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2018 YEAR IN REVIEW
SIGNIFICANT INSURANCE DECISIONS IN 2018

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*, 545 S.W.3d 479 (Tex. 2018), the Texas Supreme Court withdrew its judgment and opinion of April 7, 2017 and issued a new opinion in its place. 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."

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 that govern "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."

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."

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." "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." 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.

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

In *In re North Cypress Medical Center Operating Co*., No. 16-0851, 2018 WL 197437, -- S.W.3d. -- (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." 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."

FIFTH CIRCUIT HOLDS THAT SETTLEMENT PROCEEDS RESULTING FROM INDEMNITY AGREEMENTS BETWEEN A GENERAL CONTRACTOR AND ITS SUBCONTRACTORS ARE "OTHER INSURANCE" AND MAY OFFSET AMOUNTS COVERED BY THE POLICY, PLACING BURDEN OF PROVING WHETHER PORTION OF SETTLEMENTS WERE COVERED UNDER POLICY ON THE INSURED.

In *Satterfield and Pontikes Const. Inc.*, 898 F.3d 574 (5th Cir. 2018), Satterfield and Pontikes Construction, Inc. ("S&P") was hired as a general construction contractor for a courthouse construction project by Zapata County, Texas. S&P hired numerous subcontractors.

According to the court, "the project did not go well" and Zapata County terminated S&P and retained new contractors to complete the construction. Zapata County sued S&P and the parties arbitrated their dispute. An arbitration panel found that S&P failed to build the courthouse in a good and workmanlike manner and that the courthouse suffered physical harm and damage. The panel awarded Zapata County over $8 million in damages, attorney fees, and arbitration costs.

S&P included its subcontractors in the arbitration, seeking money pursuant to the indemnification clauses in the subcontracts. With notice to its insurer, U.S. Fire, of its efforts to settle, S&P subsequently entered into settlement agreements with its subcontractors for approximately $4.4 million. The settlement agreements did not allocate the proceeds to the damages/liabilities they covered.

Because the settlements did not cover the arbitration award, S&P turned to its insurance providers, including its excess provider, U.S. Fire, to pay the balance of the arbitration award. U.S. Fire argued that it could not determine whether the funds S&P recovered from subcontractors of the courthouse project went to damages covered under U.S. Fire's policy because S&P failed to allocate those proceeds when settling with the subcontractors. U.S. Fire argued that if the subcontractor settlements were used to pay for damages covered under U.S. Fire's policy, then S&P would be getting a double recovery and would be unjustly enriched.

U.S. Fire, however, contended there was no shortfall for it to pay and denied S&P's claim. According to U.S. Fire, there was no shortfall because certain damages awarded by the arbitration panel (for mold remediation, attorney's fees, prejudgment interest, and arbitration fees) were not covered under its policy, and once those damages and another insurer's first layer of insurance were removed from the $8 million award, the subcontractor settlement proceeds (i.e. "Other Insurance" according to U.S. Fire) was greater than the amount of potentially covered damages under its policy.

S&P then sued U.S. Fire. The district court granted summary judgment in favor of U.S. Fire.

On appeal, S&P argued that the subcontractor settlements were not "Other Insurance" and, therefore, U.S. Fire was not entitled to use the settlement proceeds to offset amounts covered by its policy. Other Insurance" was defined in the policy as "any type of Self-Insurance or other mechanism by which an Insured arranges for funding of legal liability for which this policy also provides coverage."

S&P characterized the subcontractor settlements as the products of "contractual risk transfer mechanisms" arguing that the subcontractor indemnity contracts were intended to "shore up leaks or gaps in insurance coverage." The Fifth Circuit disagreed. The Court held that the plain language of the policy allowed it to affirm the district court. "An indemnity agreement falls under the plain language of the 'Other Insurance' provision of U.S. Fire's policy—which is very broad—because it is a 'mechanism by which an Insured arranges for funding of legal liabilities for which [U.S. Fire's] policy also provides coverage' and therefore, the settlement proceeds resulting from an indemnity agreement also count as "Other Insurance."

In a second issue on appeal, S&P argued that the district court erred when it placed the burden on S&P to show that the subcontractor settlements were allocated to either covered or noncovered damages under U.S. Fire's policy and that it had the right to allocate the subcontractor settlement proceeds to the damages not covered by U.S. Fire's policy. The Fifth Circuit disagreed, reasoning that S&P was in a better position to allocate the settlement proceeds. "U.S. Fire did not have the power to structure the settlements to attribute the proceeds to one kind of damages or another." Therefore, S&P had the burden of proof to show it properly allocated its settlement proceeds between covered and noncovered damages, and if S&P could not meet its burden, it is assumed that all of the settlement proceeds went first to satisfy the covered damages under U.S. Fire's policy.

Relying on *Menchaca's* "Independent-Injury Rule", Fifth Circuit affirmed dismissal of policyholder's extra-contractual claims because policyholder's extra-contractual claims were not truly "independent" of the insured's entitlement to policy benefits.

In *Moore v. Allstate Texas Lloyd's*, No. 17-10904, 2018 WL 3492818, -- Fed.Appx. -- (5th Cir. July 19, 2018), the United States Court of Appeals for the Fifth Circuit considered an insurers motion to dismiss an insured's extra-contractual claims based on the Texas Supreme Court's *Menchaca* opinion. The dispute arose out of a storm-related event in which the insured's residential property sustained damages. The insured filed a claim with Allstate, who inspected the property three times. The first inspection occurred on January 3, 2016, when an Allstate employee determined that no storm damage occurred; the second inspection occurred two weeks later when that same employee examined the property and reached the same conclusion; and the third inspection occurred on January 30, 2016 when Allstate sent an independent engineer to inspect the property. On February 15, 2016, Allstate notified Moore of a "laundry list of perils, which Allstate would not cover under the claim." Moore sued Allstate in Texas state court asserting breach of contract and extra-contractual claims including under the Texas Deceptive Trade Practices Act and the Texas Insurance Code.

The federal district court granted Allstate's motion to dismiss, finding that "Moore failed to plead facts sufficient to state a viable breach of contract claim." Specifically, the court found that Moore failed to explain "'what happened or the nature of, or even the extent of, the damages his property allegedly incurred;' what Allstate 'did or failed to do that he alleges made the inspections inadequate;' or 'the date on which he made his claim or explain why he says [Allstate's] response was untimely.'" In addition, the district court noted that, at "most, . . . Moore's 'complaint seems to be that he did not get paid as much as he thinks he should have been paid, but he has not alleged any facts to show that [Allstate] breached a contract between them.'" *Id.* On appeal, Moore argued that he pleaded sufficient facts to state a cause of action and, thus, the District Court erred in granting the motion to dismiss. The Fifth Circuit agreed with the District Court's dismissal.

The District Court dismissed Moore's extracontractual claims, holding that there "can be no recovery for extra-contractual damages for mishandling claims unless the complained of acts or omissions caused an injury independent of those that would have resulted from a wrongful denial of policy benefits." According to Moore, in *Menchaca*, the Texas Supreme Court "established that if statutory violations cause an injury that is independent from breach of contract, then a plaintiff can recover even if the policy does not provide benefits." Moore also argued "that the independent-injury rule 'does not reflect a pleading requirement, especially before any discovery has been conducted.'" The Fifth Circuit stated that Moore was correct to point to *Menchaca*, but that "Moore misreads *Menchaca*." Specifically, Moore pointed to *Menchaca*'s fourth rule, the "Independent-Injury Rule" which provides that "if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits."

The Fifth Circuit noted that the independent-injury rule applies "only if the damages are truly independent of the insured's right to receive policy benefits . . . . That is, the independent-injury rule 'does not apply if the insured's statutory or extra-contractual claims "are predicated on [the loss] being covered under the insurance policy" . . . or if the damages "flow" or "stem" from the denial of the claim for policy benefits.'" Rather, "when an insured seeks to recover damages that 'are predicated on,' 'flow from,' or 'stem from' policy benefits, the general rule applies and precludes recovery unless the policy entitles the insured to those benefits." Applied in the immediate case, Moore's common law and statutory claims "are predicated on the loss being covered under his residential policy. Thus, the general rule applies. Because Moore fails to state a breach of contract claim, and thus a right to receive policy benefits, Moore cannot recover for Allstate's alleged extra-contractual violations."

The U.S. Court of Appeals for the Fifth Circuit ruled that a $20 million judgment against a restaurant that gave alcohol to a minor was excluded by the criminal acts exclusion in the restaurant's commercial general liability insurance policy.

In *Century Surety Company v. Seidel*, 893 F.3d 328 (5th Cir. 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.

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

In *Wesco Insurance Company v. Layton*, 725 Fed. Appx. 289 (5th Cir. 2018), 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 HOLDS THAT MULTIPLE COLLSIONS CAUSED BY A RUNAWAY TRACTOR-TRAILER ARE A SINGLE ACCIDENT SUBJECT TO THE $1 MILLION PER ACCIDENT LIMIT IN A COMMERCIAL AUTO POLICY.

In *Evanston Insurance Company v. Mid-Continent Casualty*, --F.3d --, No. 17-20812, 2018 WL 6037507 (5th Cir. Nov. 19, 2018), the United States Court of Appeals for the Fifth Circuit addressed whether a multiple-vehicle crash caused by a runaway truck was a single occurrence under a commercial auto policy. The facts before the court were as follows.

Over a 10-minute period in Houston on November 15, 2013, a truck owned by Houston-based Global Waste Services LLC struck a Dodge Ram, a Ford F150, a Honda Accord, a toll plaza and a Dodge Charger. Two people, including the truck driver, died, and two others were injured, one very seriously. At the time of the accident, the Global truck was being driven by a Global employee who was driving erratically and lost control of the truck. In the ensuing litigation, Mid-Continent, which had issued a commercial auto insurance policy to Global with a $1 million per accident limit, paid out $1 million in settlement of one of the plaintiff's claims against Global. It then withdrew from the litigation, claiming exhaustion of its policy limit.

Excess insurer Evanston Insurance then settled the remaining litigation for an additional $2.2 million.

Evanston subsequently filed suit in U.S. District Court in Houston seeking reimbursement from Mid-Continent for a portion of the payments Evanston made on Global's behalf, and the entirety of its defense costs. Evanston contended each separate impact between another vehicle or object constituted a separate accident subject to separate liability limits, while Mid-Continent asserted that under Texas law there was only one accident because the various injuries stemmed from the truck driver's negligence.

The district court ruled in Evanston's favor, holding two accidents had occurred, and ordered Mid-Continent to pay Evanston about $1 million plus the costs of Evanston's defense. On appeal, the Fifth Circuit overturned the lower court concluding, "[t]he ongoing negligence of the runaway Mack truck was the single 'proximate, uninterrupted, and continuing cause' of all the collisions…The language of the contract provides that all injuries — no matter the number of vehicles involved or the number of claims made — arising from continuous or repeated exposure to substantially the same conditions are considered a single accident."

In reaching its conclusion, the Fifth Circuit reiterated what it previously recognized in a prior opinion: "While a single occurrence may result in multiple injuries to multiple parties over a period of time," "if one cause is interrupted and replaced by another intervening cause, the chain of causation is broken and more than one occurrence has taken place." If, on the other hand, the proximate cause for the injuries is continuous and unbroken, only one occurrence has taken place.