million. The policy provision provided that defendant would not "settle any Claim, incur any Defense Costs or otherwise assume any contractual obligation or admit any liability with respect to any Claim in excess of" $5 million without plaintiffs' consent. Upon signing the consent agreement defendant acquiesced to the relief sought in the federal action and agreed that a final judgment could be presented to the federal court for signature and entry without further notice to defendant. Although the federal court did not approve the settlement until it entered a final judgment almost six months after plaintiffs had been notified of the settlement, defendant was not free to walk away from the consent judgment before entry of a final judgment, and it had settled the claim within the meaning of the insurance policy at the time it signed the consent agreement.

*171 RESEARCH REFERENCES
Am Jur 2d, Insurance §§ 1385, 1390, 1640, 1646.

Couch on Insurance (3d ed) § 199:48.

NY Jur 2d, Insurance §§ 1909, 2060-2063.

ANNOTATION REFERENCE
See ALR Index under Compromise and Settlement; Insurance and Insurance Companies.

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POINTS OF COUNSEL

DLA Piper US LLP, New York City (*Joseph G. Finnerty III, Arthur F. Fergenson* and *Howard S. Schrader* of counsel), and *Bondas, Skarzynski, Walsh & Black, LLC* (*James A. Skarzynski, Evan Shapiro* and *Eleftherios Stefas* of counsel) for appellants.

I. The First Department violated the Supremacy Clause of the United States Constitution by nullifying a federal court final judgment. (*Frew v Hawkins*, 540 US 431;*Hunt v Mobil Oil Corp.*, 557 F Supp 368;*Washington v Washington State Commercial Passenger Fishing Vessel Assn.*, 443 US 658; *Delaware Val. Citizens' Council for Clean Air v Commonwealth of Pa.*, 755 F2d 38;*Central Nat. Bank v Stevens*, 169 US 432;*Riggs v Johnson County*, 6 Wall [73 US] 166;*Stoll v Gottlieb*, 305 US 165;*Deposit Bank v Frankfort*, 191 US 499;*Matter of New York State Commr. of Correction v Gulotta*, 194 AD2d 540;*Jamaica Hosp. v Blum*, 68 AD2d 1.) II. The First Department misapplied basic principles of contract interpretation to the insurance policies' "investment banking" exclusion. (*Mount Vernon Fire Ins. Co. v Creative Hous.*, 88 NY2d 347;*Silva v Utica First Ins. Co.*, 303 AD2d 487;*Matter of Manhattan Pizza Hut v New York State Human Rights Appeal Bd.*, 51 NY2d 506;*People v Shapiro*, 50 NY2d 747;*Bailey v AGR Realty Co.*, 260 AD2d 322;*State of New York v Home Indem. Co.*, 66 NY2d 669;*Newin Corp. v Hartford Acc. & Indem. Co.*, 62 NY2d 916;*Hartford Acc. & Indem. Co. v Wesolowski*, 33 NY2d 169;*Matter of Ideal Mut. Ins. Co. [Superintendent of Ins. of State of N.Y.-Harbour Assur. Co. of Bermuda]*, 231 AD2d 59;*Tierra Props. v Lloyd's Ins. Co.*, 206 AD2d 288.) III. The court below erred in not holding that Bear *172 Stearns' failure to obtain the insurers' consent prior to its settlement with the regulators voided coverage under the policies. (*Argo Corp. v Greater N.Y. Mut. Ins. Co.*, 4 NY3d 332;*Royal Zenith Corp. v New York Mar. Mgrs.*, 192 AD2d 390;*AIU Ins. Co. v Valley Forge Ins. Co.*, 303 AD2d 325;*Travelers Indem. Co. v Eitapence*, 924 F2d 48;*Valentino v State of New York*, 48 AD2d 15;*Silverman v Member Brokerage Servs.*, 298 AD2d 381;*Winston v Mediafare Entertainment Corp.*, 777 F2d 78;*Flores v Lower E. Side Serv. Ctr., Inc.*, 4 NY3d 363;*Brown Bros. Elec. Contrs. v Beam Constr. Corp.*, 41 NY2d 397;*Matter of Express Indus. & Term. Corp. v New York State Dept. of Transp.*, 93 NY2d 584.) IV. The trial court and the First Department erred in not ruling that Bear Stearns' future payments for "independent research" and "investor education" programs are not "loss" covered by the policies. (*Loblaw, Inc. v Employers' Liab. Assur. Corp.*, 57 NY2d 872;*Breed v Insurance Co. of N. Am.*, 46 NY2d 351;*Roundabout Theatre Co. v Continental Cas. Co.*, 302 AD2d 1;*Continental Ins. Cos. v Northeastern Pharm. & Chem. Co., Inc.*, 842 F2d 977;*Mazzola v County of Suffolk*, 143 AD2d 734;*2619 Realty v Fidelity & Guar. Ins. Co.*, 303 AD2d 299;*Avondale Indus., Inc. v Travelers Indem. Co.*, 887 F2d 1200;*Ellett Bros., Inc. v United States Fid. & Guar. Co.*, 275 F3d 384;*Maryland Cas. Co. v Armco, Inc.*, 822 F2d 1348.)

Proskauer Rose LLP, New York City (*John H. Gross, Seth B. Schafler, Francis D. Landrey, Matthew J. Morris* and *Sarah Reisman* of counsel), for respondent.

I. The insurers' Supremacy Clause argument was not preserved and is without merit. (*Bingham v New York City Tr. Auth.*, 99 NY2d 355;*Motor Veh. Mfrs. Assn. of U.S. v State of New York*, 75 NY2d 175;*Lichtman v Grossbard*, 73 NY2d 792;*Matter of Barbara C.*, 64 NY2d 866;*Balbuena v IDR Realty LLC*, 6 NY3d 338;*Capitol Records, Inc. v Naxos of Am., Inc.*, 4 NY3d 540;*Department of Treasury v Fabe*, 508 US 491;*SEC v National Securities, Inc.*, 393 US 453;*Munich Am. Reins. Co. v Crawford*,

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141 F3d 585;*Washington v Washington State Commercial Passenger Fishing Vessel Assn.*, 443 US 658.) II. There are triable issues of fact as to whether the payment labeled as disgorgement is a loss as that term is defined in the policy. (*Zuckerman v City of New York*, 49 NY2d 557;*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851;*Lipsky v Commonwealth United Corp.*, 551 F2d 887;*Cambridge Fund, Inc. v Abella*, 501 F Supp 598;*Singleton Mgt. v Compere*, 243 AD2d 213;*Matter of Halyalkar v Board of Regents of State of N.Y.*, 72 NY2d 261;*Matter of Becker v DeBuono*, 239 AD2d 664;*Allstate Ins. Co. v Zuk*, 78 NY2d 41;*173*Public Serv. Mut. Ins. Co. v Goldfarb*, 53 NY2d 392;*Messersmith v American Fid. Co.*, 232 NY 161.) III. The Appellate Division correctly granted summary judgment to Bear Stearns on the investment banking issue. (*Belt Painting Corp. v TIG Ins. Co.*, 100 NY2d 377;*RJC Realty Holding Corp. v Republic Franklin Ins. Co.*, 2 NY3d 158;*242-44 E. 77th St., LLC v Greater N.Y. Mut. Ins. Co.*, 31 AD3d 100;*Uribe v Merchants Bank of N.Y.*, 91 NY2d 336;*Metropolitan Life Ins. Co. v Noble Lowndes Intl.*, 84 NY2d 430;*State of New York v Home Indem. Co.*, 66 NY2d 669;*Newin Corp. v Hartford Acc. & Indem. Co.*, 62 NY2d 916;*Hartford Acc. & Indem. Co. v Wesolowski*, 33 NY2d 169;*Ender v National Fire Ins. Co. of Hartford*, 169 AD2d 420;*Mount Vernon Fire Ins. Co. v Creative Hous.*, 88 NY2d 347.) IV. The Appellate Division correctly granted summary judgment to Bear Stearns on whether the policy covers payments for investor education and independent research. (*Vermont Teddy Bear Co. v 538 Madison Realty Co.*, 1 NY3d 470;*Westview Assoc. v Guaranty Natl. Ins. Co.*, 95 NY2d 334;*Mazzuoccolo v Cinelli*, 245 AD2d 245;*S.E.C. v Lorin*, 869 F Supp 1117;*ZKZ Assoc. v CNA Ins. Co.*, 89 NY2d 990;*Woodson v American Tr. Ins. Co.*, 281 AD2d 282;*Yoi-Lee Realty Corp. v 177th St. Realty Assoc.*, 208 AD2d 185;*Maryland Cas. Co. v Armco, Inc.*, 822 F2d 1348;*Ellett Bros., Inc. v United States Fid. & Guar. Co.*, 275 F3d 384;*Gerrish Corp. v Universal Underwriters Ins. Co.*, 947 F2d 1023.) V. There are triable issues of fact concerning the settlement issue. (*Isadore Rosen & Sons v Security Mut. Ins. Co. of N.Y.*, 31 NY2d 342;*Prudential Lines v Firemen's Ins. Co. of Newark, N.J.*, 91 AD2d 1;*Texaco A/S [Denmark] v Commercial Ins. Co. of Newark, N.J.*, 160 F3d 124;*Luria Bros. & Co., Inc. v Alliance Assur. Co., Ltd.*, 780 F2d 1082;*Silverman v Member Brokerage Servs.*, 298 AD2d 381;*Hover v National Grange Ins. Co.*, 20 AD2d 178;*Winston v Mediafare Entertainment Corp.*, 777 F2d 78;*Joseph Martin, Jr., Delicatessen v Schumacher*, 52 NY2d 105;*Schlegel Mfg. Co. v Cooper's Glue Factory*, 231 NY 459;*Souveran Fabrics Corp. v Virginia Fibre Corp.*, 37 AD2d 925.)

Jacob H. Stillman, Washington, D.C., and *Mark Pennington* for Securities and Exchange Commission, amicus curiae.

I. The U.S. Securities and Exchange Commission's complaint alleged that Bear Stearns failed to guard against conflicts of interest that threatened the independence of its securities analysts and sought disgorgement of the ill-gotten gains arising from this misconduct. II. Bear Stearns agreed to pay disgorgement, and the District Court entered a judgment ordering it to do so. III. Despite the plain language of the complaint of the consent to *174 judgment and of the final judgment, Bear Stearns urged in the Appellate Division that it did not pay disgorgement, and that the US Securities and Exchange Commission used a "legal fiction" to obtain compensatory damages.

OPINION OF THE COURT

Graffeo, J.

In this insurance dispute, we conclude that the insured breached a policy provision obligating it to obtain the consent of its liability carriers before settling claims in excess of $5 million. We therefore reverse the order of the Appellate Division denying the insurers' motion for summary judgment.

Defendant Bear Stearns Companies, Inc., a finan-

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cial services firm, was issued a **2 primary professional liability insurance policy by plaintiff Vigilant Insurance Company that provided coverage for losses resulting from claims made against the insured for its wrongful acts. The Vigilant policy afforded $10 million in coverage after Bear Stearns exhausted its $10 million self-insured retention. Plaintiffs Federal Insurance Company and Gulf Insurance Company further provided Bear Stearns an additional $40 million in coverage under follow-form excess liability policies.FN*Pursuant to the terms of these insurance contracts, Bear Stearns agreed not to settle any claim in excess of $5 million without first obtaining the consent of its insurers. In addition, the policies excluded coverage for claims arising from investment banking work undertaken by Bear Stearns.

In early 2002, the U.S. Securities and Exchange Commission (SEC), National Association of Securities Dealers (NASD) and New York Stock Exchange (NYSE), along with state attorneys general, initiated a joint investigation into the practices of research analysts working at financial services firms and the potential conflicts that could arise from the relationship between research functions and investment banking objectives. The investigation focused on allegations that research analysts employed at 10 major financial institutions, including Bear Stearns, were improperly influenced by investment banking concerns. Toward the end of 2002, the regulators met separately *175 with each of the investigated firms to discuss a global settlement.

On December 20, 2002, Bear Stearns signed a settlement-in-principle document, acknowledging that each regulator would commence an action or administrative proceeding against it and that Bear Stearns would subsequently "consent to the action and the relief sought without admitting or denying the allegations." Bear Stearns further agreed to pay $50 million in retrospective relief, plus $25 million to fund independent research and $5 million for investor education. The document indicated that the terms of the settlement were subject to approval by the SEC and other regulators. Also taking place on December 20, 2002, the regulators issued a press release announcing they had achieved an industry-wide settlement with the 10 financial institutions that would result in payments of more than $1.4 billion in penalties, restitution and education funds.

A few months later, Bear Stearns executed a consent agreement in which it acceded to the entry of a final judgment in the SEC's federal lawsuit against Bear Stearns in the United States District Court for the Southern District of New York. Under the terms of the **3 "Consent of Defendant Bear, Stearns & Co. Inc.," dated April 21, 2003, Bear Stearns consented to be permanently enjoined from violating a number of NASD and NYSE rules and agreed to pay a total amount of $80 million allocated as follows: $25 million as a penalty, $25 million in disgorgement, $25 million for independent research and $5 million for investor education. Of the $50 million in retrospective relief, $25 million was designated to resolve the SEC action and related proceedings instituted by the NASD and NYSE, while the remaining $25 million covered the settlement of proceedings with various state regulators. Bear Stearns explicitly agreed not to seek insurance coverage for the $25 million penalty. The agreement also allowed the SEC to present a final judgment to the federal court "for signature and entry without further notice" to Bear Stearns.

Three days after executing the settlement agreement, Bear Stearns sent letters to its insurers requesting their consent to the settlement. The insurers disclaimed coverage and commenced this declaratory judgment action seeking a declaration that the $45 million sought by Bear Stearns (after depletion of the $10 million self-insured retention) was not covered by the policies.

*176 In October 2003 the federal District Court found the Bear Stearns settlement to be "fair, ad-

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equate, and in the public interest," and entered a final judgment ordering Bear Stearns to pay the agreed-upon sum of $80 million. Shortly thereafter, the insurers moved for summary judgment in this declaratory judgment action. In support of their motion, the insurers argued that they were not liable for all or part of the $45 million sought by Bear Stearns for four reasons. First, they asserted that Bear Stearns could not recover any of the settlement because it had breached the policy provision obligating it to obtain the insurers' consent before settling the case. Second, they claimed that the investment banking exclusion precluded recovery of the settlement proceeds. Third, the insurers contended that the $25 million disgorgement payment was uncollectible either as a matter of public policy or under contract interpretive principles. Finally, they posited that neither the $25 million payment for independent research nor the $5 million payment for investor education was covered because those liabilities were not "losses" within the meaning of the policies.

Supreme Court found that triable issues of fact existed as to whether Bear Stearns breached the policy clause prohibiting it from settling without the insurers' consent and whether the investment banking exclusion applied. Siding with the insurers on the disgorgement issue, the court held that the $25 million disgorgement payment did not constitute damages under the terms of the policies and that Bear Stearns was not entitled to look behind the settlement to ascertain whether the entire $25 million truly represented ill-gotten gains. The court also rejected the insurers' position that the $25 million payment for independent research and $5 million payment for investor education were not losses under the policies. Bear Stearns and the insurers **4 appealed.

The Appellate Division modified, by granting Bear Stearns summary judgment on the investment banking exclusion and independent research/investor education issues and denying the insurers summary judgment on the disgorgement issue, and otherwise affirmed. The court concurred with Supreme Court in finding an issue of fact as to whether Bear Stearns breached the provision obligating it to obtain the consent of the insurers, but determined that the investment banking exclusion was not applicable. Despite the agreement by Bear Stearns to pay $25 million as disgorgement, the court found "an issue of fact as to *177 whether the portion of the settlement attributed to disgorgement actually represented ill-gotten gains or improperly acquired funds" (34 AD3d 300, 302 [2006]). Finally, the court rejected the insurers' contention that the combined $30 million payment for independent research and investor education were not covered losses.

The Appellate Division granted the insurers leave to appeal and certified the following question to this Court: "Was the order of the Supreme Court, as modified by this Court, properly made?" We conclude that it was not.

The insurers raise a number of objections to the Appellate Division order, but we find it necessary to address only one of them. The insurers contend that the Bear Stearns settlement is not recoverable because Bear Stearns breached the policy provision obligating it to obtain their consent prior to settling the regulator lawsuits. Specifically, the insurers claim that Bear Stearns resolved and finalized the settlement of the case when it executed the settlement-in-principle in December 2002 or, at the latest, when it signed the consent agreement in April 2003 without advising the insurers. Bear Stearns counters that the courts below properly found a triable issue of fact as to whether its execution of these two documents constituted a breach of the policy provision.

The primary insurance policy, whose terms and conditions are incorporated into the follow-form excess policies, provides in relevant part:
"The Insured agrees not to settle any Claim, incur any Defense Costs or otherwise assume any con-

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tractual obligation or admit any liability with respect to any Claim in excess of a settlement authority threshold of $5,000,000 without the Insurer's consent, which shall not be unreasonably withheld . . . The insurer shall not be liable for any settlement, Defense Costs, assumed obligation or admission to which it has not consented."

As with the construction of contracts generally, "unambiguous provisions of an insurance contract must be given their plain and ordinary meaning, and the interpretation of such provisions **5 is a question of law for the court" (*White v Continental Cas. Co.*, 9 NY3d 264, 267 [2007] [citation omitted]).

We conclude that Bear Stearns breached this provision when it executed the April 2003 consent agreement before notifying *178 the insurers or obtaining their approval. As contemplated by the earlier settlement-in-principle, Bear Stearns signed the April 2003 agreement acquiescing to the relief sought in the SEC federal action. Under this agreement, Bear Stearns agreed to pay $80 million, covering four payment categories, in order to resolve the various federal and state regulatory actions and proceedings pending against it. Bear Stearns further accepted injunctive relief that prevented it from violating certain NASD and NYSE rules. And it acknowledged that the SEC could present a final judgment to the federal court for signature and entry without further notice. In short, Bear Stearns did everything within its ability to settle the matter and no further action was required on its part.

We are unpersuaded by the contention that a triable issue of fact exists because the federal court did not approve the settlement until it entered a final judgment in October 2003. Parties are free to enter into a valid settlement agreement that is made subject to court approval. Notably absent from the agreement, however, was any provision similarly subjecting it to the insurers' approval. Having signed the consent agreement, Bear Stearns was not free to walk away from it before entry of a final judgment (*see TLC Beatrice Intl. Holdings, Inc. v CIGNA Ins. Co.*, 2000 WL 282967, *7, 2000 US Dist LEXIS 2917, *20-21 [SD NY 2000] ["Although the Court, whose approval was sought by the parties, could accept or reject the Settlement, subject to that approval the parties themselves were bound by the Settlement's terms" (citation omitted)], *affd sub nom. Lewis v Cigna Ins. Co.*, 234 F3d 1262 [2d Cir 2000] [table; text at 2000 WL 1654530, 2000 US App LEXIS 27848 (2000)]). In executing the April 2003 agreement, Bear Stearns settled a claim within the meaning of the insurance policy provision.

As a sophisticated business entity, Bear Stearns expressly agreed that the insurers would "not be liable" for any settlement in excess of $5 million entered into without their consent. Aware of this contingency in the policies, Bear Stearns nevertheless elected to finalize all outstanding settlement issues and executed a consent agreement before informing its carriers of the terms of the settlement. Bear Stearns therefore may not recover the settlement proceeds from the insurers.

Accordingly, the order of the Appellate Division should be reversed, with costs, plaintiffs' motion for summary judgment*179 granted, judgment granted declaring in accordance with this opinion and the certified question answered in the negative.

Judges Ciparick, Read, Smith, Pigott and Jones concur; Chief Judge Kaye taking no part.

Order reversed, etc.

FOOTNOTES

FN* The Travelers Indemnity Company is the successor-in-interest by merger to Gulf Insurance Company. Bear Stearns was also covered by additional excess policies not relevant to this appeal.

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