SPRING 2018 INSURANCE COVERAGE UPDATE*

Message from the OACTA Insurance Coverage Committee Chair, Michael M. Neltner:

The following cases represent the more relevant insurance coverage cases decided by the Ohio Supreme Court, lower state appellate courts, and federal courts applying Ohio law in late 2016/early 2017. Many thanks to Megan Faust of Roetzel & Andress, William H. Falin of Moscarino & Treu LLP, Dawn R. Bonnett of Grange Insurance, and Gerald V. Southard of Rolfes Henry Co., LPA for assisting with these summaries.

Ohio State Court Decisions

1. Injured Party Was Estopped from Relitigating Driver Had Permission to Drive the Insured Vehicle When the Court Previously Ruled that the Named Insured Did Not Negligently Entrust the Vehicle to the Driver.

(*Hicks v. State Farm Mut. Auto. Ins. Co.*, 2017-Ohio-7095, 2nd Dist., Aug. 4, 2017)

On May 24, 2010, Danny Norman, Sr. rented a vehicle from Rent a Heap for his son Danny Norman, Jr. to use. On June 5, 2010, the vehicle was in an accident while Roy Crackle, III was driving it, and Danny Jr. was a passenger. Another passenger James Hicks was seriously injured. Hicks initially filed suit against Danny Sr. claiming Danny Sr. negligently entrusted the vehicle to Crackle. Alternatively, Danny Sr. was liable for "downstream negligent entrustment" for negligently entrusting the vehicle to Danny Jr. who negligently entrusted it to Crackle. The court held in *Hicks I* that Danny Sr. did not negligently entrust the vehicle to Crackle or Danny Jr.

In *Hicks II* (the current case), Hicks filed suit against State Farm seeking a declaration that Crackle was an insured under the State Farm personal auto policy issued to Danny Sr. State Farm argued Crackle was not an insured because the court in *Hicks I* had already decided that Danny Sr. did not give Crackle consent to drive the vehicle. As such, Crackle could not be an insured under the State Farm policy.

The State Farm policy provided the following pertinent language:

> **Who is an Insured**
>
> When we refer to *your car*, a *newly acquired car*, or a *temporary substitute car*, insured means:
>
> 1. ***you***;
> 2. ***your spouse***;
> 3. the ***relatives*** of the *first person* named in the declarations;
> 4. any other *person* who is not insured for vehicle liability coverage by any other insurance policy, a self-insurance program, or a liability bond while using

such a ***car***. The use of such ***car*** must be within the scope of consent of ***you*** or ***your spouse***; and

5. Any other *person* or organization liable for the use of such a ***car*** by one of the above *insureds*.

Danny Sr. was the only named insured on the State Farm policy. Crackle could, therefore, only be an insured for liability coverage if Danny Sr. or his wife gave Crackle consent to use the vehicle. In *Hicks I,* the court determined (1) Danny Sr. only provided Danny Jr. consent to drive the vehicle; and (2) Danny Sr. expressly prohibited Danny Jr. from allowing another party to drive the vehicle. The *Hicks II* court determined these facts indicated both a lack of negligent entrustment and a lack of consent under the State Farm policy. Because the *Hicks I* court already concluded that Crackle did not have consent of Danny Sr. to drive the vehicle, Hicks was collaterally estopped from re-litigating this factual issue.

2. Court Finds a Minivan Being Used by the Named Insured's CEO for Transportation to the Named Insured's Business Location in Place of a Broken Down Covered Auto is a Temporary Substitute.

(*Conaway v. Cincinnati Ins. Co.*, 2017-Ohio-8787, 3rd Dist., Dec. 4, 2017)

Cincinnati Insurance Company (CIC) issued a business auto policy to Lee's Hydraulic & Pneumatic Services, LLC (Lee's). The policy listed a 1999 Ford F-450 which the CEO and owner of Lee's Kyle Conaway. Kyle and his father Darrin Conaway lived and worked together. They used the Ford to commute to work. On January 7, 2014, Kyle drove the Ford to get gas for the next day's commute to Lee's. While on their way to get gas, the truck broke down. After learning it would be a while to get a tow, Kyle called another Lee's employee Mark Schlachter to pick them up. Mark took them to Kyle and Darrin's home in Mark's minivan. Due to the weather, Mark stayed the night with the intent to drive all three of the gentlemen to Lee's for work the next day. On January 8, 2014, while driving the minivan, a gust of wind caused the vehicle to move to the left. Mark overcorrected causing an accident. Kyle and Darrin were ejected from the vehicle. Kyle was injured, and Darrin died as a result of the accident.

Kyle and Darrin's Estate filed suit against CIC seeking a declination that the policy provided coverage for the injuries to Kyle and death of Darrin. Kyle and the Estate claimed the minivan was a temporary substitute vehicle for a covered auto, the Ford. Because Kyle and Darrin were occupying a temporary substitute vehicle, they argued they were entitled to coverage under the policy.[1] The CIC policy provides coverage to a "natural person . . . for injuries that occur while 'occupying' an 'auto' for which coverage is provided in the coverage Form or a temporary substitute for such covered 'auto'." The covered auto must "be out of service because of its breakdown, repair servicing, 'loss,' or destruction." The term "temporary substitute" is not defined in the CIC policy.

[1] Note the opinion does not mention the type of coverage Kyle and the Estate are seeking, Medical Payments or Uninsured/Underinsured Motorists Coverage. Based on ISO forms CA 9903 and CA 2133, it could be either or both.

Kyle testified that he intended to use the Ford to commute to work on January 8, 2014. Further, that if the Ford had not broken down on January 7, 2014, Kyle would have driven the vehicle to Lee's on the day of the accident. Kyle further testified that he intended to use the minivan until he covered auto was repaired. The court concluded that the minivan was a temporary substitute vehicle as a matter of law.

3. The Business Pursuits Exclusion Applied Regardless of Payment Not Being Exchanged When the Insured Was Motivated by Making a Profit.

(*Am. Family Ins. v. Phillips*, 2017-Ohio-8670, 6th Dist., Nov. 22, 2017)

Walter Apling hired Jake Phillips to demolish a barn for Apling. Jake, who worked for his father's excavating company Jim Phillips Excavating, agreed to do the job for $3000. Jake and Apling discussed the options for accomplishing the demolition. Apling agreed to the lower priced method which required Jake to dig a pit, knock down the barn, put the debris in the pit, and burn the debris. Jake estimated it would take about two days to complete the job.

On April 3, 2013, Jake took his father's excavator to Apling's property to dig the pit. The next day, Jake returned to the property to complete the job. After noticing the wind picked up, Jake decided to stop working and allow the fire to burn out. Believing the fire was fully extinguished, he left the property. Unfortunately, the fire had not been fully extinguished and Apling's granary, home and garage were all damaged by the fire.

Apling was insured by Woodville Insurance. Apling's brother Charles Apling, who also lived at Apling's property, also sustained damages. He was insured by Erie Insurance. After payment of the damages to their respective insureds, Woodville and Erie filed suit against Jake, Jake's father Jim Phillips, and Phillips Excavating. Jim Phillips had a farm/ranch policy with American Family Insurance. American Family provided Jake and Jim with a defense under a reservation of rights. A consent judgment was reached in the amount in the amounts of $209,488.66 and $40,260.34 in favor of Woodville and Erie respectively against Jake and Jim.

American Family filed a declaratory judgment action seeking a declaration that no coverage was owed due to the business pursuits exclusion. Woodville and Erie counterclaimed seeking a declaration that American Family pay the consent judgments. The trial court granted American Family's summary judgment that the business pursuits exclusion applied barring coverage. Woodville, Erie, Jake and Jim appealed.

The American Family policy provided the following exclusion, "We will not pay for damages due to bodily injury or property damage arising out of business pursuits of any insured[.] The term "business" is defined by the policy as "any profit motivated full or part time employment, trade, profession or occupation, and including the use of any part of the premises for such purpose."

American Family argued that the exclusion applied because Jake's occupation includes the type of work that was done at the Apling property. Additionally, Jake admitted that he took the job to make money. There was no real dispute that the job at issue was part of Jake's occupation or trade. He had completed similar jobs about ten times prior to this event. Woodville and Erie instead argued that Jake took the job as a favor to a "country neighbor," not as a business transaction. To support their argument, Woodville and Erie explained that Jake waived the agreed upon fee. Further, Apling signed an Affidavit that the work was not done as a business transaction and that the demolition was not being done on behalf of Phillips Excavating.

The court held that the business pursuits exclusion applied to bar coverage.

> We find that despite the narrative that Woodville sought to advance when it deposed Jake in 2016, by his own admission, Jake undertook the Apling barn demolition – the type of work he customarily performs to earn a living – with *a* purpose of making a profit.

4. An Employee's Injury is Not Barred by The Workers' Compensation or Employer's Liability Exclusions When the Insured Is Not the Injured Workers' Employer.

(*Goodell v. Motorists Mut. Ins. Co.*, 2017-Ohio-8425, 6th Dist., November 3, 2017)

Wylie & Sons employed Brian Goodell who was injured while in the course and scope of employment in servicing a truck. The truck was put in gear by Shawn Pasquale, who worked in the garage often and described as a friend of Thomas Wylie. It was undisputed that Pasquale was allowed to be in the garage and work on the company vehicles including the truck that caused Goodell's injuries.

Goodell filed suit against Pasquale and Motorists. Goodell, prior to the rulings on the summary judgment motions, dismissed Motorists. Goodell obtained a default judgment against Pasquale. Goodell then filed a supplemental complaint against Motorists seeking to recover the judgment. Motorists issued a Commercial Auto policy to Wylie & Sons. Motorists argued the policy did not provide coverage for Goodell's injuries because Pasquale and Goodell were co-employees and the workers' compensation and employer's liability exclusions applied.

The court first rejected Motorist's claim that Pasquale was a co-employee of Goodell because Motorists did not establish that Pasquale was an employee of Wylie & Sons. The court then determined the workers' compensation and employers' liability exclusions did not apply to Pasquale's liability. The workers' compensation exclusion excluded liability coverage when the insured or the insured's insurer was liable under any workers' compensation law or similar law. The employer's liability exclusion excluded liability coverage to an injury to "an 'employee' of <u>the</u> 'insured' arising out of and in the course and scope of employment by <u>the</u> 'insured'[.] Further, the policy had a severability clause

requiring that each insured be considered separately to determine the application of the policy exclusions to each individual insured.

It was undisputed that (1) Goodell was in the course and scope of employment with Wylie & Sons; (2) Pasquale was an insured; and (3) Pasquale was not Goodell's employer. Because Pasquale was not liable for Goodell's injuries under any workers' compensation law, the workers' compensation exclusion did not apply to Pasquale's liability. Because Goodell was not an employee of Pasquale, the employer's liability exclusion did not apply to Pasquale's liability.

5. Homeowners Policy Did Not Provide Mold Coverage When the Insured Failed to Provide Any Evidence of Mold. Anti-Concurrent Causation Language in the Policy Precluded Coverage for Damages Caused by Covered and Non-Covered Losses.

(*Hartman v. Erie Ins. Co.*, 2017-Ohio-668, 6th Dist., February 24, 2017)

Erie issued a homeowners policy to Chad and Erin Hartman. The Hartmans alleged their home and personal property were damaged on May 29, 2015 from a backup of water from the storm drain system. Erie paid $11,500 for the Hartmans' loss. Erie does not contest that this loss was the result of water backing up through the sump pump only.

On June 27, 2015, the Hartmans filed an additional claim for damage to their property due to another backup of water from the storm drain system and water entering the house through the basement windows. Hartmans also noticed damage to the foundation after the substantial rain. Erie denied the June claim in full stating the anti-concurrent causation language precluded coverage for the damages. Hartmans claimed that the backup endorsement broadened the coverage and removed the application of the anti-concurrent language.

The Hartmans alleged there should have been additional coverage for the May claim pursuant to the "Additional Payments" policy provisions for the cost of testing and remediating damage for fungi or bacteria. Erie's claims representative for the May claim Alexander Davis attested that the Hartmans never advised Erie of any fungi or mold during the investigation of the claim. Davis further testified that he did not see any evidence of mold upon his inspection of the house after the remediation work was completed. Erie hired an expert Stephen Bostwick to review the claim and inspect the Hartman property. He concluded that mold likely would not occur due to rainwater, as opposed to sewage water, backing up through the storm drain. Further, Bostwick did not see any evidence of mold upon his inspection which occurred several months after the May and June losses. Finally, the water remediation company hired by the Hartmans treated the home with an anti-microbial agent that was intended to prevent mold. Therefore, the court agreed with Erie that the policy's mold endorsement was not triggered.

The court also agreed with Erie that the anti-concurrent causation language applied to the June claim to bar coverage when the alleged damages occurred due to a covered and a non-covered loss. Erie provided evidence in the form of an email from Hartman stating water was coming into the home through the windows. Erie's claims representative for the June claim John Fetters inspected the property and noticed mud on the basement windows indicating water had come through them. Additionally, Bostwick opined that the damage to Hartmans' home resulted from rainwater that pooled in culvert, rather than backed up from the culvert. Bostwick further opined the damage to the foundation was a result of hydrostatic pressure. Based on this evidence and no evidence from Hartman to the contrary, the court held there was no coverage for the June claim under the Erie policy.

6. Summary Judgment Reversed in favor of National Freight Hauling and Brokerage Company Where Question of Fact Existed as to the Actual, Implied, or Apparent Agency of Trucking Company's Broker and Insurer Under Notification Clause of Policy.

(*Kaplan Trucking Co. v. Grissly Falls, Inc.*, 2017-Ohio-926, 8th Dist. March 16, 2017)

In 2010, Kaplan, an Ohio based national freight hauling and brokerage company entered into a brokerage agreement with Grizzly Falls, Inc., an Alabama trucking company to haul cargo owned by independent third parties. The contract included a clause indemnifying Kaplan against any and all losses, damages, and expenses relating to the loading, handling, transportation, unloading, or delivery of shipments, including the full value of the cargo involved, fees, and costs. Another section of the Contract required that Grizzly carry liability insurance for loss or damage to cargo for no less than $100,000, and for Kaplan to be named an additional insured under the policy. Grizzly secured a cargo policy through Kunkel & Associates, Inc., issued by Westchester as the insurer. Westchester's producer and broker was Westrope & Associates. The coverage did not extend to cargo transported by vehicles not listed on the Policy schedule and the failure to notify Westchester of a change of vehicle within 30 days of the triggering event resulted in denial of coverage.

Grizzly supplied Kaplan with a certificate of insurance identifying Kaplan as the certificate holder, Kunkel as the producer, Westchester as the cargo insurer, and Progressive Insurance Company as the automobile liability insurer. On March 26, 2013, Grizzly was involved in an accident while transporting three excavators pursuant to the Contract. The cargo was deemed to be a total loss. Kaplan asserted that Westchester agreed with the cargo owner that $105,824.40 was a reasonable value for the loss, and Kaplam remitted the sum to the cargo owner. Kaplan demanded reimbursement from Grizzly, who filed a claim with Westchester and was denied coverage. Several months prior to the accident, Grizzly had purchased the truck involved to replace the truck listed on the schedule. Grizzly advised Kunkel, who contacted Progressive, but failed to notify Westchester. As a result, the truck was excluded from coverage.

Kaplan filed suit against Grizzly and Westchester alleging breach of contract by Grizzly, and equitable subrogation as to Westchester. Kaplan then filed a supplemental complaint against Westchester pursuant to R.C. 3929.06(A)(2), which provides that a judgment creditor of an insured, who has not received payment within 30 days of the judgment may file a supplemental complaint against the insurer to obtain payment of the judgment amount.

In their motion for summary judgment, Kaplan, in addition to reliance on the Policy and related documents, argued that based on the terms of a producer agreement between Westchester and Westrope, and case law interpreting 3929.27, which provides that a person who solicits and procures insurance is considered the agent of the entity who issues the policy, Westrope did not act as Westchester's agent. The trial court granted summary judgment for Westchester ruling that "no reasonably mind would conclude that the Westrope letter altered the terms of the policy between Westchester and Grissly, such that Grizzly could update its policy with Westchester simply by informing Kunkel of a change in vehicles." Because the vehicle involved was not covered under the policy, Westchester did not breach an obligation to Pay Grizzly under the policy.

On appeal, the court noted that it is undisputed that Grizzly notified Kunkel of the vehicle change, that Kunkel notified Progressive regarding the change for purposes of the vehicle's liability policy, but that Kunkel admittedly failed to notify Westrope or Westchester. As a result, in order for Grizzly's notice to be effective against Westchester there must be an agency relationship between Kunkel, Westrope, and Westchester. The court analyzed the agency relationship at the time the Policy was purchased that is specifically covered by R.C. 3929.27, as well as agency status at the time of notice. The court looked to agency principles of express or implied authority.

The producer agreement had express language disclaiming agent liability, but the court did not find this to be determinative. The court then looked to differences in the language in Westchester and Westrope's Policy Contact Information and found Westchester's simple directive to "contact us" to not serve as exclusionary language as to Westrope. As a result, the court found that there was a genuine issue of material fact as to Westrope's authority to bind Westchester so that notice to Westrope equates to notice to Westchester.

For Westchester to be bound by Kunkel's failure to notify, the record must have supported the extension of apparent authority to Kunkel. The producer agreement between Westchester and Kunkel did not limit the agency relationship. The court looked to an email exchange between Kunkel and Westrope as presenting a question as to authority. Kunkel contacted Westrope, indicating Kunkel's understanding that Notice to Westrope was notice to the insurer. Westrope then informed Kunkel of Westchester's determination that coverage would be effective as of that date. Kaplan also asserted that the denial of coverage should be estopped based upon the aforementioned conduct and relationship of the parties. Ultimately, the court found genuine issues of material fact as to the agency relationship between the parties, as well as the equitable principle of estoppel and thus summary judgment was inappropriate.

7. Absent Specific Language to the Contrary, Business Insurance Policy Covers Only Losses Occurred by an Employee While in the Scope of Their Employment.

(*Herman v. Sema*, 2018-Ohio-281, 8th Dist. January 25, 2018)

On May 20, 2014, Herman and Wright, Plaintiffs, were parked along the right shoulder of the westbound lanes of I-90, with emergency flashers operating. Both were in the scope of their employment with the ODOT, when Sema struck their vehicle, causing injuries to both. Plaintiffs filed a complaint against Sema, Pekin Insurance Company, Allstate Fire and Casualty Insurance Company, and the Ohio Bureau of Workers Compensation.

Herman's business Lawnstars had a business auto policy with Pekin. However, the vehicle he was operating at the time was an ODOT vehicle, not his personal vehicle. Pekin denied Herman's claim for underinsured motorist coverage stating that Plaintiffs were not working within the course and scope of employment with Lawnstars at the time of the accident. The trial court agreed, granting summary judgment in favor of Pekin.

On appeal, Herman argued that the policy does not contain specific language stating that the coverage only applies when the collision occurs while he is in the scope of employment for Lawnstars, and that it is a generic policy. The court looked to Ohio Supreme Court precedent in *Westfield Ins. Co. v. Galatis*, 100 Ohio St.3d 216 (2003), that held:

[A]bsent specific language to the contrary, a policy of insurance that names a corporation as an insured for uninsured or underinsured motorist coverage covers a loss sustained by an employee of the corporation only if the loss occurs within the course and scope of employment. Additionally, where a policy of insurance designates a corporation as a named insured, the designation of "family members" of the named insured as "other insureds" does not extend insurance coverage to a family member of an employee of the corporation, unless that employee is also a named insured."

Thus, absent specific language to the contract, the coverage covers only those losses that occur to an employee of Lawnstars is within the course and scope of their employment. Because Plaintiffs were within the course and scope of their employment for ODOT, coverage does not extend to them and Pekin's motion for judgment on the pleadings was affirmed.

8. As contained in an Insurance Contract "driving Privilege" refers to a person's legal authorization to operate a motor-vehicle upon a public highway, such that driver's permit holder who operates without a license operator supervision is without "driving privileges."

(*Founders Ins. Co. v. Gurung*, 2017-Ohio-8983, 9th Dist. Dec. 13, 2017)

Dianne Badea was injured when a bus in which she was a passenger collided with a car operated by Ran Gurung. At the time of the collision, Gurung was operating the car using a temporary driver's permit, which required him to be accompanied by a licensed operator. Although there were two passengers in Gurung's car, none of them was a licensed operator.

Before either Gurung or Badea could file suit, Gurung's insurance carrier – Founders Insurance Company – Filed a complaint against Gurung and Badea. In the complaint, Founders sought a declaration that because Gurung was operating his car in violation of a condition of his driving privileges as contained in the insurance contract between Gurung and Founders, Founders was not required to defend or indemnify Gurung in a lawsuit filed by Badea.

Subsequently, Founders and Gurung filed cross-motions for summary judgment around the ambiguity of the term "driving privileges" under the insurance contract. Founders argued that even though the term is not defined in the insurance contract, the term – in the context of the subject collision – refers to driving "in accordance with the terms and conditions of licensure for a temporary permit." Since Gurung was driving without licensed operator supervision, he did not have driving privileges at the time of the collision. Gurung, however, argued that the term rather refers only to permission to drive that is often given to people whose driver's license has either been revoked or suspended. Since his license had neither been suspended nor revoked, the meaning of "driving privilege," as used in the insurance contract, did not apply to him. The trial court granted Founders' motion for summary judgment.

The Ninth District Court of Appeals affirmed the summary judgment in Founder's favor, holding that since "driving privileges" can be given a definite legal meaning, there was no ambiguity that the term refers to a person's legal authorization to operate a vehicle upon the public highways. Here, under R.C. 4507.05, Gurung – as a driver's permit holder – was required to have a licensed operator supervision at the time of the collison. Since Gurung did not have such supervision, he was in violation of R.C. 4507.05 and was without authorization to operate his car. As such, Gurung was in violation of the insurance contract provision. Founders, thus, had no legal obligation to defend or indemnify Gurung in connection with the collision.

9. In litigation involving a claim for UIM coverage, an appellate court will not address an issue not raised in summary judgment.

(*Warren v. Safeco Ins. Co*, 2017-Ohio-7598, 9th Dist. Sep. 13, 2017)

Everett Warren ("Warren") and his wife were injured by a motorist, while Warren and his wife were at a crosswalk. At the time of the accident, Warren and his wife had insurance with Safeco Insurance Company ("Safeco"), where their policy provided $100,000.00 per person and $300,000.00 per accident in underinsured motorists ("UIM") coverage. The motorist's insurance policy also provided $30,000.00 per person and $60,000.00 per accident in liability coverage. Warren and his wife settled all of their claims against the motorist with the motorist's insurer for the policy limit of $60,000. In addition, Warren's wife filed a personal injury claim against Safeco for UIM coverage, and Warren filed a derivative loss of consortium claim under the same coverage. The two claims settled for $70,000. Subsequently, Warren filed additional non-economic damages claims against Safeco under the UIM coverage. Safeco denied the latter claims as those claims were not bodily injuries as required for UIM coverage under the insurance policy. Warren filed a complaint in response to the denial.

At trial, Safeco and Warren cross-filed motions for summary judgement surrounding the interpretation of the term "bodily injury." The trial court, finding the term to be unambiguous, granted Safeco's summary judgment. Warren appealed.

On appeal, Warren, for the first time, introduced an allegation that he was entitled to UIM coverage because of a hematoma he had developed because of the accident, abandoning his non-economic damages claims, which were at the center of his motion for summary judgment. Affirming the trial court's ruling, the Appellate court held that because Warren's argument in his summary judgment differed from his argument on appeal, the Court could not address the issue of whether Warren was entitled to coverage for UIM, stating that – as a general rule – an appellate court will not consider arguments not raised before a lower court.

10. Refusal to Renew Policy Coverage for a House with Heaved And Cracked Basement Floor As Result Of Heavy Rain Were Not a Cancellation And Were Consistent With Nonrenewal Provision of Policy

(*Puljic v. State Farm Fire & Cas. Co.*, 2017-Ohio-8808, 11th Dist. Dec. 4, 2017)

After a heavy rainstorm, Ankica and Tom Puljic ("Insured") discovered that their basement floor had heaved and cracked. Insured reported the damages to their insurance company, State Farm Fire and Casualty Company ("State Farm"). Subsequently, State Farm inspected the basement and concluded that subsurface water had pushed upward and caused the damages, having ruled out leaks from the municipal water service lines and the house's plumbing lines. Furthermore, the subsurface water buildup occurred suddenly. Pursuant to Insured's homeowners insurance with State Farm, State Farm

denied coverage, citing a provisions in the insurance policy that excluded coverage for the following damages:

- "settling, cracking, shrinking, bulging, or expansion of pavements, patios, foundation, walls floors, roofs or ceilings."
- water damage, defined as "water below the surface of the ground, including water which exerts pressure on, or seeps or leaks through a building, sidewalk, driveway, foundation, swimming pool or other structure."
- "defect, weakness, inadequacy, fault or unsoundness in: (1) planning, zoning, development, surveying, siting; [and] (2) specifications, workmanship, construction, grading, compaction."

Additionally, State Farm refused to renew the insurance policy upon expiration.

Challenging State Farm's conclusion and denial of coverage, Insured hired an expert who concluded – after inspecting the basement – the subsurface water buildup may have been caused by drainage pipe misalignment, which would have been a gradual process. Based on this conclusion, Insured filed a complaint against State Farm for declaratory judgment for breach of contract. State Farm filed a motion for summary judgment, which the trial court granted.

On appeal, Insured raised three issues: 1) since the experts offered different opinions as to the time it took for the damages to occur, there was a genuine issue of material fact barring summary judgment; 2) since the experts disagree as to the term ground (soil line vs. floor line) summary judgment was improper; and 3) State Farm's refusal to renew the insurance policy constituted retaliatory cancellation.

The Appellate Court disagreed with Insured, affirming the trial court's ruling. The Court held 1) since both experts concluded that the damages to the basement were caused by subsurface water, the length of time it took for the damages to take effect was immaterial if the insurance policy excluded coverage for subsurface water damage; 2) the different technical terms used by the competing experts did not change the fact the water accumulated under the basement floor caused the heaves and cracks; and 3) since State Farm sent a letter to Insured that it would not renew the insurance policy after the expiration date – a right granted under the insurance policy – State Farm's refusal to renew did not constitute retaliatory cancellation.

11. Not So Good Vibrations: Homeowner's Claim for Damage to Home Based on "Lay" Belief That it was Caused by Construction "Vibration" Properly Denied Based on "Straightforward" Exclusion for and Expert Testimony Establishing That Wear and Tear and Cracking and Settling Was Cause of Loss

(*King v. Am. Family Ins.*, 11th Dist. Trumbull No. 2016-T-0096, 2017-Ohio-5514)

In this case, a plaintiff-homeowner alleged that "significant vibrations" from a nearby construction project caused damage to her home, including cracks, leaks and mold. She made a claim for the damage under her homeowner's policy with American Family. American Family retained an engineer who examined the home and concluded that the damage was not caused by construction vibration but rather by normal, long term shrinking and swelling due to seasonal moisture variations, creep and shifting of concrete due to time and moisture loss. "Chatter" and other signs of damage from vibration were not present. American Family denied the plaintiff-homeowner's claim based on that engineering report and the policy's coverage exclusion for damage caused by wear and tear and settling, cracking, shrinking, bulging or expansion of pavement, walls, floors or ceilings.

The plaintiff brought suit against American Family for breach of contract. Supported by an affidavit from its retained engineer, American Family moved for summary judgment, arguing that it was entitled to judgment on the plaintiff's claim as a matter of law based on the policy's exclusion for damage caused by wear and tear and cracking and settling. The plaintiff opposed American Family's motion arguing that her testimony and affidavits of neighbors attesting to significant construction vibrations and the lack of damage prior to the construction project created issues of fact as to the cause of the damage to the plaintiff's home and the applicability of the coverage exclusion. The trial court granted American Family's motion, finding that: (1) the plaintiff's evidence was insufficient to rebut the engineer's expert testimony that the damage to the plaintiff's home was caused by long term wear and tear and cracking and settling and not construction vibrations; and (2) therefore, the policy's exclusion for this damage precluded coverage under the policy. The plaintiff appealed, arguing that the trial court erred in granting American Family summary judgment because genuine issues of fact existed as to the cause of the damage to her home and resulting application of the policy exclusion.

The Eleventh District Court of Appeals affirmed the grant of summary judgment in American Family's favor. In doing so, it recognized that because the causes of structural damage are often complex, expert testimony is needed to establish them. The Court also recognized that American Family's qualified engineer provided "detailed descriptions of the likely cause of each item of damage" and that the plaintiff's evidence failed to "demonstrate that the cause of the damages she alleged is vibration."

The Court also recognized long-standing Ohio law that "an insurance policy is a contract, and its construction is interpreted as a matter of law." The Court noted that American Family's homeowner's policy excluded coverage for losses caused by "a. wear and tear, marring, scratching, deterioration… and e. settling, cracking, shrinking, bulging or expansion of pavements, patios, foundations, walls, floors, roofs and ceilings." Therefore, giving the policy its "plain and ordinary meaning," the "straightforward" terms of the policy excluded coverage for the normal wear and tear and cracking and shrinking that were shown to be the cause of the damage to the plaintiff's home.

12. Up in Smoke: An Independent Agent is Not an Agent of an Insurer Until Notice of Placement or Acceptance of an Application for Coverage with a Specific Insurer; An Insured's Failure to Read the Policy Bars a Policy Reformation Claim

(*LG Mayfield LLC v. United States Liab. Ins. Group*,
2017-Ohio-1203, 88 N.E.3d 393 (11th Dist.))

Plaintiff LG Mayfield ("Mayfield") sought general liability and property damage insurance for its restaurant known as "Oak & Embers." Defendant Eisner assisted Mayfield in applying for and procuring that insurance from United States Liability Insurance ("USLI"). Eisner met with Mayfield to review the application and coverages and provided a copy of the policy to Mayfield after it was issued. Mayfield's representatives admitted that they never read the policy. The restaurant was subsequently damaged by fire. Afterwards, Eisner told Mayfield that it had business interruption coverage but the claim for that coverage was denied by USLI because it was not included in the issued policy.

Mayfield brought suit alleging negligent procurement and misrepresentation claims against Eisner for failing to procure and provide the missing business interruption coverage. It also asserted breach of oral contract and contract reformation claims against USLI. Eisner and USLI filed motions for summary judgment, which the trial court granted after denying Mayfield's motion to delay a ruling on Eisner's motion so that Mayfield could conduct additional discovery it claimed it needed to oppose that motion. Mayfield appealed.

On appeal, the Eleventh District Court of Appeals held that the trial court did not abuse its discretion in denying Mayfield's request to delay ruling on Eisner's motion for summary judgment pending additional discovery because Mayfield failed to submit an affidavit justifying why it was unable to oppose the pending summary judgment motion as required by Civ. R. 56(F). After reaching this conclusion, it then reversed the entry of summary judgment in Eisen's favor and affirmed summary judgment in USLI's favor.

With respect to the negligent procurement claim against Eisen, the Court found that submitted deposition testimony gave rise to a reasonable inference that Mayfield requested and Eisen recommended business interruption coverage. Therefore, the Court held that there were genuine issues of material fact as to whether Eisen "was negligent in

procuring the insurance policy that did not include business interruption coverage." The claims against Eisen were, accordingly, remanded for further adjudication.

However, the Court affirmed the entry of summary judgment in USLI's favor on Mayfield's breach of oral contract and contract reformation claims. The Court rejected Mayfield's argument that because Eisner was acting as ULSI's agent when he orally promised to obtain business interruption coverage there were factual issues as to whether USLI breached an oral contract. The Court held that even if Mayfield requested that Eisen obtain that coverage, Eisen was not acting as USLI's agent at that time. In reaching this conclusion, the Court, citing the Supreme Court of Ohio's decision in *Damon's Missouri, Inc. v. Davis*, 63 Ohio St.3d 605, 590 N.E.2d 254 (1992), recognized that "an 'insurance broker' is one who acts as a middleman between the insured and the insurer, and who solicits insurance from the public under no employment from any special company…whereas an 'insurance agent' is one who represents an insurer under an employment by it." Whether "a person acts as a broker or agent is not to be determined by what he is called but is to be determined from what he does…". A broker or independent insurance agent does not become an agent for a particular insurer until: (1) he or she notifies the customer, the potential insured, that he or she he intends to place the customer's coverage with a particular insurer; or (2) he or she accepts an application for insurance with a particular insurer on behalf of the customer.

With this in mind, the Court held that because Eisen contacted and sought quotes from three different insurance companies after speaking with Mayfield about its insurance needs, he was, at the time of this alleged negligent failure to procure business interruption coverage, acting as a "broker," and not as an "agent" for any particular insurer. Therefore, he was not USLI's agent at the time he provided the information to USLI to obtain a quote that lacked the allegedly requested coverage.

The Court also rejected Mayfield's argument that Mayfield's and Eisen's post-fire belief that there was business interruption coverage in the USLI policy supported a "mutual mistake justifying reformation of the contract." The Court noted that reformation is an equitable remedy that must be supported by clear and convincing evidence of a mutual mistake that "affects the insurance policy to such an extent that the contract is not a correct integration of the agreement of the parties." Agreeing with the Eighth District Court of Appeals, the Court also recognized that "a court should not reform an insurance policy where the party seeking reformation has failed to fulfill his duty to read the policy." Therefore, because Mayfield's representatives admitted that they failed to read the issued policy, and there was no dispute that USLI provided the coverage it was asked to provide and no indication that it was mistaken in providing the coverage that was sought, equitable reformation was not available.

13. A Primer in Policy Construction: A Scrivener's Typographical Error Will Be Enforced Against the Insurer According to its Ordinary and Commonly Understood Meaning

(*Bluemile, Inc. v. Atlas Indus. Contrs., Ltd.*, 10th Dist.
Franklin Nos. 16AP-789, 16AP-791, 2017-Ohio-9196)

Bluemile, a provider of cloud, network, data hosting and voice services, suffered a temporary service disruption when a contractor caused an electric short by inserting his screwdriver into one of Bluemile's computer drives. Because of its inability to provide voice and other network services to its customers, Bluemile lost voice and cloud business income. Bluemile sought coverage for its lost business income and lost extended business income ("EBI") under its insurance policy with Hartford. Although Hartford paid part of Bluemile's claim, it refused additional EBI payments based on its disagreement with Bluemile over the duration of the EBI coverage provided by the policy. Bluemile contended that EBI coverage extended from the date of repair up through the date its operations were restored to the condition that would have existed if no loss or damage occurred. Hartford contended that there was a typographical error in the policy and that EBI coverage was limited to a period of 90 days from the date of repair.

Bluemile brought a breach of contract and declaratory judgment action against Hartford seeking the additional EBI coverage that it believed it was entitled to receive. The trial court granted Bluemile's motion for partial summary judgment and declaratory relief, finding that the policy's terms required Hartford to pay EBI from the date of repair up through the date its operations were restored to the condition that would have existed if no loss or damage occurred. Hartford appealed.

On appeal, the Tenth District Court of Appeals analyzed the parties' arguments using Ohio's well-recognized rules of contract construction and interpretation, starting with the rule that the construction and interpretation of written contracts involves issues of law for a court's determination. The Court then recognized that: (1) it must first look to the four corners of the contract to determine if an ambiguity exists; (2) if the terms are clear and precise, no ambiguity exists and the contract must be enforced as written; (3) the intent of the parties is presumed to reside in the policy's language and is to be determined by the plain and ordinary meaning of that language; (4) when terms are unambiguous, a court cannot create a new contract by finding an intent that is not expressed in that clear language; (5) a contract is ambiguous if its meaning cannot be determined from its four corners or if the policy language is susceptible to two or more conflicting, yet reasonable interpretations; (6) the test for determining an ambiguity is not what the insurer intended it to mean or what a lawyer would think it means but what a reasonably prudent layman applying for insurance would have understood; and (7) any ambiguity in an insurance contract must be construed against the insurer.

Bearing these rules in mind, the Court examined the Hartford policy's terms relating to the duration of EBI coverage. Piecing together language contained in the policy form

and applicable endorsements, the Court noted that the policy provided that EBI coverage was to be paid during the period that:

> (1) Begins on the date property is actually repaired, rebuilt or replaced and "operations" are resumed; and
> (2) Ends on the earlier of:
> (a) The date you could restore your "operations" with reasonable speed, to the condition that would have existed if no direct physical loss or physical damage occurred; or
> (b) 90 consecutive days after the date determined in (a) above.

The Court concluded that giving this language a reasonable construction according to its plain, ordinary and commonly understood meaning, Hartford's EBI coverage ended on the date Bluemile could restore its operations to the condition they were in prior to the service interruption or 90 consecutive days after that restoration, whichever is earlier.

Hartford argued that a "scrivener's error" required the Court to give the policy a different meaning. Hartford argued that the "(a)" in subsection 2(b) should have been a "(1)" so that the duration of EBI coverage would be limited to 90 days from the date of repair and resumption of operations. Hartford also argued that disregarding this error made section 2(b) meaningless because Bluemile could never restore its operations earlier than 90 days after that restoration. Therefore, the policy should be interpreted through correction of this typographical error because courts must construe contracts to give effect to every provision and to avoid rendering any term meaningless. The Court rejected Hartford's argument, stating that it was an invitation to impermissibly rewrite a contract under the guise of construction when the policy's language was clear as written on its face. The Court also noted that if any ambiguity existed as a result of Hartford's "scrivener's error," that ambiguity had to be construed in favor of Bluemile.

14. Once Again, No Matter How They Might Be Characterized, a Third-Party Cannot State Tort Claims for Recovery Against An Insured's Liability Insurer

(*Kamnikar v. Fiorita*, 10th Dist. Franklin No. 16AP-736, 2017-Ohio-5605)

This case arises out of an accident in the parking lot of an ice skating rink when a stopped car occupied by the Kamnikars was rear-ended by a car driven by Fiorita. Fiorita allegedly admitted fault at the scene. Although police responded, no report was prepared because the accident occurred on private property. The Kamnikars made a claim with Fiorita's liability insurer, Encompass, after the accident. Encompass denied the claim, advising the Kamnikars that "after a careful investigation, we have found that our insured was not legally responsible for the accident." Encompass refused to provide the Kamnikars with any information concerning its investigation, which consisted of an

interview of a non-witness and review of information provided by an appraiser. It also told them to file a claim with their own insurer.

The Kamnikars subsequently brought suit against Fiorita and Encompass, seeking recovery against Encompass based on negligent misrepresentation, fraud, bad faith, lack of good faith and fair dealing, and negligence claims. The trial court granted Encompass' motion to dismiss those claims. Fiorita subsequently admitted his negligence and the Kamnikars obtained a jury verdict against him for $3,087.05. The Kaminkars then appealed the trial court's dismissal of their claims against Encompass.

The Tenth District Court of Appeals affirmed the dismissal of the claims against Encompass. The Court found that the Kaminkars could not recover on any bad faith or lack of good faith claims against Encompass because well-settled Ohio law makes it clear that an insurer's duty to act in good faith only runs to its insured. Consequently, "a third party has no cause of action for bad faith against the tortfeasor's insurance company."

The Court similarly held that the Kamnikars' negligence claims against Encompass failed based on Ohio's economic-loss rule and the lack of any duty owed by Encompass to the Kaminkars. The Court found that the Kamnikars' claim that Encompass' conduct caused them to incur unnecessary legal costs sought recovery of purely economic loss arising from Encompass' alleged negligence and was, therefore, barred by the economic-loss rule. The Court found that the Kamnikars' claim that Encompass should be held liable for negligent performance of a third party undertaking also failed to state a claim because Ohio courts do not recognize a duty owed by a liability insurer to a third-party claimant and, in any event, the Kaminkars claim was that Encompass' negligence caused them economic, not physical, harm.

Finally, the Court held that the Kamnikars' fraud and negligent misrepresentation claims were also properly dismissed because "an insurance company's duty to conduct a good-faith investigation of the claim filed against its insured is a duty the insurer owes to its insured…It is not a duty the insurer owes to a third party." The Court also noted that because the Kamnikars never abandoned their claim against Fiorita or filed a claim with their own insurer, they could not prove the reliance on any advice provided by Encompass necessary for recovery on their fraud and misrepresentation claims.

15. An Agent is Ordinarily Ordinary, Not a Fiduciary: Agent Cannot Be Liable for Failing to Procure Optional Coverages Absent Facts Demonstrating a Specific Coverage Request or Fiduciary Relationship

(*FDT Group, LLC v. Guaraci*, 10th Dist. Franklin No. 16AP-679, 2017-Ohio-663)

Plaintiff FDT Group was in the business of acquiring, remodeling and managing properties. At the time of the events giving rise to this lawsuit, FDT owned approximately 20 properties. It acquired insurance for each property through a "competitive bidding" process, using three different insurance agents, including

Defendant Guaraci, to provide coverage quotes from which a policy would be selected. FDT would use a manager to solicit and obtain the quotes and to select the purchased coverage, generally using price as the deciding factor. FDT expected the agents to try to sell additional, possibly unnecessary, coverages and selected the coverages it wanted, often declining coverage options it found unnecessary. Although FDT claimed that all of its agents provided assurances that they were using their knowledge and experience to work on FDT's behalf and fit its needs, FDT's representatives never told the agents that they were relying on their expertise.

After FDT acquired a new commercial property, it sought quotes to insure the property without requesting any specific coverages. Guaraci, who had procured insurance for only two of the nineteen properties FDT previously owned, provided a quote after getting information from FDT about the property and visiting it himself. Although part of the property was below grade, Guaraci's quote did not include water backup coverage because it was optional, FDT did not request it, and FDT declined that coverage on the two other policies Guaraci procured for FDT. Guaraci's quote was accepted. Although the policy was issued and delivered to FDT, FDT's representatives admitted that they did not review the policy for the coverages it provided and did not contact Guaraci with any concerns relating to the policy's coverages. The property subsequently sustained a loss due to water backup. After FDT's claim for that loss was denied due to lack of coverage, FDT brought suit against Guaraci alleging negligent placement and negligent misrepresentation claims based on Guaraci's failure to recommend water backup coverage. The trial court granted Guaraci's motion for summary judgment on FDT's claims and FDT appealed.

The Tenth District Court of Appeals affirmed the trial court's judgment in Guaraci's favor, noting that the issue of whether Guaraci had a duty to specifically recommend water backup coverage for the property turned on whether Guaraci had an ordinary business or fiduciary relationship with FDT.

In reaching its decision, the Court recognized that a fiduciary relationship giving rise to a duty to act primarily for the benefit of another might be found where both the customer and his or her insurance agent know that the customer is relying on the agent based on a special trust and confidence in the agent. However, the relationship between an insurance agent and his or her client is not, as a general rule, a fiduciary relationship, but rather, an ordinary business relationship. When such an "ordinary business relationship" exists, an insurance agent procuring insurance for a client, has: (1) a duty to exercise good faith and reasonable diligence in obtaining the insurance a customer requests; and (2) if the insurance agent knows that customer is relying on his expertise, a duty to exercise reasonable care in advising the customer. In turn, the customer has a "corresponding duty to examine the policy, know the extent of its coverage, and notify the agent if said coverage is inadequate."

Based on the facts before it, the Court held that the relationship between FDT and Guaraci was an "ordinary" and not a "fiduciary" relationship and, as a result, Guaraci could not be held liable as a matter of law for failing to specifically recommend the water

backup coverage missing from the policy that was issued for the property. The Court noted that Guaraci's choosing of optional coverages to include in his quotes, his pursuit of FDT's business, touting of his trustworthiness and expertise, prior explanation of coverages, visit to the property, and prior provision of sample contracts and agent recommendations did not give rise to a "fiduciary" relationship. Instead, an "ordinary" relationship was demonstrated by the presented facts, including FDT's understanding that Guaraci would make recommendations in his own self-interest, the lack of a personal relationship between FDT and Guaraci, FDT's use of a "competitive bidding" process to receive multiple quotes and FDT's admission that it knew that it was its responsibility to make sure the coverage it wanted was included in the policy it received.

16. No Duty to Defend an Allegation of Breach of a Stock Purchase Agreement Under a Policy Insuring Employment Practice Liability Coverage

(*Orthopedic & Neurological Consultants, Inc. v. Cincinnati Ins. Co.*, 2018-Ohio-185, 10th Dist., January 18, 2018).

In 2016, Dr. Simek, Dr. Otis, and Dr. Yu filed a complaint alleging multiple claims against Orthopedic & Neurological Consultants, Inc. ("ONC"). The plaintiffs alleged that between 1998 and 2009, the plaintiffs became employee-shareholders in ONC and partners in a real estate partnership. Because of ONC's breach of their fiduciary duties to the plaintiffs, the complaint alleged the plaintiffs decided to discontinue their positions as shareholders and partners. Subsequently, the plaintiffs executed a partnership interest agreement, in which the plaintiffs sold their interest in the partnership back to ONC. The plaintiffs also executed stock purchase agreements which effectuated the buy-out of the plaintiffs' shares, along with a new employment agreement with ONC.

Shortly after receiving notice of the plaintiffs' suit, ONC initiated its own action against its insurer, The Cincinnati Insurance Company, alleging Cincinnati Insurance had breached its duties to defend and indemnify ONC in the underlying action. ONC's policy provided employment practices liability ("EPL") coverage. "[T]he policy's EPL Coverage part provides coverage for losses incurred by [ONC] resulting from employment related claims." *Id.* at ¶ 3.

Both ONC and Cincinnati Insurance moved for summary judgment as to the issue of whether Cincinnati Insurance was obligated to defend or indemnify ONC in the underlying case. The trial court found no duty to defend, and thus partially granted Cincinnati's motion for summary judgment.

On appeal, the appellate court held there was no duty to defend if no allegations within a complaint, if true, would invoke coverage. Under the insured's policy, Cincinnati Insurance had a duty to defend ONC against any "claim." A "claim," as defined under the policy, meant a civil proceeding commenced by the filing of a complaint, brought by a past or present employee, alleging the "breach of any oral, written or implied employment contract or quasi-employment contract, an [e]mployment related misrepresentation, and wrongful retaliation." *Id.* at ¶ 10. Based on the court's reading of the allegations in the underlying complaint, the core theory of recovery was founded on ONC's breach of the stock purchase agreement. Because the factual allegations contained

within the underlying complaint did not seek liability against ONC based on an alleged violation of the employment agreement, the appellate court affirmed the trial court's finding that Cincinnati Insurance owed no duty to defend ONC.

17. In a Case Involving Two Property Losses, Trial Court Bats .500 on Appeal.

(*Zinser v. Auto-Owners Ins. Co.*, 2017-Ohio-5668, 12th Dist., July 3, 2017.)

This declaratory judgment action stems from two insurance claims filed by the insured for incidents occurring in Fairfield, Ohio. In October 2013, the insured reported the theft of three AC units from the insured property. Although the insured had yet to install the AC units, he had grounded the units to the building by connecting wire to each individual unit. The insured reported the theft to the Fairfield Police Department after discovering the theft; however, the police report indicated the AC units "were not attached to the business." The insured submitted photographs indicating severed ground wire coming from the rear of the building, along with photographs of tire tracks to his insurer, Auto-Owners Insurance Company. Auto-Owners subsequently denied the insured's claim, citing policy provisions excluding coverage for building materials not attached to the insured building.

In February 2015, the insured filed an additional claim as a result of wind damage to the siding of the insured building. Due to concerns regarding matching of the replacement siding, the insured obtained estimates for re-siding the entire building. Auto-Owners provided payment for the wind-damaged siding in the amount of $6,579.94, which did not include full replacement of the siding of the entire building. Auto-Owners further informed the insured that an additional $2,970.70 in recoverable depreciation would be paid if the insured made the necessary repairs for the wind damage. The insured subsequently cashed the actual case value payment for the loss, but never made repairs in order to pursue recoverable depreciation.

Shortly thereafter, the insured filed a complaint for declaratory judgment seeking a judicial determination as to the issues of whether the policy afforded coverage for the stolen AC units, as well as coverage for full replacement of the siding of his building for the wind loss claim. After the trial court granted Auto-Owners summary judgment as to both issues, the insured appealed.

On appeal, the Twelfth District Court of Appeals determined the trial court improperly granted summary judgment to Auto-Owners regarding the insured's claim for theft of the AC units. The insured's policy afforded coverage for direct physical loss or damage to property covered under the policy. Covered property included building fixtures, machinery and equipment, and business personal property located within 100 feet of the insured building. Because there was a factual question as to whether the ground wire indicated the insured's intent to permanently attach the AC units to the structure, the appellate court held that the granting of summary judgment was inappropriate. Additionally, the appellate court rejected the trial court's finding that the insured failed to demonstrate physical evidence of the loss of the AC units. The trial court had focused on the police report, which stated the AC units were not attached to the building. However,

the insured's photographs showing severed ground wire and tire tracks was sufficient to establish physical evidence demonstrating loss.

Regarding the claim for the wind loss, the appellate court affirmed the trial court's finding in granting summary judgment in favor of Auto-Owners. The insured maintained that the Ohio Administrative Code required Auto-Owners to pay the cost of replacing the building siding, in its entirety, because replacing only a portion of the siding would cause the building to be two different colors. The court determined there was no indication in the record, beyond the insured's displeasure, which indicated the repairs would not result in a reasonable comparable appearance in the siding. Furthermore, the insured's decision not to dispute the amount Auto-Owners paid for the claim, along with the fact the insured cashed the check without repairing the damaged siding, waived any argument for additional compensation as to the insufficiency of the amount of loss paid by Auto-Owners.

Federal

1. Justifiable Reliance When Misrepresentations by Insurer's Employee Guides Insured's Understanding of Coverage Under Personal Umbrella Policy.

(*Abboud v. Liberty Mut. Ins. Group, Inc.*, 2017 U.S. App. LEXIS 19881.)

This case involves an appeal of the district court's dismissal of the insured's claim for negligent misrepresentation, in which the insured asserted that Liberty Mutual negligently represented that its personal umbrella liability policy would provide uninsured/underinsured motorist coverage as provided within the insured's underlying auto insurance policy. In 2011, Dr. John Abboud purchased auto insurance coverage from Liberty Mutual. Abboud's policy provided single-limit coverage with a per-accident limit of liability of $1.0 Million, and a per accident UM/UIM limit of $500,000.

Abboud later contacted Liberty Mutual after receiving an unsolicited email advertising personal umbrella coverage. He spoke with Daniel Fissel, a customer service representative with Liberty Mutual. Based on Fissel's recommendation, Abboud modified his auto insurance coverage from a single-limit policy to a split-limit coverage, with the intention of adding additional coverage through an umbrella policy. Fissel testified that he typically advised insureds to switch to split-limit coverage as it is less expensive than a single-limit policy. Although he would not have recommended a reduction of personal auto liability limits, Fissel admitted that he may have recommended a reduction if Abboud was also purchasing an umbrella policy for the purposes of providing additional liability limits of insurance. After Abboud's conversation with Fissel ended, Abboud's auto policy was amended to provide split-limit coverage of $250,000 per person/$500,000 per accident liability coverage and $100,000 per person/$200,000 per accident UM/UIM coverage. Because Fissel did not have the authority to sell umbrella policies, Abboud was then transferred to another sales employee to continue discussing umbrella coverage. Abboud did not remember the name of the Liberty Mutual

employee with whom he spoke regarding umbrella insurance; however, he understood that Liberty Mutual would be mailing umbrella coverage paperwork to him.

Abboud later received a pre-filled application form from Liberty Mutual. The portion of the application regarding UM/UIM coverage was left blank. Liberty Mutual later issued an umbrella policy to Abboud after receiving the signed application in November 2012. However, the umbrella policy included an exclusion for UM/UIM coverage "unless these coverages are specifically listed on your policy declarations."

After the policies were renewed in 2013, Abboud's mother was killed when struck by a third-party motorist. The third-party motorist's insurance carrier tendered their limit of liability of $100,000, after which Abboud filed a UIM claim on behalf of his mother under his auto and umbrella policies with Liberty Mutual. Liberty Mutual denied coverage under the auto policy, since the third-party motorist's liability insurance carrier had already paid the equivalent of the UM/UIM limit of liability under Abboud's auto policy. Liberty Mutual then further denied coverage under the umbrella policy, maintaining that the umbrella policy did not include UM/UIM coverage.

Abboud filed suit alleging breach of contract, negligent misrepresentation, breach of fiduciary duty, and negligent hiring. The matter was removed to federal court in the Northern District of Ohio. The district court later granted summary judgment in favor of Liberty Mutual, and Abboud subsequently appealed only the district court's dismissal of his claim of negligent misrepresentation.

The court of appeals reversed the district court's decision granting summary judgment on Abboud's negligent misrepresentation claim. The appellate court found that summary judgment was inappropriate because the district court failed to consider ambiguity in the umbrella coverage provisions and application for insurance. The appellate court also found the trial court failed to factor statements made by employees of Liberty Mutual which indicated justifiable reliance by Abboud that the umbrella policy afforded UM/UIM coverage. The appellate court determined that Liberty Mutual's pre-filled application signed by Abboud was unclear as to whether coverage for UM/UIM was provided, since the application referenced Abboud's underlying auto policy, which afforded UM/UIM coverage. Additionally, the court held the UM/UIM provision within the umbrella policy was ambiguous, as it excluded UM/UIM coverage unless specifically listed on the declarations. Because Abboud's auto insurance policy listed on the umbrella declarations provided UM/UIM coverage, the court found that this language created ambiguity as to whether UM/UIM insurance was afforded under the umbrella policy.

The court also addressed arguments raised concerning comparative negligence with regard to an insured's failure to read their insurance policy on negligent misrepresentation claims. Although Abboud read and understood his insurance policies, the court found that his understanding was guided by the misrepresentations made by Liberty Mutual's employees; thus, the court held that the issue of comparative negligence should therefore also be sent to a jury along with the negligent misrepresentation claim.

2. Notice of Civil Proceedings by the Ohio Environmental Protection Agency Triggers Duty to Defend Under Pollution Policy.

(*Olymbec USA, LLC v. Aspen Specialty Ins. Co.*, 2017 U.S. Dist. LEXIS 152083.)

The plaintiff, Olymbec USA, LLC ("Olymbec"), leased a warehouse to defendant, Closed Loop Refining and Recovery, Inc. ("Closed Loop"). The lease agreement required the lessee to purchase insurance and name the lessor as an additional insured, as well as provide defense and indemnity for the lessor for all claims of liability stemming from the lessee's use of the property. Closed Loop used the property to store and recycle cathode ray tubes ("CRTs").

Closed Loop purchased a commercial general liability and environmental insurance policy from Aspen Specialty Insurance Company ("Aspen"). Olymbec was an insured under this policy pursuant to a policy provision which included any person or organization which Closed Loop agreed to include as an insured pursuant to an insured contract with regard to bodily injury, property damage, environmental damage, or personal and advertising injury arising out of Closed Loop's operations.

In March 2016, Olymbec learned that the Ohio Environmental Protection Agency ("Ohio EPA") had initiated a civil proceeding against Closed Loop for operating an unpermitted hazardous waste facility at the leased location. The Ohio EPA informed Olymbec that it was responsible under Ohio law for corrective measures related to Closed Loop's unpermitted hazardous waste facility. Thereafter, Olymbec notified Aspen of the Ohio EPA's civil proceedings and requested coverage under the policy. Olymbec filed suit after Aspen denied coverage, asserting six causes of action: (1) declaratory judgment; (2) breach of contract; (3) third-party beneficiary liability; (4) bad faith; (5) defense and indemnification by Closed Loop; and (6) negligence of Closed Loop.

Aspen moved to dismiss the complaint for failure to state a claim upon which relief could be granted based on Federal Rule of Civil Procedure 12(b)(6). Olymbec contended that it had sufficiently pled facts to maintain a finding that it was an insured under Closed Loop's policy, and that it timely requested coverage for the alleged environmental damages, including clean-up costs, for which Aspen denied coverage without adequately investigating. The court found Aspen's argument unavailing as to whether Olymbec's claim was a "pollution incident" under the policy. There was evidence of hazardous waste released onto the leased property caused by broken CRTs, and that the breakage of CRTs caused "release of hazardous waste, including lead, onto the property." Therefore, the court held that the alleged release of pollution was sufficient to establish potential coverage under the policy.

The court further held that Olymbec alleged sufficient facts to present a plausible claim for pollution under the policy based on the Ohio EPA's threat to hold Olymbec responsible under Ohio law for any remediation measures resulting from Closed Loop's operation of an unpermitted hazardous waste facility. Because claims for clean-up costs made against an insured were covered under the policy, the court determined Olymbec's complaint sufficiently plead facts to present a claim for coverage under the policy.

3. Loss as a Result of Arson is Not Precluded Under an Exclusion for Vandalism or Malicious Mischief.

(*Wells Fargo Bank, N.A. v. Allstate Ins. Co.*, 2017 U.S. Dist. LEXIS 192610.)

Wells Fargo Bank ("Wells Fargo") filed suit against Allstate Insurance Company ("Allstate") after it denied a claim based on an exclusion within a homeowner's policy which precluded coverage for loss caused by vandalism or malicious mischief. The insured dwelling became vacant after the homeowner defaulted on the mortgage in 2013. Wells Fargo submitted a claim the following year, after a fire caused by an unknown arsonist damaged the dwelling. Allstate denied coverage based on a policy exclusion for vandalism or malicious mischief to an insured dwelling when vacant or unoccupied for 30 or more days prior to the loss.

The matter of whether loss as a result of arson is precluded under a vandalism or malicious mischief exclusion was one of first impression in Ohio. Persuasive authority from other jurisdictions was divided as to whether vandalism or malicious mischief encompassed arson. Wells Fargo maintained that, based on principles of contract interpretation, the exclusion for vandalism and malicious mischief does not apply to arson when viewed in context of the entire policy. The terms should be given the same meaning throughout the whole policy; thus, when viewed as a whole, Wells Fargo contended that arson is not a form of vandalism or malicious mischief.

In determining whether loss by arson was precluded under the vandalism and malicious mischief exclusion, the court applied Ohio law as to the basic rules of contract interpretation of insurance policies. Since the policy did not define the words "arson," "vandalism," or "malicious mischief," the court looked to the plain and ordinary meaning of the terms. Under the plain and ordinary meaning of these terms, the court found that "arson" could reasonably be interpreted to be included within an act of vandalism or malicious mischief with regard to the act of burning a dwelling.

Although arson could be interpreted within the terms of vandalism or malicious mischief, the court noted that Ohio law requires insurance policies to be examined in their entirety, and terms within a policy must be given the same meaning throughout the insurance contract.

Under the policy, a separate vacancy provision was included under loss to personal property. However, the vacancy provision under the personal property section of the policy included additional language limiting or excluding loss caused by fire, in addition to loss by vandalism or malicious mischief. Thus, when viewing the terms of the contract as a whole, the court held loss to the dwelling caused by vandalism or mischief did not include loss caused by fire or arson. If Allstate intended to include arson within the meaning of vandalism and malicious mischief within the policy, the court held the drafter of the policy should have defined the terms as such.

4. Failure to Promptly Report Claim Negates Coverage

(*GMS Management Company, Inc. v. Evanston Insurance Company*, 689 Fed.Appx. 439, 6th Cir. May 18, 2017).

This was an appeal from the Northern District of Ohio. GMS Management Company, Inc. ("GMS") owned apartment buildings in Ohio and held a tenant discrimination liability insurance policy with Evanston Insurance Company ("Evanston"). On August 16, 2013, GMS received notice from the Ohio Civil Rights Commission ("OCRC") that Thomas Fasanaro filed a housing discrimination charge against GMS. On December 3, 2013, after an attempted mediation failed and the OCRC began an investigation, GMS reported the claim to Evanston.

The Evanston policy required that a claim be "promptly reported" to Evanston, and reported "in no event later than sixty (60) days from the date of the institution of any legal or administrative proceeding." The policy further stated that reporting within the requisite sixty days was a "condition precedent to coverage." Evanston denied coverage to GMS based on GMS's failure to report the claim for almost four months after receiving notice.

GMS filed a declaratory judgment action against Evanston, alleging breach of contract and bad faith. The district court granted summary judgment to Evanston on both claims, finding that Evanston properly denied coverage and that the denial was not in bad faith.

GMS appealed, but the Sixth Circuit affirmed, finding that there was no coverage under these facts.

***5.* Big Lots, Big Torches and Big Occurrences**

(Big Lots Stores, Inc. v. American Guarantee & Liability Insurance Company, 240 F.Supp.3d 725, S.D. Ohio, E. Div. March 02, 2017)

Big Lots filed a declaratory judgment action against American Guarantee under its umbrella policy, alleging breach of contract and bad faith for underlying products liability lawsuits regarding Big Lots' sale of allegedly defective "large tabletop torches" sold in combination with allegedly improper fuel.

The Torch Case plaintiffs' allegations about the role Big Lots played in their injuries were not entirely consistent. Some complained that Big Lots was involved in the design and manufacture of the torches while others alleged that Big Lots only purchased for resale, marketed, distributed and sold the torches. With the exception of some New Jersey plaintiffs, the Torch Case plaintiffs alleged that other parties were also responsible for the torches' malfunctioning. Specifically, they alleged that Designco designed and

manufactured the torches, that Bureau Veritas and the affiliated BV India tested the torches for safety and compliance, and that HOC produced the torch fuel that was incompatible for use with the torches sold by Big Lots.

As to the coverage action, Big Lots and American Guarantee disagreed about their "respective obligations for payment of the settlement and costs of defense" in the settlement of the Texas action, and American Guarantee refused to participate in the settlement of an action in Illinois.

The court determined initially that Big Lots, as the insured, had the duty to prove coverage. The central issue, said the court, was whether there was one occurrence or multiple occurrences under the Policy. The court found that the number of occurrences under an insurance policy is determined based on the language of the policies at issue, and the facts of a particular case, citing *Westfield Ins. Co. v. Cont. Ins. Co.,* 2015 WL 1549277, at *4 (N.D. Ohio Apr. 6, 2015).

The Arch Policy used the ISO definition of "occurrence" found in the vast majority of commercial general liability policies (an occurrence is "an accident, including continuous or repeated exposure to substantially the same general harmful conditions"). Big Lots argued that this language was "susceptible to more than one interpretation" and thus should be construed "liberally in favor of the insured and strictly against the insurer," but the Court found that the definition was unambiguous, and applied a "cause test" to determine the number of occurrences under the policy. Citing *Parker Hannifin Corp. v. Steadfast Ins. Co.*, 445 F.Supp.2d 827 (N.D. Ohio 2006). Under the cause test, the court considers "if there was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damages." If there is, then there is a single occurrence under an insurance contract. The converse is also true: Where there are multiple proximate causes, each is a separate occurrence under an insurance contract.

Other courts, however, have applied the cause test and reached different conclusions about the number of occurrences that took place under an insurance contract. Some have held that there was a single occurrence where a company sold and shipped eight loads of contaminated birdseed to feed and grain dealers, finding that each of the eight sales of the contaminated birdseed constituted an "occurrence" under the policy. In conducting this type of analysis, the Fifth Circuit explained its decision as follows:

> *We think that the 'occurrence' to which the policy must refer is the occurrence of the events or incidents for which Pincoffs is liable. It was the sale of the contaminated seed for which Pincoffs was liable. Although the cause of the contamination is not clear, it seems apparent that Pincoffs received the seed in a contaminated condition and did not itself contaminate the seed. However, it was not the act of contamination which subjected Pincoffs to liability. If Pincoffs had destroyed the seed before sale, for instance, there would be no occurrence at all for which the insured would be liable. But once a sale was made there would be liability for any resulting damages. It was the sale that created the exposure to 'a condition which resulted in property damage neither expected nor intended from*

the standpoint of the insured,' under the definition of the policy. And for each of the eight sales made by Pincoffs, there was a new exposure and another occurrence.

The Ninth Circuit, however, found that there were 28 separate occurrences—one for each claim asserted by a homeowner who used lime plaster that was unsuitable for interior use— and affirmed the district court's holding that the single "underlying cause of the plaster pitting was [the insured's] failure to warn end-users that the high-periclase lime was unsuitable for indoor use." There was no other cause or intervening business decision that interrupted the insured's failure to warn. Likewise, the Tenth Circuit reversed a district court's determination that there had been two separate occurrences under policies when contaminated food had been prepared and served at two different places, causing physical injury. The Tenth Circuit based its reasoning on the fact that there was a single occurrence, because all of the plaintiffs' injuries were "proximately caused by the restaurant's ongoing preparation of contaminated food."

Big Lots also argued that the product liability claims at issue should constitute a "single occurrence" based on a product liability case where the claims arose after a number of consumers sustained serious injuries and even suffered death when their chenille robes—which had been "spec'd, imported, inspected and sold" by the insured—caught fire. The court in that case applied the cause test and determined that the "single cause" of the losses for which the insured sought coverage was the insured's "alleged negligence and/or strict liability in connection with production and distribution of an unreasonably dangerous

The Court here stated that in determining the number of occurrences, it is necessary to look at whether "there was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damages." Since several of the Torch Case plaintiffs alleged that there were multiple proximate causes of the injuries they suffered, including: (1) the creation and approval of the torches' design specifications; (2) the improper testing of the torches; and (3) the improper shelving of the torches with a recommended, yet allegedly incompatible, torch fuel and the fact that the fuel manufacturer (HOC) supplied Big Lots with a reformulated fuel that had a new, dangerously low flash point and failed to warn Big Lots of the change, despite its knowledge that the fuel would be sold with incompatible torches, which the Court found constituted "an intervening cause that interrupts Big Lots' so-called 'chain of business decisions,'" then therefore there is no single, proximate, uninterrupted cause that led to all of the injuries and damages in the Torch Cases.

The Court also found it noteworthy that the Torch Case plaintiffs did not use the phrase "chain of business decisions" in their complaints. Rather, this was a term devised by Big Lots to fit its single occurrence theory. The Court noted that to hold that a "chain of business decisions" is a single proximate cause giving rise to a single occurrence under an insurance policy would create a standard so general that it would present no standard at all, and under this analysis, almost any loss could be viewed as resulting from a 'chain of business decisions.'"

The Court therefore determined that there were multiple occurrences under the American Guarantee Policy and granted American Guarantee's Motion for Summary Judgment.

5. When Does the Offense Occur? The Million Dollar Question

(Selective Insurance Company of the Southeast v. RLI Insurance Company, 706 Fed.Appx. 260, August 24, 2017).

In this case, a city's current excess liability insurer brought action against the city's previous excess liability insurer to determine which insurer was liable for the city's settlement of a wrongly accused murderer's malicious prosecution and deprivation-of-due-process claims for $5.25 million. The Northern District of Ohio determined that excess coverage was triggered when the civil rights plaintiff was first arrested and that the insurer providing excess coverage at that time was responsible for paying him.

The Sixth Circuit reversed and held that coverage was not triggered until the police withheld new exculpatory evidence from the defense lawyers and, therefore, responsibility for payment had to be assigned to the insurer providing excess liability coverage at the later date.

Like a number of these false imprisonment cases, this one includes allegations that the police failed to follow up on information that may have exculpated the plaintiff and even may have falsified witness statements to implicate the plaintiff over some other more culpable suspect.

The issue in this case for coverage purposes, however, was when exactly did coverage for the judgment arise. Here, the City of Barberton switched primary insurance carriers on June 29, 1998 from National Casualty Company (NCC) to CNA, and switched excess carriers from RLI Insurance Company to Selective Insurance Company. Both primary carriers had a duty to defend the City and individual officers in the event of a lawsuit and were responsible for covering up to $1 million in damages. Both excess carriers were responsible for liability beyond the initial $1 million in damages—up to the policy limits—with no duty to defend.

Six months later, Barberton detectives again failed to follow up on information that may have exculpated the plaintiff. On January 5, 1999, a Barberton police officer arrested a man named Earl Mann for two aggravated robberies. During his arrest, Mann reportedly asked the arresting officer: “Why aren't you charging me with the Judy Johnson murder too?” Mann also reportedly disclosed to the officer that he had been living with his common-law wife since being released from prison the previous June, in a house that happened to be next door to the victims’ former residence. Following his training, the officer prepared an inter-departmental memorandum containing this information (the “Mann memorandum”) and put this memorandum in a bin intended for documents to be shared with the detective bureau. However, the plaintiff’s criminal defense attorneys

were never given the memorandum. The chief of Barberton's detective bureau—who should have been the one to collect the memorandum from this bin—was terminally ill and later died during the course of the underlying lawsuit without being deposed.

Four months later, the plaintiff was tried by jury and he was convicted on all charges in June 1999. He was sentenced to life with no eligibility for parole until 2054.

After his conviction, the evidence against him began to erode. In 2002, a child witness in the case recanted her testimony, saying that she had been swayed by the adults around her and that she no longer believed plaintiff was the perpetrator. The same year, plaintiff learned in a news report that Earl Mann—the man whose incriminating statements had not been disclosed to Plaintiff's lawyers—had lived next to Johnson at the time of the murder and had been convicted of molesting three young children in separate cases. Plaintiff, 615 F.3d at 674 n.4. By chance, Plaintiff was incarcerated in the same prison as Mann. Plaintiff managed to get one of Mann's cigarette butts, smuggle it out of prison, and have it tested for Mann's DNA. The test confirmed that Mann's DNA matched the DNA found on Johnson's body. On the basis of this DNA evidence, Plaintiff was exonerated and released in 2005.

In 2006, Plaintiff and his family brought suit in federal court against the City of Barberton and several individual police detectives and officers for malicious prosecution and deprivation of due process under 42 U.S.C. § 1983. Plaintiff focused on alleged misconduct at the beginning of his arrest and indictment, such as the falsification of one witness's account, the discrediting of an alibi witness account, and the failure to follow up on the DNA evidence. During discovery, however, Plaintiff learned for the first time that detectives had failed to turn over the exculpatory Mann memorandum to him.

This Mann memorandum turned out to be crucial for Plaintiff's case. The district court denied immunity for the individual defendants with respect to Plaintiff's 42 U.S.C. § 1983 deprivation-of-due-process claim and the Ohio malicious-prosecution claim. The court reasoned that withholding the exculpatory Mann memorandum violated Plaintiff's clearly established constitutional rights under *Brady v. Maryland* which was enough for the § 1983 claim to continue. The court further reasoned that, even if the police did have probable cause to arrest and indict Plaintiff based on the child witness's initial identification, the probable cause had "evaporated" upon discovery of the Mann evidence, such that the malicious prosecution claim could survive as well.

In November 2010, Plaintiff, the Barberton defendants, and the three participating insurers settled at mediation for $5.25 million. Responsibility for the settlement was split among the three participating insurers: The pre-June-29-1998 primary insurer NCC paid $1 million, its policy limit; the post-June-29-1998 primary insurer CNA also paid $1 million, its policy limit, and Selective paid $3.25 million in excess coverage. Selective was also assigned all of the rights the Barberton defendants enjoyed vis-à -vis RLI, enabling Selective to sue RLI under the City of Barberton's insurance policy. The settlement agreement made clear that it extinguished all of Plaintiff's claims against the

defendants and their insurers, but did not link the $5.25 million payment to either the § 1983 deprivation-of-due-process claim or the Ohio malicious prosecution claim.

In July 2012, Selective brought the coverage action against RLI, seeking declaratory judgment and monetary relief for the $3.25 million in excess coverage that Selective paid under the settlement agreement with Plaintiff. Both parties moved for summary judgment. RLI argued that it was not responsible for either Plaintiff's § 1983 deprivation-of-due-process claim or his Ohio malicious-prosecution claim because the basis for both claims was the withholding of the Mann memorandum—an alleged Brady violation strong enough to overcome qualified immunity—which occurred in January 1999, six months after the RLI policy period ended. RLI based this reasoning on the language of its policy with the City of Barberton which stated that it was only responsible for "all sums which the insured becomes legally obligated to pay ... because of ... [p]ersonal injury ... caused by an occurrence which takes place during the policy period." "Personal injury" was clearly defined to include "malicious prosecution," and "occurrence" was defined as: "... an act or series of acts of the same or similar nature committed during this policy period. Such act or series of acts must constitute an offense included in the definition of the term personal injury in this policy. All loss arising out of such act or series of acts, regardless of the frequency thereof or the number of claimants, shall be deemed to arise out of one offense ...."

In other words, RLI argued that it was responsible only for an "act or series of acts" that together "constitute an offense" -- such as malicious prosecution -- that was "committed during th[e] policy period." Therefore, because the alleged Brady violation that was the basis of Plaintiff's claims occurred outside of the RLI policy period, RLI concluded that it could not be responsible for any of the liability arising out of Plaintiff's suit against the Barberton defendants.

The district court, however, disagreed with RLI, reasoning that "[a]s the Court sees it, for the purposes of the present dispute, RLI assigns undue significance to the alleged Brady violation." According to the district court, although the January 1999 Brady violation was enough on its own for Plaintiff's malicious prosecution claim, there was also evidence of wrongdoing by the Barberton defendants that occurred during RLI's policy period, such as the dismissal of alibi witnesses and the DNA mismatch. Therefore, Plaintiff may have had a viable malicious prosecution claim even before the alleged Brady violation, including during the RLI policy period. The district court then relied on what it called the "majority rule" from other circuits that had addressed insurance liability for malicious prosecution claims, and which held that coverage for malicious prosecution is triggered at the time that the underlying criminal charges are filed. Accordingly, the district court held that RLI's policy was triggered when Plaintiff was first arrested, making RLI liable for the entire amount in excess coverage that Selective had paid out.

RLI appealed and the Sixth Circuit ruled that because the Barberton defendants had probable cause until the alleged Brady violation, such that the malicious prosecution and the deprivation of due process could only have occurred in January 1999, after the end of the RLI policy period, then the existence of probable cause was a question for a fact-

finder. However, in this case, it was clear that probable cause existed, as a matter of law, all the way until the alleged Brady violation because, under Ohio law, "a finding of guilty of a criminal offense ... even though later and finally reversed by a reviewing court, raises a conclusive presumption of probable cause and constitutes a complete defense in a later action for malicious prosecution." Thus, a Brady violation such as the one alleged here constituted such "fraud or unlawful means," and this is what allowed Plaintiff to overcome qualified immunity in the underlying suit. However, all of the other alleged problems with the case against Plaintiff—the unreliability of a six-year-old's identification, the discrediting of alibi witness testimony, the DNA mismatch—were available to Plaintiff for his criminal defense, such that they could not have constituted the "fraud or unlawful means in securing a conviction" necessary to rebut probable cause at any time prior to the alleged Brady violation.

Since neither party contested that this act occurred in January 1999, six months after the end of the RLI policy period on June 29, 1998, then under the plain language of its policy, RLI was not responsible for the Barberton defendants' liability to Plaintiff.

The Sixth Circuit therefore reversed the judgment of the district court and remanded the case.

6. Surface Water or Covered Cause of Loss?

(Oak Hill Investment IV, LLC, v. State Farm Fire and Casualty Company, 2017 WL 4286779, N.D. Ohio W. Div. Sept. 29, 2017).

Plaintiff Oak Hill Investment IV LLC owned a two-story office building located in Toledo, Ohio. Defendant State Farm Fire and Casualty Company insured the building and business personal property under the Businessowners Coverage Form

A severe rainstorm combined with a clogged scupper drain on the roof and caused water to rise and eventually enter an open air conditioning unit. The water flowed through the HVAC ductwork and damaged the interior of the building. After the storm, State Farm inspected the property twice and both times found the damage to the interior of the building was not covered under the Policy. State Farm paid for some of the personal property claims under an Inland Marine Endorsement. Not satisfied, Oak Hill filed suit for declaratory judgment, breach of contract, and bad faith, requesting punitive damages.

The Policy stated as follows regarding coverage for the interior of the building:

1. We will not pay for loss to:

e. The interior of any building or structure, or the property inside any building or structure, caused by rain, snow, sleet, ice, sand or dust, whether driven by wind or not, unless:

> *(1) The building or structure first sustains damage by a Covered Cause Of Loss to its roof, outside walls, or outside building glass through which the rain, snow, sleet, ice, sand or dust enters; or*
>
> *(2) The loss is caused by thawing of snow, sleet or ice on the building or structure.*

The court found the language unambiguous and held that damage to the interior of the building would only be covered if the roof is damaged by a Covered Cause of Loss and then rainwater comes through the area of the roof that is damaged. Because the water that caused the damage to the interior of the building entered through an air conditioning unit on the roof and the unit through which it entered was not damaged (rather, instead, it was the scupper drain, clogged with debris, which caused the water to rise on the roof and enter the unit), then the water did not enter the interior of the building through the damaged drain but instead the undamaged air conditioning unit and this was not a Covered Cause of Loss but rather surface water which was excluded.

The court further found, however, that the "Overflow or Back-Up Exclusion" in the policy, which excluded coverage for losses caused by water that backs up or overflows from drains, was ambiguous under these facts because, although the water did accumulate on the roof because the drain was clogged, it did not necessarily back up or overflow from the drain. The water did not overwhelm the drain and there was no damage to the pipes stemming from it. Instead, the drain was completely sealed. Therefore this was not a basis to deny coverage, although coverage was still barred due to the surface water exclusion.

7. Failure to Cooperate with Insurer Means No Coverage

(Bolton v. State Farm Fire & Casualty Co., 2017 WL 5132732, N.D. Ohio W. Div Nov. 6, 2017)

In this case, Plaintiffs Earnest and Georgia Bolton filed a complaint against State Farm Fire & Casualty Company in the Lucas County Court of Common Pleas asserting claims for breach of contract, bad faith, and unfair trade practices. State Farm removed the case to federal Court.

This case was a residential fire case and the issue was arson and the failure by the insureds to cooperate with State Farm's investigation, including an Examination Under Oath ("EUO").

State Farm wrote a letter to the insureds' attorney, stating that, "Your clients' [sic] have failed to comply with State Farm's requests for records, documents and information, in failing to provide the following: the cellular telephone call detail for the Bolton's' [sic] cellular telephone "Family Plan" for the dates of December 31, 2014; January 1, 2015;

and January 2, 2015; their 2013 and 2014 federal, state, and local income tax returns; the bank records for the two (2) accounts that the insured's have at the Jeep Federal Credit Union; the account at the Huntington National Bank; the financial records for the Bolton Adult Family Home; the call detail for their home phone; and the failure to provide the contact information for Earnest Bolton Jr.'s girlfriend, “Janai”.

As you were previously advised, this information, along with your clients' examinations under oath are material to State Farm's evaluation of your clients' claim of loss. As a result of your clients' failure to produce the records, documents, and information as set forth above, State Farm cannot fully investigate your claim of loss and make a coverage decision regarding your clients' loss.”

The court found that it was undisputed that State Farm’s investigation caused it to determine the fire was caused by arson, and State Farm engaged in a reasonable investigation of Plaintiffs' alibis and finances in order to determine whether they had a motive or opportunity to start the fire. Because Plaintiffs did not dispute they failed to produce: 1) call detail records for landline telephones; 2) a Capital One credit card statement for the month in which the fire occurred; 3) complete bank account records for all accounts; and 4) complete financial records for the Bolton Adult Family Home, the court found that the failure to provide these documents was a material and substantial breach of the cooperation clause which “resulted in substantial and material prejudice to” State Farm and summary judgment was appropriate in State Farm’s favor against Plaintiffs’ coverage claims.

8. Determining Where the “Occurrence” Lies

Scott Fetzer Co. v. Zurich American Ins. Co., 2017 WL 7048824, N.D. Ohio E. Div. Nov. 16, 2017)

This case concerned whether an underlying suit for sexual harassment and assault constituted three occurrences under the insurance policy language.

The magistrate recommended that Zurich American Insurance Company’s motion for summary judgment be granted and that the Scott Fetzer Company’s motion for partial summary judgment be denied.

This was a failure-to-supervise-an-employee case who was a convicted sex offender and who harassed and assaulted three of his female co-workers on numerous sales trips to sell vacuum cleaners door-to-door for Fetzer’s Kirby vacuum subsidiary. Fetzer settled a Missouri state court lawsuit filed by the three victims and made an insurance claim with Zurich, which agreed there was coverage, but the issue was the proper allocation of loss among the various carriers and whether the claims represented one or multiple “occurrences” under the insurance policy definitions.

Fetzer argued that there was only one “occurrence” -- the purported negligence of Scott Fetzer in connection with the hiring, retention, and supervision of Fields” -- and therefore only one deductible.

Zurich argued that the Missouri lawsuit involved multiple “occurrences” because the claims involved different persons, locations, situations, and even different policy years. Thus, Fetzer should have paid multiple deductibles.

The parties stipulated that Ohio law governed and, as seen in the prior *Big Lots* case summary, Ohio applies a ‘cause test’ when determining the number of occurrences under an insurance policy.

The Magistrate found that Fetzer had multiple warnings and knew or should have known of Fields' criminal history. These facts indicated that negligence of Fetzer with respect to each of the three Missouri plaintiffs constituted a separate occurrence under the Policies.

Further, the Magistrate found Zurich’s citation of several sexual misconduct cases from non-Sixth Circuit jurisdictions persuasive that involved multiple victims. In those cases, the courts generally found that there was a separate occurrence for each victim who was sexually assaulted or molested. The Magistrate therefore recommended that Fetzer’s motion for partial summary judgment be denied and that Zurich’s motion for summary judgment be granted.