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INSURANCE LAW UPDATE

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ETHICS OPINION 669: A TEXAS DEFENSE ATTORNEY HIRED BY AN INSURANCE CARRIER TO DEFEND AN INSURED IN A LAWSUIT IS NO LONGER ABLE TO INFORM THE INSURANCE CARRIER THAT THE INSURED IS FAILING TO COOPERATE IN THE DEFENSE OF THE LAWSUIT.

The Professional Ethics Committee for the State Bar of Texas was recently presented with the following question: Under the Texas Disciplinary Rules of Professional Conduct, may a lawyer retained by an insurance company notify the insurance company that the insured client he was assigned to represent is not cooperating in the defense of the client's lawsuit?

In an opinion issued in March 2018, the Committee concluded that a defense attorney hired by an insurance company to defend one of the company's insureds cannot inform the insurance company that the client is failing to cooperate in the defense of the lawsuit. The Committee reasoned that the client's non-cooperation was, at the very least, non-privileged but confidential client information, which cannot be disclosed to third parties without the client's consent. The Committee noted that the attorney may move to withdraw from the representation, without revealing any confidential client information, and may inform the insurance company of the withdrawal.

THE TEXAS SUPREME COURT WITHDREW ITS LANDMARK *MENCHACA* OPINION AND ISSUED A NEW OPINION CONTAINING THE SAME LEGAL PRICINPLES AND RULES BUT FURTHER ADDRESSING THE PROCEDURAL EFFECTS OF THE LEGAL PRINCIPLES.

In *USAA Texas Lloyds Co. v. Menchaca*, the Texas Supreme Court withdrew its judgment and opinion of April 7, 2017 and issued a new opinion in its place. 545 S.W.3d 479 (Tex. 2018). The Texas Supreme Court began its opinion stating that the justices "unanimously reaffirm the legal principles and rules announced" in the first *Menchaca* opinion, "but we disagree on the procedural effect of those principles in this case." The dispositive issue in the second *Menchaca* opinion is whether an insured "can recover policy benefits based on the insurer's violation of the Texas Insurance Code even though the jury failed to find that the insurer failed to comply with its obligations under the policy." *Id.* at *1.

In the underlying lawsuit, the insured's home was damaged by Hurricane Ike. The insured made a claim on her homeowner's policy with USAA. USAA denied the claim twice.

Menchaca sued for breach of contract and Insurance Code violations. Three questions were submitted to the jury:

> Question 1: Did USAA fail to comply with the terms of the insurance policy with respect to the claim for damages filed by Gail Menchaca resulting from Hurricane Ike? **No.**
>
> Question 2: Did USAA engage in various unfair or deceptive practices, including failing to pay a claim without conducting a reasonable investigation with respect to that claim? **Yes.**
>
> Question 3: Determine the amount of damages resulting from USAA's failure to comply with the policy or its statutory violations calculated as the difference between the amount USAA should have paid for the damages and the amount actually paid? **$11,350.00.**

The jury found that USAA did not breach Menchaca's policy. But it also found that USAA violated the Insurance Code by failing to conduct a reasonable investigation before denying the claim and awarded the same amount of damages that would have been owed had USAA covered the claim. The trial court entered judgment for Menchaca (disregarding the jury's finding of no breach) and the court of appeals affirmed.

The Texas Supreme Court in its second *Menchaca* opinion, reaffirmed the five rules it asserted governing "the relationship between contractual and extra-contractual claims" in first-party cases:

(1) The General Rule: An insured may not recover policy benefits for an insurer's statutory violation if it has no right to those benefits under the policy.

(2) The Entitled-To-Benefits Rule: If an insured establishes a right to receive policy benefits, it may recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the loss of the benefits.

(3) The Benefits-Lost Rule: Even if the insured has no present contractual right to policy benefits, it may recover benefits under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right.

(4) The Independent Injury Rule: If the insurer's statutory violation causes an injury independent from the loss of policy benefits, the insured may recover damages for that injury even if it has no right to benefits under the policy.

(5) The No-Recovery Rule: An insured may not recover damages for a carrier's Insurance Code violation if the insured had no right to receive benefits and sustained no independent injury.

In its motion for rehearing, USAA requested that the Texas Supreme Court provide additional guidance on how parties should submit claims for policy benefits to a jury, especially when the insured seeks both breach-of-contract damages and damages for statutory violations of

the insurance code. The Court noted, however, that there is no single proper submission of the issue, as the inquiry depends on the disputed facts and issues in each case.

Trial Court's disregard of jury's answer to Question 1

With respect to the actual questions asked the jury in the underlying Lawsuit, the Supreme Court concluded that the lower court erred in disregarding the jury's answer to question 1. Rather, the supreme court suggested that the trial court should have either submitted only Question 2 (to establish that USAA violated the statute) and Question 3 ("to establish *both* that the statutory violation caused Menchaca actual damages in the form of policy benefits *and* that USAA breached the contract by failing to pay benefits Menchaca was entitled to under the policy") or, in the alternative, ask the jury first "whether Menchaca was entitled to receive benefits under the policy, and then condition[] the remaining questions on a 'Yes' answer to that first question." *Id.* at *16.

Effect of Questions 2 and 3

With respect to the jury's answers to Question 2 and 3, the Supreme Court concluded that the answers to Question 2 and 3, put together, included all necessary elements of Menchaca's Insurance Code claims including (1) that USAA violated the Insurance Code; (2) that the violation caused Menchaca to lose policy benefits to which she was entitled; and (3) that the benefits she was entitled to receive were in the amount of $11,350. In other words, the "jury's finding that USAA's statutory violation resulted in Menchaca's loss of $11,350 in policy benefits that USAA 'should have paid' necessarily constitutes a finding that Menchaca was entitled to receive those benefits under the policy." *Id.* at *19.

Fatal Conflict between Question 1, and Questions 2 and 3

The supreme court noted that the jury's answer to Question 3 (that USAA "should have paid" $11,350 in policy benefits to Menchaca) "necessarily addresses the same material fact as its answer to Question 1 (USAA 'failed to comply with the terms of the insurance policy'), because both requested findings on whether USAA failed to pay benefits Menchaca was entitled to under the policy." *Id.* at *21 (cleaned up). "The answers conflict because if USAA 'should have paid' Menchaca benefits under the policy and did not, then USAA necessarily failed to comply with the policy's terms." *Id.* Although the Court concluded that such a conflict did not constitute fundamental error and was not wholly preserved for appeal, the court concluded that, "in light of the parties' obvious confusion regarding our precedent and the clarifications we provide today", the interests of justice required remand for a new trial. *Id.* at *17.

The Texas Supreme Court rules that hospitals' discounted rates are relevant to determining what a "reasonable rate" is under Texas Hospital Lien laws.

A new decision from the Texas Supreme Court will force hospitals to show the difference in the reimbursement rates paid by insured patients and uninsured patients when they attempt to

recover costs from patients under Texas hospital lien laws. In *In re North Cypress Medical Center Operating Co*., -- S.W.3d --, No. 16-0851, 2018 WL 1974376 (Tex. April 27, 2018), Roberts was involved in a 2015 car accident and taken by ambulance to North Cypress Medical Center, where she was released after a series of tests and other emergency services. Because Roberts was uninsured, North Cypress billed her at the full "chargemaster" price, which totaled $11,037. North Cypress then filed a hospital lien against Roberts under the Texas Property Code, which allows hospitals to assert liens against causes of actions filed by people who receive emergency services for injuries caused by the negligence of another person.

The liability insurer of the driver at fault offered to settle Roberts' claim for $17,380, attributing $9,404 to past medical expenses. Roberts sought a reduction of North Cypress's bill and the parties negotiated but could not reach an agreement on the bill's amount. Roberts then sued North Cypress seeking a declaratory judgment that the hospital's charges were unreasonable and its lien invalid to the extent the amount exceeds a "reasonable and regular rate" as is required by the hospital lien statute.

During discovery, Roberts requested that North Cypress produce documents indicating the reduced rates for services provided to patients covered by numerous insurance companies. North Cypress objected to the discovery requests and moved for a protective order asserting that Roberts' request was seeking irrelevant information and was overly broad.

The trial court ordered North Cypress to produce the information, but narrowed the request to a specific time period. After North Cypress's petition for writ of mandamus with Houston's 14th Court of Appeals was denied, the hospital sought relief in the Texas Supreme Court. The issue before the supreme court was whether the reimbursement rates paid by insured patients were relevant to Roberts' case. In a 6-3 decision, the Texas Supreme Court ruled that North Cypress had to disclose its insured patient reimbursement rates to Roberts.

"The reimbursement rates sought, taken together, reflect the amounts the hospital is willing to accept from the vast majority of its patients as payment in full for such service" and "while not dispositive, such amounts are at least relevant to what constitutes a reasonable charge." *Id*. at *1. The court reasoned that "… reimbursements from insurers and government payers comprise the bulk of a hospital's income for services rendered" and that it "defies logic to conclude that those payments have nothing to do with the reasonableness of charges to the small number of patients who pay directly." *Id*., at *6.

THE AUSTIN COURT OF APPEALS CONCLUDES THAT A POLICY ALLOWING AN INSURER TO "SETTLE OR DEFEND, AS WE CONSIDER APPROPRIATE, ANY CLAIM OR SUIT ASKING FOR THESE DAMAGES" GIVES THE INSURER THE RIGHT TO SETTLE A LAWSUIT WITHOUT ITS INSURED'S CONSENT.

In *Juan A. Martin-de-Nicolas v. AAA Texas County Mut. Ins. Co.*, the Austin Court of Appeals considered whether an automobile liability insurer had the right to settle a lawsuit asserted against its insured, without the insured's consent, and prior to an adjudication of liability against the insured in the underlying lawsuit. No. 03-17-00054-CV, 2018 WL 1868048 (Tex.

App.—Austin Apr. 19, 2018, no pet. h.) (memo op.). The underlying lawsuit arose out of car accident. Martin-de-Nicolas struck another vehicle that was parked on the side of the road, facing opposite oncoming traffic. Martin-de-Nicolas sued the owner of the parked car claiming its owner, Jones, parked negligently to face oncoming traffic in violation of the Texas Transportation Code. At trial, the Justice Court determined that Jones was not negligent, Martin-de-Nicolas was 100% responsible, and should recover zero damages.

Martin-de-Nicolas filed a second suit against his insurer, AAA Texas County Mutual Insurance Co., which settled Jones's separate lawsuit for negligence and property damage against Martin-de-Nicolas. Martin-de-Nicolas instructed AAA to refuse to pay any damage claim made by Jones against him while Martin-de-Nicolas's claims were pending against Jones. AAA, in fact, settled Jones's claim against Martin-de-Nicolas without Martin-de-Nicolas's consent. In response, Martin-de-Nicolas filed suit against AAA for violations of the Texas Deceptive Trade Practices Act and Chapter 541 of the Texas Insurance Code. AAA moved for summary judgment on the ground that the DTPA and Chapter 541 do not apply to "this set of facts' in which the express terms of the insurance policy allow AAA to settle claims, including the one at issue, that it deemed appropriate." *Id.* at *1.

The language of the policy attached by AAA to its motion for summary judgment provided: "We will pay damages for bodily injury or property damage for which any covered person becomes legally responsible because of an auto accident . . . .We will settle or defend, as we consider appropriate, any claim or suit asking for these damages." *Id.* at *4. Martin-de-Nicolas argued that the trial court erred in granting summary judgment because the language of the policy did not authorize AAA to settle a claim made by Jones against Martin-de-Nicolas. Martin-de-Nicolas argued that the policy was ambiguous because it required AAA to pay damages for which the insured "is legally liable" which creates an ambiguity with AAA's "right to settle" because Martin-de-Nicolas was not liable or responsible for paying damages. The court disagreed noting that:

> Martin-de-Nicolas's construction would *prohibit* AAA from paying on a claim after making its own assessment of the claim even if, as happened in the first suit filed by Martin-de-Nicolas, a trial court has determined that its policyholder caused the damages and was legally liable. That construction would run contrary to the statutory requirement imposed on insurers to pay damages that a policyholder has "become legally obligated to pay." *Id.* at *6.

Thus, the Austin Court of Appeals concluded that Martin-de-Nicolas's construction was unreasonable, that AAA's construction was reasonable, and there was no need to construe the Policy in favor of coverage. Accordingly, the court held that the "policy affords AAA the discretion to settle claims made against its insured . . . without the insured's consent and without the need for a judicial determination regarding whether its insured was legally liable for the damages." *Id.* at *7.

Corpus Christi Court of Appeals concludes default judgment is not enforceable against auto insurer due to no notice defense.

In *Rebecca Leigh Flores, et al. v. State Farm Mutual Insurance Company*, No. 13-17-00167-CV, 2018 WL 2731883 (Tex. App.—Corpus Christi June 7, 2018, no pet. h.) (memo. op.) Rebecca Leigh Flores and Fernando Medina were involved in a vehicle collision with Vanessa Hernandez, who was driving a vehicle insured under an automobile liability policy issued by State Farm Mutual Automobile Insurance Company. State Farm received notice that Ms. Flores and Mr. Medina had retained counsel in relation to the accident. State Farm then sent a letter to Ms. Hernandez advising her that Ms. Flores and Mr. Medina were represented by counsel and instructing her to notify State Farm if she "receive[d] any contact from this attorney or their representatives[.]" *Id.* at *1. Ms. Flores and Mr. Medina later sued Ms. Hernandez for negligence and obtained a default judgment. Ms. Hernandez did not forward the lawsuit to State Farm and did not otherwise notify State Farm that she had been sued. Thereafter, Ms. Flores and Mr. Medina sued State Farm, seeking to collect on the default judgment they had obtained against Ms. Hernandez. Ms. Flores and Mr. Medina moved for summary judgment, arguing that the judgment they had obtained against Ms. Hernandez made them third-party beneficiaries with respect to the insurance policy State Farm had issued to Ms. Hernandez. State Farm filed a response, arguing that it had no duty to defend under the policy because Ms. Hernandez had not complied with the policy's notice-of-suit provisions. State Farm moved for summary judgment. The trial court granted summary judgment in favor of State Farm, and Ms. Flores and Mr. Medina appealed.

The State Farm policy provided:

> **PART E — DUTIES AFTER AN ACCIDENT OR LOSS**
> A. We must be notified promptly of how, when and where the accident or loss happened. Notice should also include the names and addresses of any injured persons and of any witnesses. If we show that your failure to provide notice prejudices our defense, there is no liability coverage under the policy.
> B. A person seeking any coverage must:
> 1. Cooperate with us in the investigation, settlement or defense of any claim or suit.
> 2. Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
> . . . .
> **LEGAL ACTION AGAINST US**
> A. No legal action may be brought against us until there has been full compliance with the terms of this policy. . . .

Id.

In its decision, the appellate court explained that, generally speaking, an injured person cannot sue the tortfeasor's liability insurer directly until the tortfeasor's liability has been determined by agreement or judgment. After judgment, the appellate court continued, the injured

person can sue the insurer as a third-party beneficiary of the insurance policy. The appellate court added that, as a third-party beneficiary, the injured party "steps into the shoes" of the tortfeasor and is bound by the policy's conditions precedent – including its notice provision. Here, the appellate court pointed out, Ms. Hernandez had not complied with the notice requirements in the State Farm policy. Moreover, State Farm was unaware of the lawsuit filed by Ms. Flores and Mr. Medina against Ms. Hernandez until after judgment had been rendered. Therefore, the appellate court ruled, State Farm had no duty to defend or indemnify Ms. Hernandez in the underlying litigation and was not liable to Ms. Flores and Mr. Medina under the policy. In addition, the appellate court added, State Farm had established prejudice as a matter of law because it had not been notified of the default judgment against Ms. Hernandez until after the default judgment had become final and nonappealable. Accordingly, the appellate court concluded that the trial court had properly granted State Farm's motion for summary judgment.

FIFTH CIRCUIT COURT OF APPEALS HELD THAT FORTUITY DOCTRINE BARRED COVERAGE FOR DEFENSE AND INDEMNITY BASED ON ALLEGATIONS IN LAWSUIT.

In *Wesco Insurance Company v. Layton*, the Fifth Circuit analyzed whether pleadings in an underlying lawsuit were sufficient to trigger the fortuity doctrine thereby precluding the insurer's duty to defend and indemnify its insured. 725 Fed.Appx. 289, No. 17-10362, 2018 WL 1472937 (5th Cir. Mar. 26, 2018). In that case, Gwendolyn Gene and Troylynn Ann Layton (together, the "Laytons") filed a lawsuit in Texas state court against Ledford E. White, among others, on August 16, 2013, alleging common-law and statutory fraud, negligent misrepresentation, breach of contract, and breach of fiduciary duty, among other claims.

Specifically, the Laytons alleged that White—their longtime attorney, advisor, and friend—had defrauded and stolen from them in connection with two transactions. First, the Laytons loaned White, at his request, nearly $400,000 to develop a property in Crowley, Texas. According to the Laytons' original petition, White never repaid those loans and lied about the existence of mineral rights on the property, even though he collected tens (if not hundreds) of thousands of dollars through the lease and sale of mineral interests. Second, White persuaded the Laytons to lend money to another of White's clients to invest in his used car business. White represented that he would act as an intermediary to facilitate loans totaling $400,000 and would personally hold car titles to ensure the Laytons were repaid. Payments stopped after the Laytons had received roughly $50,000 in principal and interest. White assured the Laytons he would pursue the borrower, and even told them (falsely) that their loan was secured by the borrower's house. He then told the Laytons he had foreclosed on the borrower's house but could not repay them because the house had diminished in value. According to the Laytons' original petition, these were all lies. The borrower had long since repaid the loan, and White had, in fact, pocketed the money for himself.

The Laytons' original petition repeatedly emphasized that White was an attorney. It described White as "a board certified real estate attorney who has served as the Laytons'

attorney, trusted advisor and confidant." The very first paragraph of the petition's "Factual Background" section reiterated that allegation. In stating their common-law fraud cause of action, the Laytons alleged that White owed them fiduciary duties because of both their friendship and attorney-client relationship. Moreover, in alleging breach of fiduciary duty, the Laytons explained first that White owed them a fiduciary duty because of their attorney–client relationship, only then adding that they also had a long-standing friendship. With respect to the used-car transaction, the Laytons alleged that White owed them fiduciary duties because he served as an intermediary, receiving money for their benefit.

On May 30, 2014, the Laytons filed an amended petition. Their amended petition asserted a negligence cause of action against White for failure to act reasonably in his role as attorney, advisor, and confidant to the Laytons. They alleged, among other things, that White was negligent for failing to reveal the extent of his conflicts of interest to them and failing to obtain the Laytons' written consent before entering into a transaction with them. The amended petition also added White's firm, Ledford E. White, P.C. ("White, P.C."), as a defendant. The amended petition concerned the same allegedly fraudulent transactions as the original petition. However, with respect to the used car transaction, the amended petition specifically alleged White provided "shoddy" legal advice and that White promised the Laytons he would hold their money in his firm's escrow account.

The jury ultimately found White and White PC liable, awarding actual damages in the total amount of $680,000.

After the Laytons filed their lawsuit, White (on behalf of himself and White PC) purchased a claims-made-and-reported Lawyers Professional Liability Policy (the "Policy") from Wesco Insurance Company. The Policy included the following "condition precedent" to coverage:

> 1. The **Insured**, as a condition precedent to the obligations of the Company under this policy, shall give written notice to the Company during the policy period:
>
> a. of any claim made against the **Insured** during the policy period;
>
> b. of the **Insured**'s receipt of any notice, advice or threat, whether written or verbal, that any person or organization intends to make a claim against the **Insured**;
>
> c. Any act or omission that may reasonably be expected to be the basis of a claim against the **Insured**.

The Policy defined "claim" as follows: "'Caim' means a written or verbal demand received by the Insured for money or services arising out of an act or omission ... in rendering of failing to render legal services. A demand shall include the service of suit...." Under the Policy, "legal services" including, among other things, services performed "in a fiduciary capacity."

White first submitted the Laytons' original petition (filed August 16, 2013) to Wesco on May 8, 2014. Wesco's Federal Rule of Civil Procedure 30(b)(6) representative testified that Wesco denied coverage because the claim was first made prior to the beginning of the policy

period. Wesco alternatively based its denial of coverage on the position that White and White, P.C.'s acts did not involve "legal services." The Laytons' counsel subsequently submitted their amended petition to Wesco to place it on notice. Wesco once more denied coverage and subsequently filed a declaratory judgment action, seeking a declaration of no coverage under the Policy.

The Fifth Circuit noted that whether the fortuity doctrine applied to preclude coverage under the Policy depended on whether the Laytons' first petition alleged sufficient facts to put White on notice that a loss had occurred before the Policy's coverage period had begun. The Fifth Circuit concluded that the allegations in the first petition were more than sufficient to put White on notice of an ongoing, potential loss, reasoning:

> The Laytons' original petition was sufficient to put White on notice of an "ongoing loss" at the time the Policy was purchased. The original petition contained a breach of fiduciary duty claim—a claim falling directly within the Policy's definition of legal services. Moreover, the original petition was replete with references to White's status as an attorney. It identified White as an attorney in its preliminary statement and then again just one paragraph later in the very first paragraph of the Factual Background section. Two of the causes of action alleged White owed the Laytons a fiduciary duty as their attorney.

The Fifth Circuit further concluded that such knowledge may also be imputed to White PC, and that it was immaterial whether White "believed" a covered claim existed. Accordingly, the fortuity doctrine applied to preclude coverage for White PC.

FIFTH CIRCUIT COURT OF APPEALS HELD THAT WHETHER DEATH FROM A MOSQUITO BITE IS "ACCIDENTAL" IS A QUESTION FOR THE JURY.

In *Wells v. Minnesota Life Insurance Company*, plaintiff filed suit claiming accidental death benefits under a policy with Minnesota Life after her husband was bitten by a mosquito carrying West Nile Virus and passed away. 885 F.3d 885, No. 16-20831, 2018 WL 1417647 (5th 2018). The Fifth Circuit reversed the district court's dismissal of the complaint based on summary judgment, holding that there were genuine disputes of material fact as to whether the husband's death was accidental and thus covered under the policy, and whether there were other causes of his death. Accordingly, the court remanded for a factfinder to decide determinative facts of plaintiff's breach-of-contract claim. However, the court affirmed the district court's dismissal of the bad-faith tort claim because Minnesota Life had a reasonable basis for denying the claim.

In *Wells*, Melton Dean Wells, age 68, went to the hospital on August 21, 2013, with a history of obesity, diabetes, and hypertension. He was suffering from a fever, headache, and altered mental status, and the doctors ultimately diagnosed him with West Nile Encephalitis ("WNE"). West Nile Virus ("WNV"), carried and transmitted to humans by the Culex mosquito, causes WNE. Over the next three weeks, Melton's condition deteriorated as he developed respiratory failure, multi system organ failure, and septic shock. He died on September 17. The certifying physician marked Melton's death as "natural", in contrast to an "accident," on the CDC.

At all times relevant to this appeal, Melton had a Decreasing Term Accidental Death Insurance Policy ("the policy") from Minnesota Life Insurance Company ("Minnesota Life"), which provides coverage

> only when your death results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a visible contusion or wound.... The bodily injury must be the sole cause of your death.... Your death must occur within 90 days after the date of the accidental injury.

But even if a death falls within that insuring clause, coverage may still be excluded. Important here, Exclusion Four reads:

> In no event will we pay the accidental death benefit where your death is caused directly or indirectly by, results from, or there is contribution from ... bodily or mental infirmity, illness or disease....

Following Melton's death, his wife submitted a claim under the policy for payment of accidental-death benefits. Minnesota Life denied her claim, explaining it had received no information to support that Melton's death resulted directly or indirectly from any accidental bodily injury sustained. Instead, it was Minnesota Life's position that the WNE was exacerbated by Melton's diabetes, morbid obesity and age and, therefore, his death was due or there were contributions from bodily or mental infirmity, illness or disease, which is excluded under the policy.

As to the mosquito bite being accidental, the Fifth Circuit concluded there was a fact issue because there was evidence that the wife was shocked at the bite, testimony that the cause of Melton's death was accidental bodily injury, and the fact that Melton's WNV is assignable to an unnatural, determinate act (according to the Fifth Circuit). In other words, a jury could conclude that the bite was unintended, unexpected, and unforeseen—that is, an accidental bodily injury under the policy. In addition, the Fifth Circuit concluded that the wife's construction of the sole cause provision—that is, that ancillary complications cannot themselves serve as concurrent proximate causes of an accidental death where those complications arose directly from, and only because of, the accident—was reasonable. Consequently, a fact finder may find the mosquito bite was the sole proximate cause of Melton's death.

The U.S. Court of Appeals for the Fifth Circuit has ruled that a $20 million judgment against a restaurant that committed the criminal act of giving alcohol to a minor was not covered by the restaurant's commercial general liability insurance policy.

In *Century Surety Company v. Seidel*, -- F.3d. --, No. 17-10026, 2018 WL 3115781 (5th Cir. June 25, 2018), Ajredin Deari, owner of Pastazios Pizza, Inc., allegedly lured an 18-year-old woman to his restaurant, plied her with alcohol despite her protests, and then drove her to a nearby hotel and sexually assaulted her. Deari later pleaded no-contest to the crime of aggravated assault. The woman sued Deari (alleging a variety of intentional torts) and the Pastazios restaurant (alleging negligence, gross negligence, Dram Shop liability, false imprisonment, and premises liability). She obtained a judgment for more than $20 million against Pastazios and Deari. With respect to Pastazios, the court found the restaurant liable for gross negligence, Dram Shop liability, and "negligent" false imprisonment, and imposed punitive damages.

The woman sought to enforce the judgment against the restaurant's general liability insurance carrier, Century Surety Company, asserting that Century had breached its duties under the policy to defend and to indemnify Pastazios with respect to her lawsuit. The U.S. District Court for the Northern District of Texas granted summary judgment in favor of Century, and the woman appealed to the Fifth Circuit.

The Century policy excluded coverage for bodily injury: arising out of or resulting from a criminal act committed by any insured. The Fifth Circuit affirmed, holding that because all of the woman's injuries arose out of or resulted from the restaurant's criminal act of giving alcohol to a minor, the policy's criminal act exclusion applied and barred Pastazios' coverage claims.

In its decision, the circuit court noted that the policy did not define "crime" and, therefore, turned to Couch on Insurance to conclude that a misdemeanor is a crime. The court explained that, in Texas, it was a Class A misdemeanor to give alcohol to a minor in the absence of her parents. The Fifth Circuit noted that the woman's complaint against Pastazios stated that she was a minor and that Pastazios, the restaurant itself, had given her more than one alcoholic beverage. Thus, the Fifth Circuit found, the woman's bodily injury arose out of or resulted from a criminal act committed by Pastazios, the insured. In fact, the circuit court said, the woman's complaint was "unequivocal" that all of her injuries arose out of Pastazios' provision of alcohol. Accordingly, the Fifth Circuit concluded, coverage was precluded because all of the woman's injuries arose out of or resulted from Pastazios' criminal act of giving alcohol to a minor.

The U.S. Court of Appeals for the Fifth Circuit affirms summary judgment in wind/hail case, enforcing concurrent cause doctrine.

In *Certain Underwriters at Lloyd's of London v. Lowen Valley View, LLC*, 892 F.3d 167 (5th Cir. June 6, 2018), an employee of the insured (Hilton Garden Inn) noticed that the shingles on the roof "looked bad" and called a contractor to investigate. The contractor discovered evidence of significant hail damage, and the owner/operator of the hotel notified its insurance agent of the damage. The agent filed a notice of loss with the property insurer, Lloyd's, the same day, listing the date of loss as June 13, 2012—about a year and a half prior to the date of notice. The agent based the date of loss on a weather history report that listed nine separate hail events of varying severity between January 2006 and December 2014.

After receiving the claim, Lloyd's sent an adjuster to inspect the property. The adjuster determined that the roof would need to be replaced at an estimated cost of $429,000. Lloyd's then retained an engineering firm to analyze the claim. The engineering firm confirmed that the damage was caused by hail and concluded that the most recent hailstorm with hailstones large enough to cause the damage was on June 13, 2012. In a second report, the engineering firm described its first report as concluding that the damage "most likely" occurred on June 13, 2012. Lloyd's then denied the claim and—the same day—filed a lawsuit seeking a declaratory judgment that it owed no coverage to the insured. After the lawsuit was filed, Lloyd's engineering firm identified four different dates on which hail reports and weather radar data suggested there was hail at the location of the hotel. Only one of those four dates, June 13, 2012, fell within the relevant policy period, and the policyholder had no proof of when the damage actually occurred. The only evidence that it happened on June 13, 2012, was the engineering firm's comment that the damage "most likely" occurred on that date, and the engineering firm stated that it never intended to suggest that June 13, 2012, was the known date of loss. The insurance carrier moved for summary judgment.

The trial court granted the carrier's motion for summary judgment based on the concurrent cause doctrine (i.e., when a covered and non-covered peril combine to cause damage, the insured bears the burden of demonstrating how much of the damage was caused solely by the covered peril). The Fifth Circuit agreed, stating, "Given the undisputed evidence of severe hail storms outside the coverage period, Lowen Valley's evidence does not afford the jury a reasonable basis on which to allocate the damage." *Id.* at 172. The court went on to affirm the dismissal of the insured's extra-contractual claims as well, relying on *Menchaca* for the proposition that "an insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits." *Id.* (citing *USAA Tex. Lloyds Co. v. Menchaca*, 14-0721, 545 S.W.3d 479, 489, 2018 WL 1866041, at *5 (Tex. Apr. 13, 2018)).

WESTERN DISTRICT OF TEXAS HOLDS THAT DAMAGES RESULTING FROM A COLLISION THAT WAS CAUSED BY A DRIVER OPERATING A VEHICLE WHILE INTOXICATED ARE THE NATURAL AND PROBABLE CONSEQUENCE OF A DELIBERATE ACT AND, THEREFORE, ARE NOT THE RESULT OF ACCIDENTAL CONDUCT AS REQUIRED TO TRIGGER COVERAGE UNDER AUTOMOBILE LIABILITY INSURANCE POLICY.

In *Frederking v. Cincinnati Insurance Company*, the Western District addressed whether there was coverage under an employer's policy for damages arising from an employee's drunk driving. No. SA-17-CV-651-XR (W.D. Tex. Mar. 27, 2018) (slip opinion). In that case, Plaintiff Richard Bret Frederking allegedly suffered serious personal injuries in a motor vehicle collision that was caused by Carlos Xavier Sanchez. Sanchez was allegedly operating a motor vehicle owned by his employer, Advantage Plumbing Services ("Advantage"), at the time of the collision. Advantage was the named insured under a Business Auto Coverage insurance policy issued by Defendant that was in full force and effect at the time of the collision.

Plaintiff filed suit against Sanchez and Advantage in state court in the case *Richard Brett Frederking v. Carlos Xavier Sanchez and Advantage Plumbing Services, Ltd.*, No. 2015-CI-060614 (224th Dist. Ct., Bexar County, Tex. Apr. 10, 2015) (the "Underlying Lawsuit"). In that case, Plaintiff alleged Sanchez drove while intoxicated, failed to yield the right-of-way at an intersection, and struck Plaintiff's vehicle. Sanchez was arrested after the collision, taken to the Bexar County jail, later pled guilty to criminal charges of driving while intoxicated, and admitted his actions or inactions were the cause of the collision.

Because Plaintiff alleged that at the time of the wreck, Sanchez was operating a vehicle owned by and assigned to him by his employer, Advantage, Plaintiff sued both Sanchez and Advantage. Plaintiff brought claims for negligence, gross negligence, respondeat superior, and negligent entrustment. Defendant Cincinnati Insurance Company defended Sanchez and Advantage in the Underlying Lawsuit under a reservation of rights. The trial court granted Advantage partial summary judgment and dismissed the respondeat superior claim, finding that Sanchez did not act in the course and scope of his employment for Advantage at the time of the collision. The jury considered claims of negligence and gross negligence against Sanchez and a claim of negligent entrustment against Advantage. The jury found that Sanchez was negligent and that Advantage was negligent under the theory of negligent entrustment. The jury also found that Sanchez was grossly negligent. Plaintiff was awarded $137,025.00 in compensatory damages and interest, jointly and severally, against Sanchez and Advantage. Plaintiff was further awarded $207,550.00 in punitive damages with interest against Sanchez.

Defendant paid Plaintiff an amount of $153,086.94 in satisfaction of the full amount of the compensatory damages awarded against Advantage and Sanchez jointly and severally. Plaintiff then fully released Advantage from the judgment against it. Plaintiff also partially released Sanchez from the compensatory portion of the judgment, but not from the punitive damages portion resulting from the finding of gross negligence.

Plaintiff filed a declaratory judgment action against Cincinnati, attempting to collect the award of punitive damages in the underlying lawsuit. Plaintiff sought, among other declarations, a declaration that Cincinnati was contractually obligated to pay the punitive damage award from the underlying lawsuit. Cincinnati, on the other hand, denied it was obligated to pay the punitive damage award.

Assuming Sanchez was an "insured" under the Auto and Umbrella Policies at the time of the collision, the district court addressed whether there was a genuine dispute of material fact as to whether the Policies covered the punitive damages awarded for the finding of gross negligence in the Underlying Lawsuit. The district court noted that the policies' insuring agreements required accidental conduct in order to be triggered. Moreover, the district court pointed out that the Fifth Circuit has held that a deliberate act is not an accident if (1) the resulting damage was 'highly probable' because it was 'the natural and expected result of the insured's actions,' (2) "the insured intended the injury," or (3) the insured's acts constitute an intentional tort, in which case, the insured is presumed to have intended the injury.

It was undisputed that there was no finding that Sanchez intended the injury or that his actions constituted an intentional tort. Instead, Cincinnati argued that the resulting damage from the collision was "highly probable" because a car collision is "the natural and expected result" following the deliberate act of becoming intoxicated and operating a vehicle. Plaintiff, however, argued that Sanchez's conduct constituted an "accident" under Texas law because the collision that resulted from Sanchez's conduct was not intended or expected.

After noting that the jury found Sanchez acted with gross negligence, the district court discussed two cases in which Texas state courts had concluded the consequences of an insured's deliberate acts were highly probable and, therefore, not accidental. For example, in *Trinity Universal Ins. Co. v. Cowan*, the Supreme Court of Texas considered principles similar to those at issue in *Frederking*. A photo lab clerk received a roll of film containing revealing pictures of the plaintiff, made extra prints, took them home, and later showed them to friends. *Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 820 (Tex. 1997). The clerk left the photos with one friend whom he told to throw the photos away, but that friend showed the photos to another person who was a friend of the plaintiff. *Id.* at 820–21. The plaintiff sued the clerk for negligence and gross negligence. *Id.* at 821. The clerk's homeowners' insurance carrier defended the clerk under a reservation of rights, and the clerk was found negligent and grossly negligent. *Id.* On appeal, the insurance provider argued that the clerk's conduct was not a covered "occurrence under the policy." *Id.*

The *Cowan* court found that the clerk intentionally copied the plaintiff's photographs and showed them to friends, even though the clerk testified that he did not intend for the plaintiff to learn of his actions. *Id.* The court held that the clerk's conduct was not an "accident" because "[h]e did exactly what he intended to do when he purposefully copied the photographs and showed them to his friends," and the fact that he didn't intend the plaintiff to learn of his actions "is of no consequence" to that determination. *Id.* at 827–28. The court held that the plaintiff's invasion of privacy was of a type that "ordinarily follow[s]" from the clerk's conduct and the resulting injuries could be "reasonably anticipated from the use of the means, or an effect" that

the clerk could "be charged with ... producing." *Id.* at 828 (quoting *Republic Nat. Life Ins. Co. v. Heyward*, 536 S.W.2d 549, 555–56 (Tex. 1976)).

Similarly, in *Wessinger v. Fire Ins. Exchange*, the court held that after the plaintiff voluntarily became intoxicated, deliberately repeatedly hit the victim in the head, and severely injured the victim's eye, the conduct did not constitute an "accident" under the insurance policy. *Wessinger v. Fire Ins. Exch.*, 949 S.W.2d 834, 841 (Tex. App.—Dallas 1997, no writ). The court stated that, although being intoxicated may explain why the plaintiff violently attacked the victim, "it does not change the fact that punching or striking [the victim] was a voluntary and intentional act and thus not accidental." *Id.* The court further held that the victim's eye injuries following the plaintiff striking him in the head, regardless of how serious the injuries actually were, may be reasonably anticipated, and ought to be expected, such that the conduct was not a covered accident or occurrence. *Id.*

Similar to the findings in *Cowan* and *Wessinger*, the district court concluded that Sanchez's collision with Plaintiff and Plaintiff's resulting injuries were the natural and expected result from a driver operating a vehicle while intoxicated. The district court reasoned that just as the clerk in *Cowan* intended to make copies of the photographs and the plaintiff in *Wessinger* intended to hit the victim in the head, Sanchez intentionally became intoxicated and operated a vehicle. The district court noted that although Sanchez may not have intended to get in an automobile collision or cause injuries to Plaintiff, similar to how an invasion of privacy ordinarily follows from making unauthorized copies of photographs and an eye injury ordinarily follows from striking someone's head, a car collision and injuries to another driver ordinarily follow from someone driving while intoxicated. In other words, the collision and injuries were "highly probable."

Finally, Plaintiff argued that because the Policies stated that Cincinnati was obligated to pay "all sums" an insured must pay as damages due to bodily injury, Cincinnati must indemnify Sanchez for the punitive damages. The district court disagreed, noting that the Plaintiff's argument did not overcome the fact that under the Policies' language, Cincinnati was only required to indemnify an "insured" for an "accident" or "occurrence."

For the reasons stated above, the district court concluded that, under Texas law, Sanchez's conduct, which was found to be grossly negligent in the Underlying Lawsuit, was not an "accident" or "occurrence" to trigger coverage under the Policies. Accordingly, there was no genuine dispute of fact and Cincinnati was entitled to summary judgment that it had no duty to indemnify Sanchez for the punitive damages awarded from the gross negligence finding.

Southern District of Texas abates lawsuit for plaintiff's failure to comply with new insurance code section 542A.003 notice letter requirements.

In *Jose Luis Perrett v. Allstate Insurance Company*, No. 4:18-CV-01386, 2018 WL 2864132 (S.D. Tex. June 11, 2018), the insured sued Allstate Insurance Company alleging violations of the Texas Deceptive Trade Practices Consumer Protection Act, the Texas Insurance

Code, and breach of contract related to a claim arising from Hurricane Harvey. After Perrett filed in state court Allstate timely removed.

On October 10, 2017, Perrett's counsel sent Allstate a letter alleging that Allstate violated the Texas Insurance Code and the Texas Deceptive Trade Practices Act. Allstate moved to abate under § 542A.003 of the Texas Insurance Code, which requires plaintiffs seeking damages to give prior written notice of the complaint and the damages, including fees, "not later than the 61st day before the date a claimant files an action." Allstate argued that Perrett's notice did not include "a statement of the acts or omissions giving rise to the claims and the amount of reasonable and necessary attorney's fees incurred by the claimant" or a statement that a copy of the notice was provided to the claimant. Perrett argued that the notice satisfied the statutory requirements.

The Southern District (Chief Justice Lee Rosenthal) found that although the notice letter satisfied the requirements in § 542A.002(b), it did not satisfy § 542A.003(c)'s requirement that "[i]f an attorney or other representative gives the notice required under this section on behalf of a claimant, the attorney or representative shall: (1) provide a copy of the notice to the claimant; and (2) include in the notice a statement that a copy of the notice was provided to the claimant." Id. at *2. Perrett did not respond to Allstate's argument that the notice letter did not contain a statement that the letter was provided to Perrett. And because the letter did not satisfy this requirement, the case was abated until 60 days after Allstate receives proper written notice and Perrett was ordered to provide proper notice by June 18, 2018.