

Show Me the Money: Finding Insurance Coverage Where None Exists

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Introduction

If nothing else, I hope the reader comes away from this presentation remembering one resounding piece of advice: **“Read the Policy.”** Most of us would rather read a case **interpreting** a policy than read a policy. We don’t like picking through the endless unintelligible pages of cryptic policy language and endless endorsements which give with one hand and then take away with another (and sometimes give back again). **But you have to read the policy.** There is no substitute. **You** - not your law clerk, not your paralegal - **you.** The difference in the turn of a phrase or the use of the words “an insured” as opposed to “the insured” may make the difference between coverage and lack thereof.

Read the policy.

Yes, **all** of it.

This paper will attempt to discuss the most common sources of coverage in personal injury cases, the most commonly used coverage defenses, and discuss some often overlooked ideas on finding coverage.

Pleading

Even before you file suit, you have to consider potential policy exclusions so that you can plead correctly so as to not plead yourself **out** of coverage. For example, let’s look at *Saluto v. Gonzales*, 646 So.2d 1225, 94-562 (La.App. 5 Cir. 11/29/94) in which the court discussed whether the policy provided coverage for “defamation,” which it found to be an intentional tort, as opposed to “negligent infliction of emotional distress,” which is not.

Saluto filed suit against defendants alleging that they defamed him, by, among other things, accusing him of being a heroin dealer. He alleged these alleged these insults were intended to damage his reputation and that he has suffered financial losses as a result.

Section II of the policy excluded:

a. bodily injury or property damage:

(1) which is either expected or intended by an insured; or

(2) to any person or property which is the result of willful and malicious acts of an insured.

Appellants argued that defamation can be accomplished by negligent acts which would then be covered by the policy. They relied on *Williamson v. Historic Hurstville Ass’n*, 556 So.2d 103 (La.App. 4th Cir.1990). In *Williamson* the fourth circuit concluded that a homeowner’s policy excluding intentional acts did not preclude defamation since defamation can be accomplished by negligent acts:

The policy in question provides coverage for negligent acts (i.e., "accidental loss"), and only excluded "intentional or criminal acts." Since defamation can be accomplished by negligent acts, the policy's exclusionary clause does not preclude Ms. Burkhardt's coverage for the acts alleged in plaintiff's petition.

Finally, Ms. Burkhardt alleges that through her actions, she did not intend to harm the plaintiff, but merely to protect her residential neighborhood. Thus she argues that although the acts complained of may have been intentional, the harm, if any, was not. Hence she concludes the policy's exclusionary provision does not apply to the facts of her case, as alleged by the petition.

The court in *Saluto* decided that this policy excluded coverage, but it admitted that there are opposite views taken both by the fifth circuit and by its own circuit.

Had Saluto alleged negligent conduct, he may well have been able to prove the same damages and not been subject to the exclusion, but his facts were considerably more egregious than those in *Williamson*.

Some degree of guidance regarding pleading and policy interpretation (and a great lesson in perseverance) can be gleaned from the case of *Ledbetter v. Concord General Corp.*, (please see me for the full cite) 665 So.2d 1166, (La. 1996) 95-0809 La. 1/6/96, which, after traveling to the Louisiana Supreme Court numerous times, was finally decided.

In *Ledbetter*, a motel patron who was raped and kidnapped after another patron gained unauthorized access to her room brought action against motel owners and their commercial general liability (CGL) insurer. Plaintiff checked into a motel with her six year old granddaughter. They went to bed about midnight, each sleeping in separate beds. Ms. Ledbetter was awakened when she felt a deep smothering sensation and discovered a man holding his hand over her mouth, instructing her to "do as I say or I'll hurt your daughter." The man was holding a tire tool in his hand, and indicated he had a knife and gun in his boot. After a struggle, the man raped Ms. Ledbetter. He then kidnapped Ms. Ledbetter by ordering her into her car. As they drove out of the motel parking lot, Ms. Ledbetter managed to jump out of the moving car.

During their investigation, the officers found no sign of forced entry into the room but found that once the door was unlocked and cracked open slightly, the chain lock, which was improperly installed by the motel, could be easily lifted out of its slot and opened.

The court found that Coverage A of the motel's policy excluded bodily injury arising out of "Wrongful entry into, or eviction of a person from a room, dwelling or premises that the person occupies" and also included an assault and battery exclusion is set out in an endorsement to the policy that stated "Notwithstanding anything contained herein to the contrary, it is understood and agreed that this policy excludes claims arising out of Assault and Battery, whether caused by or at the instigation of, the insured, his employees, patrons, or any causes whatsoever."

The court held that "Based on this reasoning, we conclude that the assault and battery exclusion in Classic's policy is unambiguous as applied to rape. A clear and unambiguous provision in the insurance contract limiting liability must be given effect. However, turning to the kidnapping, we believe a different result must be reached. In contrast to rape, which necessarily involves a battery, a kidnapping does not necessarily involve the intentional use of force and/or violence upon the person of another. Based on this reasoning, we find that the exclusion is ambiguous as applied to Ms. Ledbetter's damages arising from the kidnapping. Exclusionary provisions in insurance contracts are strictly construed against the insurer, and any ambiguity is construed in favor of the insured. Therefore, we conclude that Classic's assault and battery exclusion does not exclude coverage for Ms. Ledbetter's damages resulting solely from the kidnapping."

Read the Policy

Automobile Cases

Is an Employee Covered by the Umbrella Policy of his Employer?

What if there's insurance, but not enough? Was the client in the course and scope of his employment? Was he using a vehicle provided by his employer? Was the defendant? Perhaps the employer's umbrella policy may provide coverage.

In *Southern American Ins. Co. v. Dobson*, cite 441 So.2d 1185 (La. 1983) the Louisiana Supreme Court decided that R.S. 22:1406(D)(1)(a), mandating UM coverage in all automobile policies, applied to commercial umbrella policies:

The plain language of R.S. 22:1406(D)(1)(a) makes it applicable to "automobile liability insurance covering liability arising out of the ownership, maintenance, or use of any motor vehicle." These policies unquestionably apply to liability "arising out of the ownership, maintenance, or use of a motor vehicle." . . .The directive of the statute, being mandatory, must be read into the terms of such a policy, absent a written waiver by the insured. There is no such written waiver in this case. Therefore, the provisions of the statute apply.

Course and Scope

Let's look at how the myriad auto policies stack up when an employee is driving a car in the course and scope of his employment. Let's say your law firm requires you to drive to Sandestin to give a speech to the LSBA. These facts are similar to those in *Dean v. State Farm Mut. Auto. Ins. Co.*, 518 So.2d 1115 (La.App. 4 Cir. 1987):

Plaintiff was injured in a one-car accident. She was a guest passenger in a car

owned by Michael Bemis and being driven by Gary Merrigner. Mrs. Bemis, wife of Michael Bemis, had asked Mr. Merrigner to drive the car.

At oral argument the parties stipulated that at the time of the accident Mr. Merrigner, an associate at the law firm of Jones Walker Waechter Poitevant Carrere & Denegre, was in the course and scope of his employment with the firm. Plaintiff was Mr. Merrigner's secretary, but was not within the course and scope of her employment at the time of the accident. Mr. Bemis is a partner with Deloitte, Haskins and Sells.

A chart showing the parties and their coverage follows:

The coverage liability of the following five insurance policies is at issue: (1) a personal auto policy issued by State Farm to Michael Bemis providing a coverage liability limit of \$100,000.00 per person on his 1981 Cadillac Seville; (2) a personal catastrophe liability policy issued by American Manufacturers Mutual Insurance Company to Deloitte, Haskins & Sells providing an excess coverage liability limit of \$1,000,000.00; (3) a personal auto policy issued by State Farm to Gary Merrigner providing a coverage liability limit of \$250,000.00 per person on his 1977 Buick Regal; (4) a business auto policy issued by Liberty Mutual to Jones Walker et al providing a coverage liability limit of \$1,000,000.00; and (5) an umbrella excess liability policy issued by Liberty Mutual to Jones Walker et al providing an excess coverage liability limit of \$2,000,000.00.

All parties agree that the personal auto policy issued by State Farm to Michael Bemis provides primary coverage and pays its limit of \$100,000.00. The parties' positions are widely divergent as to the coverage liability of the other four policies for the remaining \$675,000.00.

...

Because he was acting within the course and scope of his employment at the time of the accident, his employer, Jones Walker et al, is vicariously liable for the damages he caused.

...

The personal auto policy issued by State Farm to Gary Merrigner and the business auto policy issued by Liberty Mutual to Jones Walker et al have nearly identical other insurance, excess clauses. With respect to non-owned autos both become excess to "other collectible insurance," which in this case is provided by the personal auto policy issued by State Farm to Michael Bemis. When considered together the respective excess clauses are mutually repugnant and reciprocally ineffective; each, in the absence of the other, however, would provide coverage in excess to the State Farm policy issued to Michael Bemis. We find, therefore, that both policies apply to provide this first level of excess coverage.

The combined limits of both policies is \$1,250,000.00. We must determine how these two policies will share liability for the remaining \$675,000.00 in damages to the plaintiff.

When there is primary coverage plus multiple excess policies, an unresolved issue remains as to how the responsibility should be apportioned among the excess carriers.

...

The other insurance clauses of both policies contain pro rata provisions. The State Farm policy clause is the standard Family Automobile Policy clause referred to in the treatise passage quoted above. The Liberty Mutual business auto policy provides the clarifying language called for in the treatise. It provides,

When two or more policies cover on the same basis, either excess or primary, we will pay only our share. Our share is the proportion that the limit of our policy bears to the total of the limits of all the policies covering on the same basis.

We find, therefore, that the remaining \$675,000.00 in damages to the plaintiff shall be shared by the two policies on a basis proportional to their respective

limits. That proportional basis is 4 to 1 (1,000,000 to 250,000), or 80% for Liberty Mutual whose policy has a limit of \$1,000,000.00 and 20% for State Farm whose policy has a limit of \$250,000.00.

Accordingly, of the \$775,000.00 in damages to the plaintiff, the first \$100,000.00 is paid under the personal auto policy issued by State Farm to Michael Bemis; of the remaining \$675,000.00, the business auto policy issued by Liberty Mutual to Jones Walker et al pays 80% or \$540,000.00 and the personal auto policy issued by State Farm to Gary Merrigner pays 20% or \$135,000.00.

To effect the settlement with plaintiff the three defendant insurance companies respectively contributed to the settlement fund as follows: State Farm, \$350,000.00; AMMICO, \$340,000.00; Liberty Mutual, \$85,000.00. Since we have determined that State Farm's liability totals \$235,000.00 (\$100,000 under the Bemis policy + \$135,000 under the Marrigner policy), it is entitled to a refund of \$115,000.00 (350,000 - 235,000). Similarly AMMICO, which we have determined bears no responsibility in this case, is entitled to have refunded its entire contribution of \$340,000.00. These two refunds (totaling \$455,000.00) are owed by Liberty Mutual which contributed only \$85,000.00 toward its total responsibility of \$540,000.00. (540,000 - 85,000 = 455,000).

So the moral of this story is that when your firm sends you to Sandestin to speak at the bar convention, drive one of your partner's well-insured cars. You'll get the coverage on the car, your coverage, and the umbrella policies of your partner, yourself, and your firm.

Uninsured Motorists Coverage

When it appears the tortfeasor does not have any insurance or inadequate insurance to cover your client's damages, demand may be made upon your client's UM carrier. The very first issue to be confronted regarding UM coverage is whether or not they either rejected or selected lower UM coverage. In light of the strong public policy to have UM coverage available to innocent motorists, the UM statute specifically provides that any rejection or limits reduction by an insured must be reduced to writing.

The legion cases on the rejection issue have placed further gloss on the statutory

requirements. The Louisiana Supreme Court has held that La. R.S. 22:1406(D) is to be liberally construed, such that the statutory exceptions to the coverage requirement are strictly construed. Moreover, the state's high court has opined that the insurer bears the burden of proving the insured rejected, or selected lower limits, UM coverage. Finally, the Court has required that the insurer's rejection form must provide the insured with "meaningful selection" options. In *Tugwell v. State Farm Ins. Co.* 609 So.2d 195 (La. 1992) the court explained that a form with "meaningful selection" options is one that specifically gives the insured the opportunity to select 1) UM coverage equal to the bodily injury limits in the policy, 2) UM coverage lower than bodily injury limits in the policy or 3) no UM coverage. There need not be the option of selecting lower limits in the instance of a \$10,000.00/\$20,000.00 policy. *Daigle v. Authement*, 96-1662 (La. 4/8/97).

Little known to most of us is the fact that, under the express language of the uninsured motorists coverage, the plaintiff **need not even be required to be in a car** to have the coverage apply. All that is necessary is that the defendant be uninsured or underinsured. A plaintiff who is a pedestrian, or even an insured lying in bed who was struck by a wayward vehicle careening into his house can be covered by the language of his own uninsured motorists policy.

Read the Policy

Stacking

_____ La. R.S. 32:900(B)(2) mandates that all automobile liability policies written and delivered in Louisiana "shall insure the person named therein and any other person, as insured, using any such motor vehicle(s) with the express or implied permission of such named insured." Such mandatory coverage is known as "omnibus" coverage. Because of omnibus coverage, the

driver of a vehicle may be insured under more than one insurance policy. Questions then arise regarding which applicable policy is “primary” and which is “secondary.” Consideration of the foregoing is perhaps best accomplished through the use of an example, which ensues.

“A” is an insured under a policy which provides coverage for him when he operates **either** the vehicle described in the policy or a non-owned vehicle with the permission of the owner of the vehicle. The policy also contains a provision which states that coverage in the latter situation is in excess over any other valid insurance. “B” has the same coverage under his policy.

“A” is in an accident while permissively operating the vehicle described in “B’s” policy. The question then becomes which policy is “primary.” While the answer is dependent upon the specific language of the policies involved, the fact is that in most cases both policies will be primary and liability will be apportioned according to the prorated amount of insurance provided by the respective policies. The underlying rationale for determining both policies to be primary is that both policies contain so-called “other insurance” provisions which become “mutually repugnant” and cancel each other out.

Actual stacking of coverages occurs where there is a true “excess” policy which provides that its coverage is only triggered when underlying insurance coverage is exhausted. The typical example is an umbrella policy. Most issues relating to stacking of multiple policies are going to be resolved by policy language which determines, *e.g.*, whether an excess policy will “drop down” to provide primary coverage when the underlying insurer becomes insolvent. (See “drop down” discussion, *infra*.)

UM policy stacking was once a contentious issue that is now regulated by statute. La. R.S. 22:1406(D)(1)(c) now provides that when an occupant is injured in a vehicle not owned by him, a resident spouse or a resident relative, he may recover first from the UM carrier for the

vehicle in which he was an occupant. If that policy is exhausted, then the injured occupant may recover from one other UM policy which would provide coverage to him. Obviously the owner of the vehicle is limited to recovery from his own UM carrier.

Exclusions

What if the tortfeasor has been specifically excluded from coverage?

In *Bellard v. Johnson*, 692 So.2d 630, 96-961 La.App. 3 Cir. 3/12/97, plaintiff was struck by a car registered in the name of Rhonda K. Johnson and driven by her husband, Michael Johnson. Patterson Insurance Company issued a policy covering the car. A named driver exclusion agreement form, excluding Michael Johnson, was signed and attached as part of the policy.

The trial court denied the motion for summary judgment of appellants and granted a motion for summary judgment in favor of defendant, Patterson Insurance Company, dismissing it from the case.

The sole issue on appeal was whether the mandatory omnibus coverage provision of the Louisiana Compulsory Motor Vehicle Liability Security Law (LCMVLSL), La.R.S. 32:861, et seq., supersedes a liability insurance policy endorsement which excludes coverage for a named driver after La.R.S. 32:900(L) was added by Acts 1992, No. 979, § 1.

The court held:

R.S. 32:861 requires that every motor vehicle, except as excluded by statute, registered in Louisiana shall be covered by a liability policy as defined by LSA-R.S. 32:900 or by a liability bond or by a certificate of self-insurance.

La.R.S. 32:900(B)(2), frequently referred to as the omnibus clause, provides the following:

(B) Such owner's policy of liability insurance:

(2) Shall insure the person named therein and any other person, as insured, using any such motor vehicle or motor vehicles with the express or implied permission of such named insured against loss from the liability imposed by law for damages arising out of the ownership, maintenance, or use of such motor vehicle or motor vehicles within the United States of America or the Dominion of Canada, subject to limits exclusive of interest and costs with respect to each such motor vehicle as follows:

...

(d) An owner may exclude a named person as an insured under a commercial policy if the owner obtains and maintains in force another policy of motor vehicle insurance which provides coverage for the person so excluded which is equal to that coverage provided in the policy for which the person was excluded. The alternative coverage is required for both primary and excess insurance.

...

A reading of this statute readily shows that it is susceptible to two distinct interpretations. The concepts of "named insured" and "omnibus insured" are well established and deeply engraved in our law. La.R.S. 32:900 refers in one instance to "any named person" and in another to the "named insured" but in no instance does it refer to the concept of "omnibus insured." The statute as written can be read as an authorization to exclude both "named" and "omnibus" coverage but it can also be read just as easily to authorize exclusion of only coverage as a "named insured."

When a statute is open to more than one interpretation, it is our job to give it that which "best conforms to the purpose of the law" and in keeping with the legislative history and intent. La.Civ.Code art. 10. We are also mindful that laws on the same subject must be interpreted in reference to each other. La.Civ.Code art. 13. If we were to adopt the reasoning of the fourth circuit, we would do so only at the cost of abandoning the very strong legislative policy of protecting all persons from the danger and injustice of being injured by an insolvent or uninsured motorist who cannot respond in damages for his own carelessness and tortious conduct. A far more reasonable interpretation would honor the long-recognized legislative policy:

. . . In view of the long-standing legislative policy contained in La.R.S. 32:861, et seq., it is our view that the legislature's authorization of La.R.S. 32:900(L) extends only to the exclusion of a household member for "named insured" status and not for omnibus coverage. This interpretation "conforms to the purpose of the law" by continuing to protect the public from uninsured motorists and also gives support to La.R.S. 32:900(L) by allowing the parties to exclude "named insured" coverage.

The Louisiana Supreme Court made short shrift of that decision in *Bellard v. Johnson*, (La. 1997) 1997 WL 294553 wherein, deciding the case on a writ grant, it stated:

Granted. La.R.S. 32:900 L clearly permits the purchaser of a policy to exclude from coverage a resident of his household. The decision of the court of appeal is reversed. The judgment of the trial court granting summary judgment in favor of Patterson Insurance Company and dismissing plaintiffs' claims against it is reinstated.

Errors and Omissions Cases

So what if the tortfeasor has no coverage? Was he **supposed** to have coverage? Did he **think** he had coverage? Did he **pay** for coverage? Did his insurance agent **promise** him coverage? Well, one often overlooked source of coverage is the errors and omissions policy of the person who was supposed to be properly advising the insured as to what insurance to purchase. Let's look at some "E&O" cases.

In *Rushing v. Frazier* 477 So.2d 1317 (La.App. 3 Cir. 1985) plaintiff sued her insurer alleging that her husband had never knowingly and voluntarily waived their right to uninsured motorist coverage. Thereafter, plaintiff named her insurance agent as a party defendant alleging negligent failure to adequately explain concept of uninsured motorist coverage. In her

opposition to the motion for summary judgment, plaintiff has filed the affidavit of Donald Rushing to the effect that when the agent's secretary asked of Donald Rushing, "Do you want uninsured motorist coverage?", that Donald Rushing asked, "What exactly is it?", wherein the secretary replied that it was to cover the other person if they don't have insurance. Donald Rushing then said that if it just covered the other person that he didn't want it. Accordingly, the secretary entered on the application form that Donald Rushing had waived uninsured motorist coverage. Based on this discourse, plaintiff alleges that they were confused and in doubt as to the UM coverage and therefore were unable to make a knowing and intelligent decision as to whether or not they would opt in favor of such coverage. Defendant contends that under the appropriate statute, R.S. 22:1406(D), the insurer only has the obligation to offer UM coverage.

The court held:

. . . The first issue is whether or not an insurer owes any fiduciary duty to the insured; or is the relationship between the insurer and the insured that of a seller and buyer with no fiduciary duty on the part of the insurer toward the insured. That question was answered in the case of *Legendre v. Rodrigue*, 358 So.2d 665 (La.App. 1 Cir.1978), writ denied, 359 So.2d 1293 (La.1978), wherein the court squarely held that the relationship between an insurer and insured is that of seller and buyer, which does not create any fiduciary duty upon the insurer flowing to the insured.

In *Rushing v. Frazier*, 483 So.2d 1011(La. 1986) the Louisiana Supreme Court made

short shrift of that argument, when, deciding the case on a writ grant, it stated as follows:

Judgment of Court of Appeal . . . affirming the district court's granting of summary judgment is reversed; summary judgment is denied. Judgment of Court of Appeal, in . . . reversing the district court's denial of summary judgment is reversed; judgment of district court is reinstated. Case is remanded to the district court for further proceedings.

Is the insurance company liable if an agent fails to procure coverage?

In *Chandler v. Jones*, 532 So.2d 402, (La.App. 3 Cir. 1988), Chandler was injured when

his automobile was rear-ended by a Statewide automobile operated by Jones. State Farm was Statewide's primary automobile liability insurer which provided \$250,000 single limit coverage.

Billeaudeau was a salaried insurance agent for Wausau. He received an inquiry from Statewide concerning the procurement of excess liability insurance. Billeaudeau prepared an application for Statewide's excess coverage with Wausau indicating therein that Statewide had underlying primary fleet motor vehicle liability insurance with State Farm with \$500,000 single limit coverage. Wausau's \$1,000,000 excess coverage was contracted to commence once Statewide's liability exceeded the \$500,000 single limit coverage. When Billeaudeau executed this application he knew that Statewide's single limit coverage with State Farm was only \$250,000. Despite this knowledge, Billeaudeau issued Statewide a binder and though he brought Statewide's attention to the gap in coverage between \$250,000 and \$500,000 single limit coverage, he never again inquired from Statewide or its office personnel whether State Farm's policy limits on single limit coverage had been increased to eliminate this gap.

Jones, Statewide's employee, rear-ended Chandler, causing him damages later determined by the jury to be \$369,962.93, and exposing Statewide to \$119,960.93 damages in excess of its primary liability coverage with State Farm, but less than the \$500,000 threshold of coverage provided by Wausau.

The court held:

It is well established that an insurance agent or broker who undertakes to procure insurance for a client owes an obligation to use reasonable diligence in attempting to place or obtain the requested insurance and has a duty to notify the client promptly if it has failed to obtain the requested insurance. The client may recover from the broker or agent the loss sustained as a result of the failure to procure the desired coverage if the actions of the broker or agent warranted an assumption by the client that he was properly insured in the amount of the desired coverage. *Karam v. St. Paul Fire & Marine Insurance Company*, 281 So.2d 728 (La.1973).

In *Beam v. Intercontinental Life Ins. Co.*, 447 So.2d 12, at 14 (La.App. 2nd Cir.1984), the court held that in order for a client to recover from an insurance agent for not obtaining the requested insurance coverage, the client must prove: "(1) an undertaking or agreement by the insurance agent to procure insurance; (2) failure of the agent to use reasonable diligence in attempting to place the insurance and failure to notify the client promptly if he has failed to obtain the insurance; and (3) the actions of the agent warranted an assumption by the client that he was properly insured.

...

It is clear to us, after thoroughly reviewing the record, that Billeaudeau was negligent. He knew Statewide had a problem with its underlying insurance coverage, knowingly issued an insurance policy which did not dovetail excess coverage with the primary policy, did not advise Statewide that the lower limits of the Wausau policy could be reduced to lessen or eliminate the gap, and took no steps thereafter to inquire if the problem had been remedied. Certainly, Billeaudeau's delivery of the actual policy to Statewide reasonably impressed Statewide that it was now fully insured as requested. Billeaudeau was the insurance professional on whom Statewide relied and he can not now escape liability by urging that he delegated his duty to remedy this gap to Statewide and its employees to complete the work he was responsible for completing.

Is the agent liable if the insurer he placed the insured with becomes insolvent?

In *Barron v. Scaife*, 535 So.2d 830 (La.App. 2 Cir. 1988) the agent's E&O policy had the following endorsement:

INSURER SOLVENCY ENDORSEMENT

In consideration of the premium charged, it is understood and agreed that this policy shall not apply to claims made against the insured arising from or related to:

- A) The inability of any insurer to pay claims or to return premiums
- B) The insolvency, receivership, bankruptcy or liquidation of any insurance company.

The court held:

An insurance policy is a contract between the insured and insurer and as such has the effect of law between the parties. An insurer may limit its liability just as individuals may. A clear and unambiguous provision in an insurance contract which limits liability must be given effect. (Citations omitted)

Further, insurers may, by unambiguous and clearly noticeable provisions, limit liability and impose the obligations they assume by contract absent conflict with a statute or public policy.

In the present case, defendant alleges that the cause of action does not arise from the insolvency of Texas Fire and Casualty but instead is based on allegations of violations of Louisiana law, namely, LSA-R.S. 22:1262 and therefore does not fall within the exclusion set forth in the policy of insurance issued by Mount Hawley.

We disagree. The clear and unambiguous language of the policy specifically excludes claims "arising from" or "related to" the insolvency of any insurance company. The claim that Tri-State intentionally failed to inform its insured of the insolvency of Texas Fire and Casualty by its very wording is related to the insolvency of the insurance company, as without the insolvency of Texas Fire, there would be no claim. We can find no alternative interpretation of the language. Additionally, we cannot find that the specific exclusion violates any statutory law nor does it derogate from public policy. We determine therefore that reasonable minds must inevitably concur that the unambiguous language in the errors and omissions policy excludes the claim of negligence arising from the insolvency of Texas Fire and Casualty.

Read the Policy

Homeowner's Policy Cases

Does being shot by someone in another car qualify as a "use" of a car for the purpose of the "use of a car" exclusion to a homeowners policy?

When there's no other coverage, often the liability portion of the homeowner's policy will afford coverage under certain situations.

In *Edwards v. Horstman*, 687 So.2d 1007, (La. 1997) a passenger who was injured by gunshot fired from another vehicle brought a negligence action against the insured driver and sought recovery from driver's homeowners' insurer and uninsured motorist (UM) carrier.

The court laid out the very interesting facts as follows:

On May 13, 1986, Cynthia Edwards was in the company of numerous other high school students at a park on Cypress Lake in Bossier City, where they had gone to celebrate "Senior Skip Day." Cynthia left the park as a passenger in a top-down Chevrolet convertible; she was seated on top of the back seat. Close to that time, a Toyota truck driven by James Furgason exited the park at a low rate of speed. Furgason and his passenger, Michael Horstman, were not part of the student group at the park. The truck was immediately followed by a Monte Carlo, whose passengers became exasperated at the truck's slow rate of speed and began making obscene gestures and comments to the occupants of the truck as they attempted to pass it on the roadway. The occupants of the Toyota truck responded in kind. In addition, the passenger in the truck, Michael Horstman, pulled out a shotgun and brandished it at the occupants of the Monte Carlo. The Monte Carlo accelerated, passed the truck, caught up with, and pulled alongside the convertible driven by Shane DeMoss. The Monte Carlo's occupants informed their fellow students in the convertible that the occupants of the Toyota truck behind them in the roadway had a gun. The Monte Carlo then accelerated to get away from the truck. The truck eventually passed the DeMoss vehicle as it chased the Monte Carlo.

Shane DeMoss admitted in testimony that as he proceeded down the roadway behind the truck, he knew the occupants of the truck were armed and that they were chasing the students in the Monte Carlo. His front seat passenger, Michael Turner, climbed into the back seat to retrieve a .357 Magnum. Turner returned to the front seat and placed the gun on the seat beside him. DeMoss saw the shotgun sticking out of the Toyota truck's back window as he rounded a curve in the roadway. He testified that he thought there might be trouble between his vehicle and the truck. Nevertheless, he attempted to pass the truck. At this point the truck veered over in front of the convertible to prevent DeMoss from passing and ran DeMoss off the road. DeMoss knew that Cynthia was seated in a precarious and exposed position atop the rear seat of the convertible. He conceded that he also knew he could have stayed on the shoulder until the truck pulled far ahead. Moreover, he could have slowed his vehicle or taken an alternate route to avoid trouble. Instead, he chose to reenter the roadway and drive the convertible so as to stay close to the truck, even though the truck's passenger was pointing a shotgun at the convertible and even though its driver had already run him off the roadway. At this point DeMoss' passenger, Turner, raised his .357 Magnum in the air and fired. Simultaneously, Michael Horstman in the Toyota truck pulled the trigger of the shotgun he had been pointing at the convertible. Cynthia Edwards, still seated atop the back seat, was struck and seriously injured by shotgun pellets.

The disputed exclusion from coverage in the homeowner's policy provides in pertinent part:

SECTION II-EXCLUSIONS

1. Coverage E--Personal Liability and Coverage F--Medical Payments to Others do not apply to bodily injury or property damage:

...

e. arising out of:

the ownership, maintenance, use, loading or unloading of motor vehicles ... operated by ... an insured.

...

Having determined that DeMoss' conduct was a legal cause of Cynthia's injuries, we must next determine whether that conduct was a "use" of the automobile. We conclude that it was. In order for conduct to constitute "use" of an automobile, that conduct must be essential to the defendant's liability and the specific duty breached by the insured must flow from use of the automobile. *Picou v. Ferrara*, 412 So.2d 1297 (La.1982); *LeJeune v. Allstate Ins. Co.*, 365 So.2d 471 (La.1978). Both criteria are met in this case. The duty of Shane DeMoss to Cynthia Edwards arose because of their relationship vis-a-vis the motor vehicle and flowed from the use of the automobile. That duty was breached by DeMoss' failure to operate his vehicle in a prudent manner under the prevailing circumstances. The only conduct of DeMoss for which he was held liable by the trial court was the use of the vehicle so as to put Cynthia in harm's way. He could have avoided placing her in a danger zone by the operation of his vehicle in a prudent manner under the prevailing circumstances, i.e., stopping, slowing, or taking an alternate route to avoid the gunman in the vehicle ahead. Instead, he pursued the truck even after having been driven off the road. Thus, the "use" of the automobile was essential to the finding of liability on the part of DeMoss.

The court just didn't want to find coverage (under any type of policy) under these bizarre facts.

Contrast that decision with the "maintenance of a vehicle" exclusion in *Westfield Ins. Co. v. Herbert*, 110 F.3d 24, (C.A.7 (Ind.) 1997), which, although not heavy precedent in Louisiana, shows how courts read the language of a policy to find coverage when they want to.

On June 19, 1992, 9-year-old Candace Herbert was badly burned in a freak accident while playing in a neighbor's yard. The neighbor was 16 years old. He bought a 1985 Mercury Lynx, which sat in the family garage for about a month from the time he bought it until the day

the plaintiff was injured. Because it was not being driven, Donald had not obtained license plates or automobile liability insurance coverage for the car.

As the court stated:

On the day of the accident, the defendant was working on the car. Apparently oil was leaking through a valve cover, so he removed it in preparation for installing a new one he had purchased a day or two earlier. Later that evening, thinking he could sell the old valve cover, he decided to try to clean it up. To do that, he bought a half-gallon of gasoline. Working in the yard, he soaked the valve cover in gasoline in an attempt to loosen a gasket. He was not able to remove the gasket this way so he decided to burn it off the valve cover. Bad idea.

Predictably (to anyone perhaps but a 16-year-old), Donald's right hand caught on fire. As he tried to extinguish the fire, flames leaped to the open pan of gasoline, causing an explosion. Little Candace had the misfortune to be playing with other children in the Brumley backyard at the time. She was severely burned in the explosion.

The Brumleys were insured under a homeowners policy through Westfield, but as we mentioned, there was no automobile insurance on the Lynx. The homeowners policy contains a clause excluding insurance coverage for bodily injuries arising out of the maintenance of motor vehicles. Coverage is excluded for damage:

Arising out of:

(1) The ownership, maintenance, use, loading or unloading of motor vehicles or other motorized land conveyances, including trailers, owned or operated by or rented or loaned to an insured.

...

In the case before us, there is no finger pointing because there is only one finger. The finger here belongs to the homeowners' insurer who wants to disclaim responsibility, but we can't let the company escape. While Donald happened to hold in his hands a part to an automobile, he was not engaged in maintenance of his vehicle at the time the gasoline exploded. The maintenance of the vehicle had terminated once Donald removed the valve cover and set it aside.

... If Donald had been cleaning the valve cover to reinstall it, we might determine that his actions involved maintenance. But he was not planning to reinstall it; he was not working on the car in any manner. He was cleaning the valve cover to sell it, so he was not involved in maintaining the car when the explosion occurred.

Criminal Conduct Exclusion

Many policies contain an exclusion stating, “We do not cover any bodily injury or property damage which may reasonably be expected to result from the intentional or criminal acts of an insured person.” But does **all** criminal conduct **always** exclude coverage?

In *Young v. Brown*, 658 So.2d 750, 27,018 6/21/95, (La.App. 2 Cir. 1995) the insurance policy stated, “We do not cover any bodily injury or property damage which may reasonably be expected to result from the intentional or criminal acts of an insured person or which is in fact intended by an insured person.”

Plaintiff and a group of friends went to the home of another friend, looking for someone. They were told that he could be found sleeping in a pickup truck in front of the house. When plaintiff approached the truck, an argument ensued. Brown, who had consumed several beers and may have been intoxicated, concluded that plaintiff and his companions were a threat and got out of the truck armed with a gun. Brown fired a shot into the ground in an effort to disperse plaintiff and his companions. Thereafter, Brown stumbled as he approached the group and fell into plaintiff. The gun fired and plaintiff was shot in the stomach. Brown denies any intent to shoot or harm plaintiff. Based on the “criminal acts” exclusion, the court held that the firing of the gun was accidental and unintentional and, therefore, constituted only negligence.

In this case, the defendant pled guilty to a crime - the crime of negligent injuring. Because the insured pled guilty to the crime of negligent injuring, Allstate contends that the criminal acts clause excludes coverage.

The court held:

We have already recognized the strong public policy that prevents wrongdoers

from indemnifying themselves against their own intentional criminal acts. There is, however, another public policy related to the protection of the innocent injury victim. It has long been the recognized public policy of this state that liability insurance is issued for the protection of the general public as well as for the security of the insured. These public policies must be balanced in accord with the function performed by liability insurance and the expectations of a reasonable insurance buyer.

...

Plaintiff was injured when defendant, while wielding a gun, stumbled and fell. The gun accidentally discharged and plaintiff was struck in the abdomen. Under these facts, it is clear that defendant's actions fell below those expected of a reasonably prudent person and thus constituted negligence. Defendant was charged with and pled guilty to negligent injuring, a violation of LSA-R.S. 14:39, which states in part the following:

Negligent injuring is the inflicting of any injury upon the person of another by criminal negligence.

...

Our legislature has defined negligence for the purpose of criminalizing certain conduct. Criminal negligence, like tort negligence (albeit gross), is based upon accidental or inadvertent behavior. As in the instant case, the same conduct leading to a claim of criminal negligence is also actionable in tort. And yet, were defendant's conduct not chargeable as a crime, there would be no exclusion under the policy short of a showing that defendant acted intentionally in shooting plaintiff or that defendant intended to inflict injury. Because the negligence in question led to a criminal charge and conviction, Allstate would deny coverage. Even if criminal charges were not filed by the prosecuting authority, Allstate would claim a right to prove guilt in the civil proceeding.

Modern statutory and regulatory provisions govern most facets of human behavior and social interaction and are so extensive that liability seldom arises apart from some manner of illegal conduct. Indeed, statutes have so covered the field that fault can seldom occur that the conduct involved is not also considered a crime. It is illegal, in some instances, to possess a firearm, speed in automobiles, drive under the influence of alcohol, and let your pet outside without a leash. Allstate's suggested result can hardly have been envisioned by the parties.

An exclusion of liability insurance coverage for non-intentional, inadvertent acts of criminal negligence violates Louisiana's public policy established for the protection of innocent injury victims. Furthermore, we find the instant insurance

exclusion to be ambiguous. The term "criminal acts" is equivocal and susceptible of more than one interpretation based upon its usage and the tenor of the exclusionary language. A reasonable liability insurance buyer could construe the instant exclusion to deny coverage only for intentional criminal acts, thereby allowing coverage for damages arising out of non-intentional, criminal negligence. In light of this ambiguity, we construe the policy to provide coverage for damages arising from non-intentional acts that may rise to the level of criminal negligence. Such an interpretation recognizes the insured's reasonable expectations of coverage while voiding the exclusion only to the extent that it violates public policy.

Contrast that with *Gills v. Brown*, 672 So.2d 1093, 95-2351 (La.App. 4 Cir. 1996) in

which Brenda Brown pleaded guilty to negligent homicide under the following fact situation:

Defendant stated that on January 3, 1993, she and Brenda Gills, with whom defendant lived, went to a bar to watch a football game. While there they got into an argument. Defendant returned home and sometime later Ms. Gills returned home as well. Defendant went into her bedroom and closed the door. Ms. Gills began beating on the door, managed to get into the room and approached defendant. Defendant stated that she got a gun from underneath the bed and it fired twice. Defendant did not recall pulling the trigger. Ms. Gills was hit in the chest by one of the bullets and died.

Plaintiffs contend that the above quoted exclusions contained in the Allstate policy were limited to intentional criminal acts. Intent is not an element of the crime of negligent homicide. Therefore, plaintiffs argue, Brenda Brown's conviction of the crime of negligent homicide does not trigger the exclusion. However, the exclusionary language upon which plaintiffs base their argument is not the same as the language found in Brenda Brown's policy. The language quoted by plaintiffs, and erroneously attributed to the instant Allstate policy, is the exclusionary language that the court analyzed in *Young v. Brown*, 27-018, p. 3 (La.App. 2 Cir. 6/21/95), 658 So.2d 750, 752, writ den. 95-1811 (La. 10/27/95), 662 So.2d 1:

We do not cover any bodily injury or property damage which may reasonably be expected to result from the intentional or criminal acts of an insured person or which is in fact intended by an insured person.

...

From the facts found in *State v. Brown* coupled with the greater detail contained in Brenda Brown's deposition it is undisputed that Brenda Brown deliberately drew her gun from under her bed in the midst of an angry confrontation with the

decedent. She admitted that her hand was on the trigger. She admitted that she must have pulled the trigger. She said that she did not intend to shoot the decedent, but we know that she fired twice, killing the decedent at close range. *State v. Brown*, supra. She says that she does not remember how the gun went off, but she does not suggest that she stumbled causing the gun to discharge accidentally as was the case in *Young v. Brown*, supra.

...

We find intent under the undisputed facts of this case where the parties were engaged in an angry confrontation and one party deliberately drew a gun, placed her hand on the trigger, admits she must have pulled the trigger, firing twice killing the other party, and no explanation is offered to suggest how this could have occurred by accident.

What did the Supreme Court do?:

Writ granted. A genuine issue of material fact exists regarding whether the insured intended to injure or kill the victim. Therefore, summary judgment was improperly granted. Accordingly, summary judgment in favor of Allstate Insurance Company is hereby vacated and set aside. This case is remanded to the district court for further proceedings., *Gills v. Brown*, 675 So.2d 274 (La. 1996).

Medical Malpractice Cases

The cap on general damages in medical malpractice cases has been \$500,000.00 since 1976. Since 1997, however, depending on the case, the plaintiff may be able to recover more than \$500,000.00.

In *Conerly v. State*, 690 So.2d 980, 29,236 La.App. 2 Cir., 3/3/97 the court was confronted with a situation where more than one plaintiff was aggrieved by an act of medical malpractice. The facts are as follows:

In the instant case, there are three claimants. Timothy Conerly, on behalf of his daughter, asserted a claim for her injuries arising out of defendants' medical malpractice. Upon Christina's death the petition was amended to allege a survival action. In addition, Mr. Conerly asserted a wrongful death claim seeking damages for mental anguish and loss of companionship, love and affection. Claudia Conerly also sought damages for her daughter's wrongful death, including mental anguish and loss of companionship, love and affection.

Though they may have arisen from the same act of medical malpractice, Mr. and Mrs. Conerly's wrongful death claims are separate from the claim of the child. The injuries to these parents were distinct from the injury suffered upon the child and each parent is entitled to damages arising out of their daughter's wrongful death. La.C.C. art. 2315.2. The medical malpractice statute implicated in this case provides a monetary limitation or cap on recovery "in any action or claim" or "in connection with any claim."

The legislature has created a special scheme of compensation for those injured by medical malpractice. In the process, the substantive caps and procedures established by the legislature were particularly detailed. The potential adverse effect of the medical malpractice act is that persons catastrophically injured by medical negligence are subject to reduced quantum recovery as a consequence of the cap on damages. *Rodriguez v. Louisiana Medical Mutual Insurance Co.*, 618 So.2d 390 (La.1993).

As noted by the supreme court, statutory interpretation is guided by the principle that a statute such as the medical malpractice act, which takes away common or natural rights, is to be strictly construed and not extended beyond its obvious meaning. *Descant v. Administrators of Tulane Educational Fund*, 93-3098 (La. 07/05/94), 639 So.2d 246; *Rodriguez*, supra. When a statute grants immunities or advantages (such as the medical malpractice act's cap) to a special class (state health care providers) against the general public, the claims of the special class must be strictly construed. *Id.*

Therefore, we find that La.R.S. 40:1299.39, the provision of the public medical malpractice act limiting the rights of persons to recover for injuries or death arising out of the negligence of a state health care provider must be strictly construed. As applied to the particular circumstances of this case, we find that the cap applicable to the survival claim is separate from the parents' wrongful death claims.

How long will this type of action survive before its wrongful death?

Intentional Acts Cases

Most liability insurance policies contain some form of "intentional acts" exclusion, commonly exempting from coverage acts of a tortfeasor which are "expected or intended from the standpoint of the insured." Since the insurance contract itself is the law between the parties, the initial inquiry then must be to look to the specific policy language to determine what the

policy actually excludes. Outside of the sexual molestation arena the clause has been found to require the finder of fact to undertake a subjective analysis into the intent of the insured, usually the tortfeasor.

The most detailed analysis of how to interpret this "expected or intended" exclusion is in *Breland v. Schilling*. In *Breland* one baseball player punched another in the jaw after heated words were exchanged. The victim suffered unusually severe fractures as a result of the altercation. The policy excluded coverage for "bodily injury or property damage which is either expected or intended from the standpoint of the insured." The Court held that, under the specific language of that policy, an excluded injury is one which the insured intended, not one which he caused, however intentional the injury-producing act and held that the language excludes coverage only for those injuries which the defendant subjectively desired to inflict.

The Court distinguished the meaning of "intent" in this insurance policy from the legal meaning of "intent" in other areas such as worker's compensation, criminal law and tort law and defined intent, under the interpretation of that particular insurance contract, as follows:

In adopting the fact-sensitive test for the insured's subjective intent, we reject the approach, followed by certain courts, that an insured intends, as a matter of law, all injuries which flow from an intentional act.

. . .

While the insurance policy, perhaps in part, for public policy reasons, bars payment of claims for injuries "intended or expected from the standpoint of the insured" it does not bar coverage for unintentionally grievous injuries which, though precipitated by the insured, were never intended by him. We hold, therefore, that when minor bodily injury is intended, and such results, the injury is barred from coverage. When serious bodily injury is intended, and such results, the injury is also barred from coverage . . . When a minor injury is intended and a substantially greater or more severe injury results, whether by chance, coincidence, accident, or whatever, coverage for the more severe injury is not barred. Whether a given resulting bodily injury was intended "from the standpoint of the insured" within these parameters, is a question of fact. Such factual determinations are the particular province of the trier of fact, in this instance the trial jury.

One very recent creative twist to get around this exclusion was that in *Bilbo v. Shelter Insurance Company*, 96 1476 (La. App. 1 Cir. 1997) 1997 WL 451355 in which, under similar facts, the plaintiff alleged that the injuries to the victim were also directly attributable to the tortfeasor's parents' "negligent supervision" of the tortfeasor. The court, however, found that a *Breland* analysis was warranted and reversed the summary judgment. It stated, however, "Since we conclude summary judgment should not have been granted, we do not reach the negligent supervision claim against Vaughn's parents." So we await another day.

EMPLOYER'S VICARIOUS LIABILITY FOR INTENTIONAL TORTS OF EMPLOYEES

The Louisiana Supreme Court has held that in order for an employer to be vicariously liable for the intentional acts of its employee, the "tortious conduct of the [employee must be] so closely connected in time, place, and causation to his employment duties as to be regarded a risk of harm fairly attributable to the employer's business, as compared with conduct instituted by purely personal considerations entirely extraneous to the employer's interest." *LeBrane v. Lewis*, 292 So.2d 216, 218 (La. 1974). An employer is not vicariously liable for the intentional acts committed by its employee unless such employee is acting within the ambit of his assigned duties and also in furtherance of his employer's objectives.

In *LeBrane*, the court considered the following factors in holding an employer liable for a supervisor's actions of stabbing his co-employee:

- (1) whether the tortious act was primarily employment rooted;
- (2) whether the act was reasonably incidental to the performance of the employee's duties;
- (3) whether the act occurred on the employer's premises; and

(4) whether it occurred during the hours of employment.

Alcohol related cases

La. R.S. 9:2800.1

Limitation of liability for loss connected with sale, serving, or furnishing of alcoholic beverages

A. The legislature finds and declares that the consumption of intoxicating beverages, rather than the sale or serving or furnishing of such beverages, is the proximate cause of any injury, including death and property damage, inflicted by an intoxicated person upon himself or upon another person.

B. Notwithstanding any other law to the contrary, no person holding a permit under either Chapter 1 or Chapter 2 of Title 26 of the Louisiana Revised Statutes of 1950, nor any agent, servant, or employee of such a person, who sells or serves intoxicating beverages of either high or low alcoholic content to a person over the age for the lawful purchase thereof, shall be liable to such person or to any other person or to the estate, successors, or survivors of either for any injury suffered off the premises, including wrongful death and property damage, because of the intoxication of the person to whom the intoxicating beverages were sold or served.

C. (1) Notwithstanding any other law to the contrary, no social host who serves or furnishes any intoxicating beverage of either high or low alcoholic content to a person over the age for the lawful purchase thereof shall be liable to such person or to any other person or to the estate, successors, or survivors of either for any injury suffered off the premises, including wrongful death and property damage, because of the intoxication of the person to whom the intoxicating beverages were served or furnished.

(2) No social host who owns, leases, or otherwise lawfully occupies premises on which, in his absence and without his consent, intoxicating beverages of either high or low alcoholic content are consumed by a person over the age for the lawful purchase thereof shall be liable to such person or to any other person or to the estate, successors, or survivors of either for any injury suffered off the premises, including wrongful death and property damage, because of the intoxication of the person who consumed the intoxicating beverages.

The above statute only immunizes the seller from liability as a result of a sale to “a person over the age for the lawful purchase thereof,” but not as to liability as a result of sales to persons under the lawful age to purchase alcohol or persons injured by such persons. See *Hopkins v. Sovereign Fire & Cas. Ins. Co* 626 So.2d 880, (La.App. 3 Cir. 1993).

Is the immunity absolute? Is the reasoning of *Thrasher* still viable?

In *Thrasher v. Leggett*, 373 So.2d 494 (La.1979), a pre-La. R.S. 9:2800.1 case, liability was imposed on the seller or server of alcoholic beverages a duty “to avoid affirmative acts which increase the risk of peril to an intoxicated person.”

Examples of affirmative acts which would impose liability are found in *Pence v. Ketchum*, where a bar owner ejected an intoxicated patron onto a busy highway, and in *Pitts v. Bailes*, 551 So.2d 1363 (La.App. 3rd Cir.1989), writs denied, 553 So.2d 860 (La.1989) and 556 So.2d 1262 (La.1990), where the retailer failed to secure his parking lot when a well known band drew an exceptionally large crowd.

Is that reasoning still viable? Does it really conflict with La. R.S. 9:2800.1?

Employment Related Claims

In the past few years, it has become more difficult for employers to obtain coverage for employment-related lawsuits under their Comprehensive General Liability (CGL) policies. Carriers have argued successfully that they did not design the policy for claims from employment-related practices, but, often, these policies may afford coverage. Much of the litigation surrounds whether the incident was an “occurrence” or an “accident” as defined in the policy, or whether the action was “intentional” or wilful. Further it is necessary to read the policy to divine the definition of “insured,” which, in many policies, includes the employer, officers, directors, supervisors and often co-workers. Although sexual misconduct has been viewed as intentional misconduct, which is usually uninsurable, courts across the country often find that the conduct is so closely connected in time and place to the employer’s mission, that it is recoverable.

So now many insurers offer coverage for sexual harassment claims by offering an “employment practices” policy or employment practices endorsements to liability policies.

Although not a Louisiana case, an excellent exposition of these policy issues is contained in *Western Heritage Ins. Co. v. Magic Years Learning Centers and Child Care, Inc.*, 45 F.3d 85, (C.A.5 (Tex.) 1995) in which Mrs. Alexander, an employee of Magic Years, alleged that a Magic years employee, Mr. Wilson sexually harassed her at work, that such harassment led to her constructive discharge, that he invaded her right to privacy by asking probing questions about her personal life and sexual activities, that he unlawfully imprisoned her, that he committed assault and battery by touching her in an offensive, unwelcome manner, and that he acted with such want of care and conscious indifference as to warrant punitive damages.

Western Heritage contends that the policy's definition of “occurrence” did not cover sexual harassment, and, even if it did, the allegations in the Alexanders' suit are excluded from coverage by the “assault and battery” exclusion.

The policy defined an “occurrence” as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured." Western Heritage contended that the definition of “occurrence” excluded intentionally inflicted injuries and therefore excluded the allegations which arose out of sexual harassment because Mr. Wilson intended or expected to injure Mrs. Alexander when he harassed her and touched her in an offensive, unwelcome manner.

The court held:

. . . The general policy definition of occurrence is trumped by the following special endorsement:

Physical and/or Mental Abuse Limitation Endorsement

In consideration of the premium charged, it is hereby understood and agreed that Bodily Injury and Property Damage includes any act, which may be considered sexual in nature and could be classified as an Abuse, Harassment, Molestation, Corporal Punishment or an Invasion of an individual's right of Privacy or control over their physical and/or mental properties by or at the direction of an Insured, an Insured's employee or any other person involved in any capacity of the Insured's operation....

Regardless of whether the general definition of occurrence would exclude allegations of sexual harassment by the insured, the endorsement expressly provides for coverage of such claims. To hold otherwise would render the endorsement meaningless. See Barnett, 723 S.W.2d at 666 (stating that a court should read a contract, including an insurance policy, to give effect to each part of the contract unless doing so would do violence to the rules of law or construction).

The alleged acts of Mr. Wilson complained of in the underlying state court suit are covered by the endorsement because they all "may be considered sexual in nature and could be classified as an Abuse, Harassment, Molestation, Corporal Punishment or an Invasion of an individual's right of Privacy." Alternatively, from the standpoint of Magic Years and Mrs. Wilson, not only do the allegations in the underlying state court suit fall within the endorsement, but the alleged acts or omissions are within the general definition of occurrence, because there is no contention that Mrs. Wilson or Magic Years expected or intended to injure the Alexanders.

ASSAULT AND BATTERY EXCLUSION

Western Heritage also contends that the allegations involving assault and battery and offensive touching are excluded from coverage by the following assault and battery exclusion endorsement:

It is agreed that the insurance does not apply to bodily injury or property damage arising out of assault and battery or out of any act or omission in connection with the prevention or suppression of such acts, whether caused by or at the instigation or direction of the insured, his employees, patrons or any other person.

The underlying state court suit is based upon alleged sexual harassment, expressly covered by the policy's "physical and/or mental abuse limitation endorsement." The allegations of assault and battery, unlawful imprisonment, and intentional infliction of emotional distress are alternative legal theories of liability for the alleged sexual harassment. The physical/mental abuse endorsement would be meaningless with respect to claims of physical abuse if the assault and battery exclusion were applicable. The assault and battery exclusion is trumped by this

special endorsement, just as is the definition of occurrence.

EMPLOYER LIABILITY EXCLUSION

Western Heritage also argues that the allegations in the state court suit are excluded by the following employer liability exclusion clause:

This insurance does not apply:

(i) to bodily injury to any employee of the insured arising out of and in the course of his employment by the insured for which the insured may be held liable as an employer or in any other capacity; * * * or

(iii) to bodily injury sustained by the spouse, child, parent, brother, or sister of an employee of the insured as a consequence of bodily injury to such employee arising out of and in the course of his employment by the insured.

The policy defines an "insured" as:

any person or organization qualifying as an insured in the 'Persons Insured' provision.... The insurance afforded applies separately to each Insured against whom claim is made or suit is brought, except with respect to the limits of the Company's liability.

By this employer liability exclusion, Western Heritage may have intended to exclude coverage of claims by "any employee" of any insured, but it did not do so. Instead, the policy excludes coverage of claims by "any employee of the insured." (emphasis added). The author of the policy knew how to write the word "any", for he used it to modify "employee", but not "insured."

The definition of an "insured" in the policy provides that "[t]he insurance afforded applies separately to each Insured against whom claim is made or suit is brought." The "physical and/or mental abuse limitation endorsement," which provides for coverage of the claims at issue, states that "[t]his insurance applies separately to each Insured." Thus a claim against one insured may be covered, even though the same claim against another insured is excluded. Mindful that we must adopt any construction of an exclusionary clause urged by the insured as long as it is not unreasonable, we must read the employer liability exclusion as applying separately to each insured, excluding coverage of an insured only if that insured is the employer of the injured party or the party's spouse.

The employer liability exclusion does not apply to Mr. and Mrs. Wilson, neither of whom was Mrs. Alexander's employer, but it does apply to Magic Years, which was her employer.

All of the claims against Magic Years are excluded by the employer liability exclusion clause, because Magic Years employed Mrs. Alexander, the claims arose out of the course of her employment, and the exclusion specifically applies to the derivative claims of the injured employee's spouse.

Unlike the limiting language in the definition of "occurrence" and the assault and battery exclusion, either of which if applicable here would render the policy's "physical and/or mental abuse limitation endorsement" meaningless, the employer liability exclusion can be read together with the sexual claim endorsement. Claims by a non-employee of an insured "which may be considered sexual in nature" are covered by the policy, e.g., the claims against Mr. and Mrs. Wilson; such claims by an employee of an insured are excluded from coverage.

Read the policy

Claims made policies

What if the policy is a "claims made" policy limiting coverage to claims which occurred and were reported while the policy was in force?

In *Hedgepeth v. Guerin*, 691 So.2d 1355, 96 1044 La.App. 1 Cir. 3/27/97, (La.App. 1 Cir. 1997) Pacific Insurance Company (Pacific) issued an individual professional liability policy to Dr. Gerard G. Guerin, a Hammond podiatrist. The policy was a "claims made" policy covering the period between January 31, 1985, and January 31, 1986.

On October 2, 1985, Julia Hedgepeth, a diabetic, consulted Dr. Guerin for treatment of a callous on her right foot. On that same day, Dr. Guerin surgically removed the callous from Ms. Hedgepeth's foot and sutured the incision under local anesthesia. Thereafter, a severe infection developed, resulting in diabetic gangrene, which ultimately required the amputation of the upper left portion of Ms. Hedgepeth's right foot.

On November 10, 1985, Pacific canceled its policy of professional liability insurance covering Dr. Guerin. Thereafter, on January 31, 1986, the policy expired by its own terms.

On July 23, 1986, Ms. Hedgepeth filed a medical malpractice action against Dr. Guerin and Pacific. Dr. Guerin answered the petition, denying the allegations and averring extinguishment of the obligation by virtue of a discharge in bankruptcy granted to Dr. Guerin on May 1, 1986.

The policy is a so-called "claims made" policy.

The dispute is over "notice" to the company. There was no proof that Dr. Guerin notified Pacific Insurance Company in writing or otherwise during the coverage period.

Pacific contended that the language in its "claims made" policy, which limits coverage to acts **discovered and reported during the policy term**, is clear and unambiguous and that the trial court erred in finding that coverage existed.

In the portion of the policy entitled "COVERAGE PART," the Pacific policy provided the following "Notice":

This is known as a "claims made" policy. . . .

The "Coverage Agreement" for "Coverage M--Individual Professional Liability" provides as follows:

The company will pay on behalf of the insured:

All sums which the insured shall become legally obligated to pay as damages because of injury to which this insurance applies caused by a medical incident, occurring subsequent to the retroactive date, **for which claim is first made against the insured and reported to the company during the policy period**, arising out of the practice of the insured's profession as a podiatrist.

. . .

A claim for injury shall be considered as being first made at the earlier of the following times:

(a) when the insured first gives written notice to the company that a claim has

been made, or
(b) when the insured first gives written notice to the company of specific circumstances involving a particular person which may result in a claim. . . .

The court held:

Clearly, the Pacific policy is a "claims made" or "discovery" policy. Under a "claims made" policy, coverage is effective only if the negligent harm is discovered and reported within the policy term. This is to be contrasted with an "occurrence" policy, where the coverage is effective if the negligent harm occurs within the policy period, regardless of the date of discovery.

An insurance policy is a contract and has the effect of law between the parties. As a general rule, where a policy unambiguously and clearly limits coverage to acts discovered and reported during the policy term, such limitation of liability is not per se impermissible or invalid. This is in accordance with the general principle that, in the absence of conflict with statutory provision or public policy, insurers may by unambiguous and clear notice provisions limit their liability and impose such reasonable conditions as they wish upon the obligations they assume by their contract. (Citations omitted)

The record indicates that the Pacific policy period commenced on January 31, 1985, and continued through January 31, 1986. The alleged malpractice occurred on October 2, 1985. The Hedgepeths first filed a malpractice action against Dr. Guerin on July 23, 1986, nearly six months after the policy period had expired. Thereafter, Dr. Guerin was served with the petition for damages, and, in August of 1986, he notified Pacific of the action. The record is clear that, at no time prior thereto, was Pacific notified of the claim. Accordingly, the claim against Pacific was not "first made" during the policy period, and, as a result, under the language of the Pacific policy, there was no coverage under the policy.

However, our inquiry does not end here. In the instant case, plaintiffs challenge the validity of the "claims made" policy on the grounds that it violates statutory law. Plaintiffs' challenges to the "claims made" policy allege conflict between the Pacific policy provisions and various statutory provisions, including the Direct Action Statute, the statutes setting forth the prescriptive period for insurance and medical malpractice actions, and general provisions of the Medical Malpractice Act.

Insurers may by unambiguous and clear notice provisions limit their liability and impose such reasonable conditions as they wish upon the obligations they assume by their contract, but this ability to contract is limited by statute and/or public policy. Even "claims made" policies, which clearly and unambiguously limit an insurer's liability to its insured, may be unenforceable against third party claimants, if those provisions violate public policy or conflict with statutory

provisions.

...

In the instant case, plaintiffs' challenge to the "claims made" policy provisions involves alleged violations of the Direct Action Statute, the prescriptive period for insurance and medical malpractice actions, and general principles of the Medical Malpractice Act.

...

Accordingly, those portions of Pacific's "claims made" policy, limiting the liability of Pacific to those claims which occurred and were reported while the policy was in force, are unenforceable and without effect under the facts of this case.

Drop down

What if there is a “gap” between the primary coverage and the excess coverage? Will the excess “drop down” to cover the gap?

In *Louisiana Insurance Guaranty Association v. Interstate Fire & Casualty Company* 630 So.2d 759, (La. 1994), the court set forth the guidelines for when the excess insurer is required to “drop down.” It cited *Kelly v. Weil*, 563 So.2d 221 (La.1990), which stated that the controlling consideration in resolving this drop down issue is the language of the excess policy.

The Interstate policy's limits of liability provision provided:

LIMITS OF LIABILITY:

OUR policy is an excess policy over the PRIMARY INSURANCE.

OUR obligation does not extend beyond the limits shown in the DECLARATIONS.

WE are not obligated to pay under this policy until the PRIMARY INSURER has paid or has been held liable to pay the full amount of the PRIMARY INSURANCE.

WE shall then be liable to pay only such additional amounts necessary to provide YOU with a total coverage under the PRIMARY INSURERS and this policy

combined.

The court held:

Resolution of this case turns on whether the fourth sentence of Interstate's limits of liability provision requires Interstate to drop down and assume the insolvent primary insurer's (Champion's) obligations. . . . We find the words in this fourth sentence reflect that its meaning is dependent upon other policy provisions in at least three respects.

The first dependent word is "then." The word "then" is defined as "[n]ext in ... order." American Heritage Dictionary (1976). In this sentence, "then" means after the trigger condition imposed by the third sentence occurs. > (FN11) The second dependent word is "additional," which is defined as "a supplement." Id. Obviously, additional presupposes something coming before it, and the placement in this sentence of the word "additional" before the word "amounts" reflects the limited nature of Interstate's obligation to pay. The third limiting word is "only," which is defined as "[n]o more than." Id. In this sentence, "only" precedes "such additional amounts," further reflecting the limited nature of Interstate's obligation to pay.

Based on the above definitions, we translate this sentence as providing that after the triggering event, defined in the third sentence, the next event is the activation of Interstate's obligation to pay, and that obligation will be for no more than such supplemental amounts necessary to provide the total combined coverage. This sentence thus clarifies that the excess insurer's (Interstate's) limits are in addition to the primary insurer's (Champion's) limits.

. . .

While we construe Interstate's policy as plainly precluding drop down coverage, we nonetheless address each of the three factors LIGA contends supports the appellate court's contrary construction; namely: (i) the reasonable expectations doctrine, (ii) the rule of strict construction and (iii) public policy considerations.

While the discussion of these matters is too lengthy to reproduce here, the case presents an excellent analysis of these issues, and, should these issues arise in your case, you should consult the text of the case.

Read the Policy

Cases Spanning Several Policy Periods

What if the tort is continuous and spans several policy periods? How much coverage is there?

In *Cole v. Celotex Corp.*, 588 So.2d 376, (La.App. 3 Cir. 1991) Plaintiffs allege that during their employment they were exposed to asbestos and alleged that the named executive officers of their employer negligently failed to provide them with a safe place to work between 1945, the year they began work, and 1976, the year that, effective October 1, the Louisiana legislature amended La.R.S. 23:1032 and barred suits against executive officers unless the conduct amounts to an intentional tort. The sole defendant at trial was INA, as insurer of eleven executive officers.

The court held:

... In its brief, INA cites policy language which reads "... all bodily injury and property damage arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence." INA states that this language provides that an individual claimant's long-term exposure to substantially the same conditions must be treated as a single occurrence, triggering only one policy limit. The policies were written for yearly terms from 1944 through 1976 with coverages varying from \$10,000.00 in 1944 to \$50,000.00 in 1976 for each person injured.

Plaintiffs' treating physician, Dr. Gary Friedman, testified that plaintiffs sustained distinct bodily injury in each of their respective years of employment as a consequence of negligent exposure to asbestos dust. Thus, while plaintiffs' continued or repeated exposure may constitute but one occurrence under that policy, the INA grant of coverage and Dr. Friedman's testimony support the trial court's ruling that there was an accident/occurrence in each year of plaintiffs' exposure.

...

In *Houston v. Avondale Shipyards, Inc.*, supra at page 150, the Fourth Circuit explains the rationale for the annual exposure rule as follows:

"Inherent in the decision to place CU at risk for each year during which plaintiff was exposed and CU had a policy in effect, is a construction of the events so that we view plaintiff's exposure as an occurrence which occurs (or reoccurs) each year of plaintiff's exposure. Arguably, plaintiff is reinjured each time he inhales silica dust. To avoid infinite liability exposure, however, the factual construction of a single injury (or reinjury) each year is adopted...."

The court held that, although there were numerous, perhaps thousands, of inhalations of asbestos, that the "single injury" concept would be applied and that "by stacking the annual policies covering each respective plaintiff's exposure, there is more than sufficient coverage for each plaintiff's recovery."

Similarly, in *Society of Roman Catholic Church of Diocese of Lafayette and Lake Charles, Inc. v. Interstate Fire & Cas. Co.*, 26 F.3d 1359, (C.A.5 (La.) 1994) two pedophilic priests molested thirty-one children over a period of seven years, prompting a spate of claims from the children and their parents. The sordid picture underlying this insurance coverage dispute is that of two miscreant priests who subjected thirty-one children to extended periods of sexual molestation. These molestations began in August of 1976 and ended in June of 1983. The record on appeal does not show how many times each child was molested, nor the extent of damage resulting from each encounter. The parties agreed that each child was molested at least once during each stipulated year of molestation.

All insurance policies were "occurrence" based policies, occurrence being defined as "a continuous or repeated exposure to conditions." The court held that an "occurrence" could be the church's continuous negligent supervision of a priest, the negligent supervision of a priest with respect to each child, the negligent supervision of a priest with respect to each molestation, or each time the Diocese became aware of a fact which should have led it to intervene.

The court stated:

While there are many possible applications of the term "occurrence," we are not

without guidance. In *Lombard v. Sewerage & Water Bd. of New Orleans*, 284 So.2d 905 (La.1973), where the ongoing construction of a drainage canal damaged many adjacent property owners, the Louisiana Supreme Court discussed the proper method for determining an "occurrence" when the cause of harm continues to injure different persons:

The word "occurrence" as used in the policy must be construed from the point of view of the many persons whose property was damaged. As to each of these plaintiffs, the cumulated activities causing damage should be considered as one occurrence, though the circumstances causing damage consist of a continuous or repeated exposure to conditions resulting in damage arising out of such exposure. Thus, when the separate property of each plaintiff was damaged by a series of events, one occurrence was involved insofar as each property owner was concerned. Notwithstanding, therefore, that the same causes may have operated upon several properties at the same time resulting in varying degrees of damage, it cannot be regarded as one occurrence, but the damage to each plaintiff is a separate occurrence.

Following *Lombard*, "the damage to each [child] is a separate occurrence." See also *Interstate*, 747 F.Supp. at 624 ("Each time this negligent supervision presented Father Laughlin with the opportunity to molest a different child, the Archdiocese was exposed to new liability," which constitutes an "occurrence" under the policy language); *Maurice Pincoffs Co. v. St. Paul Fire & Marine Ins. Co.*, 447 F.2d 204, 206 (5th Cir.1971) (holding that the liability creating event constitutes an "occurrence").

2. The Number of "Occurrences" Per Child

While *Lombard* instructs that the molestation of each child is a separate occurrence, it does not answer the question of how many "occurrences" each child suffered, because the issue of multiple occurrences during successive policy terms never arose. The court's opinion in *Davis v. Poelman*, 319 So.2d 351 (La.1975) is equally unhelpful because it dealt with a single injury resulting in continuing damage over a period of time. It did not address a situation where an individual was repeatedly injured during multiple policy terms.

The most applicable line of Louisiana cases dealing with multiple injuries during successive years are the asbestosis cases. See e.g., *Cole v. Celotex Corp.*, 599 So.2d 1058 (La.1992); *Houston v. Avondale Shipyards, Inc.*, 506 So.2d 149 (La.Ct.App.), writ denied, 512 So.2d 460 (La.1987); *Ducre v. Mine Safety Appliances Co.*, 645 F.Supp. 708 (E.D.La.1986) (applying Louisiana law), approved, 833 F.2d 588 (5th Cir.1987); *Porter v. American Optical Corp.*, 641

F.2d 1128 (5th Cir.) (applying Louisiana law), cert. denied, 454 U.S. 1109, 102 S.Ct. 686, 70 L.Ed.2d 650 (1981). In *Cole*, the most recent Louisiana Supreme Court decision in this area, the court answered the question of how to determine the number of occurrences when the victim is repeatedly injured during multiple policy years. Adopting the exposure rule, the court concluded that the inhalation of asbestos fibers causes bodily injury as defined in the "occurrence" policies. The court held that an employee suffered bodily injury from an occurrence when the employee inhaled asbestos fibers during a policy year and all subsequent inhalation during that year arose out of the same occurrence. When the employee inhaled asbestos during the next policy year, again, the employee suffered bodily injury from an occurrence. Thus, each employee suffered injury from an occurrence during each year in which he inhaled asbestos. *Cole*, 599 So.2d at 1075-80.

We believe the Louisiana Supreme Court would apply the same analysis to the stipulated facts of this case. When a priest molested a child during a policy year, there was both bodily injury and an occurrence, triggering policy coverage. All further molestations of that child during the policy period arose out of the same occurrence. When the priest molested the same child during the succeeding policy year, again there was both bodily injury and an occurrence. Thus, each child suffered an "occurrence" in each policy period in which he was molested.

Read the Policy

Sexual Misconduct Cases

In *Smith v. Perkins* 94-1270 (La. App. 4th Cir. 12/28/94), 648 So.2d 482, writ denied 95-0267 (La. 3/24/95), 651 So. 2d 292. the defendant sexually molested a young girl. Her mother asserted a cause of action against the perpetrator and his homeowners' insurer. The insurance contract contained the "expected or intended" exclusion. Citing *Breland*, the Court studied the differing language in policy exclusions in several cases, found that the inquiry was a subjective one, and held as follows:

In *Doe v. Smith*, 573 So.2d 238 (La.App. 1st Cir.1990), writ den. 573 So.2d 1139 (La.1991), insurance coverage was excluded for bodily injury or property damage "which may reasonably be expected to result from the intentional or criminal acts of an insured person or which are in fact intended by an insured person." The defendant allegedly molested a minor child and the court considered whether the act was intentional and whether the damage could reasonably be expected to

result from that act. On the first issue, the court acknowledged that summary judgment is rarely appropriate for a determination of subjective facts such as intent and stated:

In cases dealing with battery, theft and shootings, the facts may influence a finding of negligence rather than intentional conduct. . . . *However, child molestation is one such rare instance where a factual determination of negligence or intentional conduct is inappropriate as a practical matter. These types of acts cannot result from careless conduct and only occur as a result of a deliberate act by the perpetrator. Additionally, the alleged acts giving rise to the instant suit occurred repeatedly over an almost ten-year period. Clearly, Smith's acts of child molestation were deliberate and, therefore, intentional acts.* (Emphasis by the court)

Doe, 573 So.2d at 243. The focus of the Court at that point of the opinion was whether the act was intentional, not whether the resulting damages were intentional.

The second inquiry under the policy language in *Doe* was whether the damage could reasonably be expected to result from the intentional act. The court applied an objective reasonable man standard to determine same.

The First Circuit later expanded application of the rule that exempted child molestation from factual inquiry when the court granted summary judgment for an insurer based on a clause that excluded coverage for bodily injury which was intended or expected by the insured. *Wallace v. Cappel*, 592 So.2d 418 (La.App. 1st Cir.1991), writ den. 593 So.2d 651 (La.1992). Thus, the same rule was applied, although the question under the policy was not whether the act was intentional but whether the resulting damage was intentional.

Two cases from this Circuit have considered "intent" under exclusionary clauses in a molestation case. *Shaw v. Bourn*, 615 So.2d 466 (La.App. 4th Cir.), writs den. 618 So.2d 409 and 412 (La.1993); *Hackett v. Schmidt*, 630 So.2d 1324 (La.App. 4th Cir.1993), writ den. 94-0266 (La. 4/4/94); 635 So.2d 1123.

Like *Doe v. Smith*, the exclusionary clause in *Shaw v. Bourn* was written in terms of a reasonable man standard. That policy excluded coverage for bodily injury or property damage:

- a. which results from an act:
 - (1) that is intended by any insured to cause harm; or
 - (2) that an insured could reasonably expect would cause harm.

This Court determined that:

The use of the words 'reasonably' and 'an' instead of the word 'the' [in the exclusionary clause] indicates that the policy does not look to the subjective fact-based test of the particular insured, but rather uses a reasonable man standard. As such, even if (defendant) is incapable of foreseeing the harm to the plaintiffs which we find was substantially certain to follow his acts of molestation, he should have because any, indeed, every reasonable man expects children to be harmed by molestation. Thus (defendant's) state of mind is irrelevant in light of the policy language . . . We further adopt the holding of *Doe v. Smith* ... and *Wallace v. Cappel* Having concluded that as a matter of law child molestation is an intentional act, we find that the trial court committed reversible error in submitting the question on policy coverage to the jury.

By adopting the holding of *Doe* and *Wallace*, this Court attempted to adopt a rule that child molestation is per se an intentional act for which coverage is excluded.

The court in *Smith*, however, after discussing the fact that the tortfeasor's intent must be analyzed subjectively, found that, objectively, "The sexual molestation of a child is certainly a deliberate, intentional act, and the emotional and physical damage is such a fundamental and natural consequence of the molestation that any predator must be held to realize that damage will result. We hold that, as a matter of law, the mere commission of sexual molestation on a juvenile is sufficient to establish that any resultant injury is 'expected or intended from the

In *Doe v. Smith*, 573 So.2d 238 (La. App. 1st Cir. 1991) an action was brought by a child's parents against a neighbor and his homeowner's insurer arising out of the neighbor's molestation of their daughter over a ten year period. The policy excluded "bodily injury or property damage which may reasonably be expected to result from the intentional or criminal acts of an insured person or which are in fact intended by an insured person." Based on that language, the Court used an objective standard to determine intent, based primarily on the use of the words "reasonably" and "an insured" as opposed to "the insured" and stated:

In *Pique v. Saia*, the Louisiana Supreme Court, in interpreting a homeowner's liability policy clause excluding coverage for "bodily injury . . . which is either expected or intended from the standpoint of the insured," determined that such

provision excluded only injuries resulting from intentional acts and did not exclude the negligent acts committed by defendant.

The aforementioned cases and the cases which follow *Breland* and *Pique* are clearly distinguishable from the instant case. The policy exclusions in *Breland* and *Pique* dealt with the narrow area of "bodily injury or property damage . . . expected or intended" by the insured and not any "bodily injury . . . which may reasonably be expected to result from the intentional . . . acts of an insured." The language of the Allstate exclusion clause in this case is significantly different from the provision in *Breland* and *Pique*. Here the exclusion is not limited to the injury or damages intended by the insured, but broadly excludes coverage for all damages reasonably expected to result from an insured's intentional act, regardless of his intention to cause any of the damage suffered. See *Travelers Insurance Company v. Blanchard*, 431 So.2d 913, 915 (La. App. 4th Cir. 1983). (Emphasis by the court)

Based on an objective analysis, the court found that the plaintiff intended the injury.

Where does this leave the innocent victim who seeks recovery from the typically impecunious tortfeasor?

The Standard of Civil Responsibility and Subjective Intent - Breland + vonDameck

A subjective analysis requires a peek into the mind of the perpetrator to discern his intent.

What if the tortfeasor has a mental disease or defect which exempts him from civil responsibility for his acts?

In *von Dameck v. St. Paul Fire & Marine Ins. Co.* 361 So.2d 283 (La. App. 1st Cir. 1978)

the court set forth the standard for civil responsibility when the defendant has such a mental disease or defect. In *vonDameck* the tortfeasor, Dr. Cayer, shot his wife three times with a handgun, then shot himself, committing suicide. The policy excluded "bodily injury which is expected or intended from the standpoint of the insured." The court stated:

However, to this court's knowledge a legal standard of insanity, insofar as delictual responsibility is concerned, has never been established by the

jurisprudence or laws of the State of Louisiana.

"Insane persons" are defined in La.R.C.C. Article 31 as:

"Persons of insane mind are those who do not enjoy the exercise and use of reason, after they have arrived at the age at which they ought, according to nature, to possess it, whether the defect results from nature or accident. . . .

"Insanity" is defined in Black's Law Dictionary 929 (4th Ed.Rev. 1968), as:

". . . such a want of reason, memory, and intelligence as prevents a man from comprehending the nature and consequences of his acts or from distinguishing between right and wrong conduct."

In the recent case of *Turner v. Bucher*, 308 So.2d 270 (La. 1975), the Supreme Court, in discussing the delictual responsibility of minors and insane persons, stated the following:

". . . (T)he Louisiana and French concepts coincide in holding that nondiscerning persons do not possess the capability of knowing the consequences of their conduct; they lack the moral guilt usually associated with delictual responsibility and, therefore, they should not be legally liable for acts under an objective standard designed for normal reasoning persons."

. . .

In view of the above jurisprudence and definitions of insanity for civil liability, we find that the trial judge was in error in simultaneously concluding that Dr. Cayer, by his actions, intended to inflict bodily injury. If a person has such a want of reason, memory, and intelligence as prevents him from comprehending the nature and consequences of his acts, he cannot at the same time intentionally inflict injury. Though Dr. Cayer may have had the intent to shoot his wife, his insanity prevented him from having the requisite intent to inflict injury.

The court found the "expected or intended" exclusion inapplicable, found that the insured was not liable for his torts, found that the insurer could not avail itself of that defense because it was personal to the insured, and allowed recovery.

No court has yet applied *von Dameck* to sexual molestation cases, but if the plaintiff is able to prove that the tortfeasor's mental disease or defect was sufficient to deprive him of the ability to understand the nature and consequences of his actions, his insurer may be required to provide coverage, in spite of the "expected or intended" exclusion.

If the language of the exclusion contains the word "reasonably," or refers to "an insured," an objective or "reasonable man" analysis must be used. If the exclusion refers to "the insured," an analysis of the tortfeasor's subjective intent is necessary. It appears that the courts view sexual molestation of children as the abhorrent social evil that it is. Consequently, the courts usually find that the tortfeasor intended the injury, regardless of whether the analysis the court uses is subjective or objective. As of yet, the Louisiana Supreme Court has neither spoken directly on these issues nor dealt with how a tortfeasor's mental disease or defect will affect the applicability of the "expected or intended" exclusion.

Interest

If you can't get all the money, you might get interest on all the money.

LSA-R.S. 13:4203 does not prohibit insurers from lowering, excluding, or extending their interest liability on amounts in excess of their policy limits. *Martin v. Champion Insurance Company*, 656 So.2d at 995. Insurers utilize supplemental payment provisions to outline their obligations with regard to interest.

In *Hedgepeth v. Guerin*, 96 1044 La. App. 1 Cir. 3/27/97 (La. App. 1 Cir. 1997) the Pacific policy contains the following supplemental payment provision:

The company will pay in addition to the applicable limit of liability:

(a) all expenses incurred by the company, all costs taxed against the insured in

any suit defended by the company and **all interest on the entire amount of any judgment therein which accrues** after entry of the judgment and before the company has paid or tendered or deposited in court that part of the judgment which does not exceed the limit of the company's liability thereon;

The jurisprudence has interpreted identical supplemental payment clauses on numerous occasions. The courts have consistently held that, under these supplemental payment clauses, the insurer intended to provide its insured with supplemental protection for all interest and costs **on the entire judgment** which accrues after entry of judgment. See *Barnes v. Thames*, 578 So.2d 1155, 1170 (La.App. 1st Cir.), writs denied, 577 So.2d 1009 (La.1991).

Read the Policy

Insurer's Liability for Excess Judgment

In the absence of bad faith, a liability insurer generally is free to settle or to litigate at its own discretion, without liability to its insured for a judgment in excess of the policy limits. On the other hand, a liability insurer is the representative of the interests of its insured, and the insurer, when handling claims, must carefully consider not only its own self- interest, but also its insured's interest so as to protect the insured from exposure to excess liability. *Holtzclaw v. Falco, Inc.*, 355 So.2d 1279 (La.1978). Thus, a liability insurer owes its insured the duty to act in good faith and to deal fairly in handling claims.

Thus, the determination of whether the insurer acted in bad faith turns on the facts and circumstances of each case. Of course, an insurer is not obliged to compromise litigation just because the claimant offers to settle a claim for serious injuries within the policy limits, and its failure to do so is not by itself proof of bad faith. The determination of good or bad faith in an

insurer's deciding to proceed to trial involves the weighing of such factors, among others, as the probability of the insured's liability, the extent of the damages incurred by the claimant, the amount of the policy limits, the adequacy of the insurer's investigation, and the openness of communications between the insurer and the insured. Nevertheless, when an insurer has made a thorough investigation and the evidence developed in the investigation is such that reasonable minds could differ over the liability of the insured, the insurer has the right to choose to litigate the claim, unless other factors, such as a vast difference between the policy limits and the insured's total exposure, dictate a decision to settle the claim.

Has the policy language been approved by the Commissioner of Insurance? If not, it may be unenforceable.

LSA-R.S. 22:620

§ 620. Approval of forms

A. No basic insurance policy form other than surety bond forms, or application form where written application is required and is to be attached to the policy, or be a part of the contract or printed life or health and accident rider or endorsement form shall be issued, delivered, or used unless it has been filed with and approved by the commissioner of insurance.

CANCELLATION

If the policy was canceled, was it canceled properly? If not, there may be coverage.

The requirements for canceling an insurance policy are set forth in La. R. S. 22:636. The statute provides in pertinent part:

A. Cancellation by the insurer of any policy which by its terms is cancelable at the option of the insurer, or of any binder based on such policy, may be effected as to any interest only upon compliance with either or both of the following:

(1)(a) Written notice of such cancellation must be actually delivered or mailed to the insured or to his representative in charge of the subject of the insurance not less than twenty days prior to the effective date of the cancellation except where termination of coverage is for nonpayment of premium.

Penalties and Attorney Fees

LSA-R.S. 22:657

§ 657. Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telemedicine reimbursement by insurers

A. All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B, shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. The insurer shall make payment at least every thirty days to the assured during that part of the period of his disability covered by the policy or contract of insurance during which the insured is entitled to such payments. **Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court.** Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, shall have jurisdiction to try such cases.

LSA-R.S. 22:658

§ 658. Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; penalties; arson-related claims suspension

A. (1) All insurers issuing any type of contract, other than those specified in > R.S. 22:656, R.S. 22:657, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any claim due any insured within thirty days after receipt of satisfactory proofs of loss from the insured or any party in interest.

(2) All insurers issuing any type of contract, other than those specified in > R.S. 22:656, R.S. 22:657, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any third party property damage claim and of any reasonable medical expenses claim due any bona fide third party claimant within thirty days after written agreement of settlement of the claim from any third party claimant.

(3) Except in the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim and of a claim for reasonable medical expenses within fourteen days after notification of loss by the claimant. In the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim within thirty days after notification of loss by the claimant. Failure to comply with the provisions of this Paragraph shall subject the insurer to the penalties provided in > R.S. 22:1220.

(4) All insurers shall make a written offer to settle any property damage claim within

thirty days after receipt of satisfactory proofs of loss of that claim.

B. (1) Failure to make such payment within thirty days after receipt of such satisfactory written proofs and demand therefor, as provided in R.S. 22:658(A)(1), or within thirty days after written agreement or settlement as provided in R.S. 22:658(A)(2) when **such failure is found to be arbitrary, capricious, or without probable cause, shall subject the insurer to a penalty, in addition to the amount of the loss, of ten percent damages on the amount found to be due from the insurer to the insured, or one thousand dollars, whichever is greater, payable to the insured, or to any of said employees, together with all reasonable attorney fees for the prosecution** and collection of such loss, or in the event a partial payment or tender has been made, ten percent of the difference between the amount paid or tendered and the amount found to be due and all reasonable attorney fees for the prosecution and collection of such amount.

La. R. S. 22:1220. Good faith duty; claims settlement practices; cause of action; penalties

A. An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.

B. Any one of the following acts, if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties imposed in Subsection A:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to pay a settlement within thirty days after an agreement is reduced to writing.

(3) Denying coverage or attempting to settle a claim on the basis of an application which the insurer knows was altered without notice to, or knowledge or consent of, the insured.

(4) Misleading a claimant as to the applicable prescriptive period.

(5) Failing to pay the amount of any claim due any person insured by the contract within sixty days after receipt of satisfactory proof of loss from the claimant when such failure is arbitrary, capricious, or without probable cause.

C. In addition to any general or special damages to which a claimant is entitled for breach of the imposed duty, **the claimant may be awarded penalties assessed against the insurer in an amount not to exceed two times the damages sustained or five thousand dollars, whichever is greater.** Such penalties, if awarded, shall not be used by the insurer in computing either past or prospective loss experience for the purpose of setting rates or making rate filings.

D. The provisions of this Section shall not be applicable to claims made under health and

accident insurance policies.

Does 22:1220 apply to persons other than the insured?

The question was answered in the affirmative in *Theriot v. Midland Risk Insurance Company*, (La. 1997) WL 261359

There is no question that La. R.S. 22:1220B(1)-(5) and La. R.S. 22:658 do statutorily create certain limited causes of action in favor of third-party claimants that derogate from established rules of insurance law. However, the expression of legislative intent in those instances is express and unambiguous. In the absence of an equally clear expression of legislative will, we are to adopt a more expansive interpretation of La. R.S. 22:1220 that would drastically affect the traditionally accepted relationships among insureds, insurers and claimants by imposing on insurers a broad, undefined duty to attempt settlement with third parties.

In sum, a reading of La. R.S. 22:1220 that results in a limited expansion of third-party rights, rather than the drastic expansion advocated by plaintiff, is the most reasonable interpretation of the statute based on its language and structure. It is also the interpretation most in keeping with the spirit of the 1990 amendments to La. R.S. 22:658, the minutes of available committee meetings, the legislative history of La. R.S. 22:1220, the principle of interpretation that penal statutes are to be strictly construed and the maxim that when a new law substantially derogates from accepted principles, the interpretation that least departs from established law should be adopted.

For all of the foregoing reasons, we conclude that although a right of action is available to both insureds and third-party claimants under La. R.S. 22:1220, only the commission of the specific acts listed in La. R.S. 22:1220B can support a private cause of action for breach of the statute.

And lastly, **Read the Policy.**