SIMPSON THACHER

INSURANCE LAW ALERT

MAY 2013

This Alert discusses decisions relating to the number of occurrences that arise from multiple incidents of injury, the proper method of allocating environmental damages among policy periods and the effect of an insurer's delayed reservation of rights. We also address discovery rulings in the context of a bad faith claim. In addition, we summarize decisions relating to whether general liability and/or directors and officers policies provide coverage for unilateral administrative agency actions. Finally, we summarize recent case law relating to whether construction defect claims constitute an occurrence under general liability policies.

- ***New York's Highest Court Rejects Policyholder's Single Occurrence Argument and Pro Rates Liability Among Multiple Policies***

  The New York Court of Appeals ruled that a priest's abuse of a minor at different locations over a six-year period did not constitute a single occurrence for insurance coverage purposes and that liability should be allocated on a pro rata basis among multiple implicated policies. *Roman Catholic Diocese of Brooklyn v. National Union Fire Ins. Co.*, 2013 WL 1875302 (N.Y. May 7, 2013). *Click here for full article*

- ***Missouri Appellate Court Rules That Policy Language Mandates "All Sums" Allocation***

  A Missouri appellate court ruled that language in several Lloyd's policies required application of "all sums" allocation to environmental contamination damages spanning multiple policy periods. *Doe Run Resources Corp. v. Certain Underwriters at Lloyd's London*, 2013 WL 1614613 (Mo. Ct. App. Apr. 16, 2013). *Click here for full article*

- ***Follow the Settlements Clause Does Not Preclude Reinsurer's Discovery Requests, Says Connecticut Court***

  A federal district court in Connecticut ruled that a reinsurer was entitled to discovery relating to a ceding insurer's post-settlement allocation decisions, notwithstanding the deference owed to a ceding insurer's settlement decisions pursuant to a follow the settlements clause. *Travelers Indem. Co. v. Excalibur Reinsurance Corp.*, 2013 WL 1409889 (D. Conn. Apr. 8, 2013). *Click here for full article*

- ***Sixth Circuit Rules That FTC Investigative Actions Do Not Constitute a "Claim" Under Directors & Officers Policy***

  The Sixth Circuit ruled that various investigative measures taken by the Federal Trade Commission did not constitute a "claim" for purposes of triggering coverage under a D&O policy. *Employers Fire Ins. Co. v. Promedica Health Sys., Inc.*, 2013 WL 1798978 (6th Cir. Apr. 30, 2013). *Click here for full article*

- ***Louisiana Court Rules on Scope of Expert Discovery in Bad Faith Action***

  A Louisiana court addressed the admissibility of expert testimony in connection with a bad faith claim. *Versai Mgmt. Corp. v. Landmark American Ins. Corp.*, 2013 WL 681902 (E.D. La. Feb. 22, 2103). *Click here for full article*

- ***Texas Court Rules That Administrative Agency Actions Do Not Constitute a "Suit" Under General Liability Policy***

  A Texas court held that the undefined term "suit" in general liability policies did not encompass unilateral administrative actions and orders. *McGinnes Indus. Maintenance Corp. v. Phoenix Ins. Co.*, 4:2011-CV-0400 (S.D. Tex. Apr. 18, 2013). *Click here for full article*

- ***New York Appellate Court Rules That Delayed Reservation of Rights Does Not Necessarily Estop Denial of Coverage***

  A New York appellate court ruled that an insurer is not automatically estopped from denying coverage by virtue of an untimely reservation of rights. *206-208 Main Street Assocs., Inc. v. Arch Ins. Co.*, 2013 WL 1831452 (N.Y. App. Div. 1st Dep't May 2, 2013). *Click here for full article*

- ***Continued Disagreement Among Courts as to Whether and When Faulty Workmanship Constitutes an Occurrence***

  Several courts construing identical "occurrence" policy language employed different reasoning to determine whether faulty workmanship claims are covered occurrences. *K&L Homes, Inc. v. American Family Mutual Ins. Co.*, 2013 WL 1364704 (N.D. Apr. 5, 2013); *Rosewood Home Builders, LLC v. National Fire & Marine Ins. Co.*, 2013 WL 1336594 (N.D.N.Y. Mar. 29, 2013); *I.J. White Corp. v. Columbia Casualty Co.*, 2013 WL 1577714 (N.Y. App. Div. 1st Dep't Apr. 16, 2013); *Scottsdale Ins. Co. v. R.I. Pools Inc.*, 710 F.3d 488 (2d Cir. 2013); *Allied Roofing, Inc. v. Western Reserve Grp.*, 2013 WL 1749707 (Ohio Ct. App. Apr. 23, 2013). *Click here for full article*

Number of Occurrences Alert:

New York's Highest Court Rejects Policyholder's Single Occurrence Argument and Pro Rates Liability Among Multiple Policies

The New York Court of Appeals ruled that a priest's abuse of a minor at different locations over a six-year period did not constitute a single occurrence for insurance coverage purposes. The court further held that liability should be allocated pro rata among multiple implicated policies. *Roman Catholic Diocese of Brooklyn v. National Union Fire Ins. Co.*, 2013 WL 1875302 (N.Y. May 7, 2013).

National Union issued three consecutive one-year policies to the church (1995-1998), each containing a $250,000 self-insured retention ("SIR") per occurrence. The church was insured by other primary carriers from 1998 to 2001. The church paid $2 million to settle claims that alleged abuse of a minor from 1996-2002. When the church sought reimbursement from Nation Union, the insurer argued that the incidents of abuse constituted separate occurrences, thus requiring payment of multiple SIRs. National Union also claimed that the settlement should be prorated among the seven implicated policies. In response, the church argued that the abuse constituted a single occurrence, requiring the exhaustion of only one SIR, and that each insurer's liability for the settlement was joint and several. The New York Court of Appeals agreed with National Union.

As a preliminary matter, the court rejected the notion that National Union had waived its number of occurrences and allocation arguments pursuant to N.Y. Insurance law § 3420(d), which requires timely notification of a disclaimer of coverage. The court explained that § 3420(d) applies to disclaimers based on policy exclusions, not to the enforcement of deductibles or matters of allocation among policy periods.

In resolving the number of occurrences issue, the court applied New York's "unfortunate event" test, which focuses on "whether there is a close temporal and spatial relationship between the incidents giving rise to injury or loss, and whether the incidents can be viewed as a part of the same causal continuum, without intervening agents or factors." Applying this standard, the court concluded that numerous incidents of abuse at different locations over a six-year period constituted multiple occurrences. The court rejected the contention that negligent supervision of the priest was the sole causal factor of the claimant's injuries, thus giving rise to only one occurrence. Therefore, the court concluded, the church was required to "exhaust the SIR for each occurrence that transpires within an implicated policy from which it seeks coverage." The court also ruled that settlement costs should be prorated among all policy

This edition of the Insurance Law Alert was prepared by Mary Beth Forshaw (mforshaw@stblaw.com/212-455-2846) and Bryce L. Friedman (bfriedman@stblaw.com/212-455-2235) with contributions by Karen Cestari (kcestari@stblaw.com).

periods in which the claimant suffered injury. The court reasoned that pro rata allocation was consistent with general liability policy language requiring injury "during the policy period."

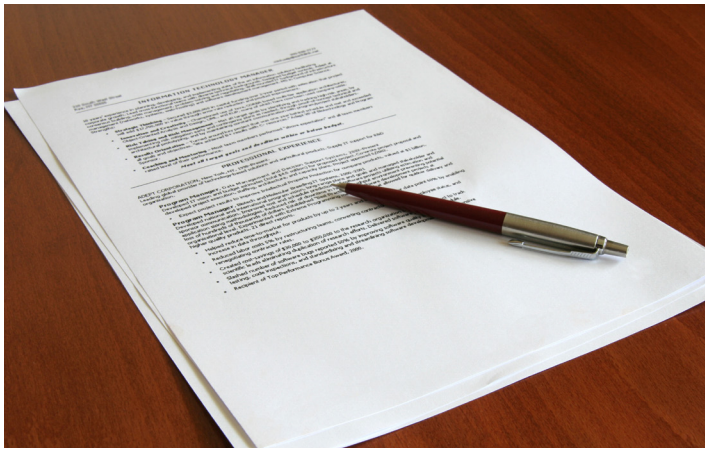
Other courts have reached different number of occurrences conclusions in the context of abuse claims. These differences are generally attributable to three factors: (1) variations in policy language (the court implied that policies containing aggregating occurrence language might justify a different result); (2) the standard for determining number of occurrences (the court acknowledged that a proximate cause test might generate a different result); and (3) factual issues (the court noted that under New York's unfortunate event test, multiple incidents of injury could, under different circumstances, give rise to only one occurrence).

Allocation Alert:

Missouri Appellate Court Rules That Policy Language Mandates "All Sums" Allocation

A Missouri appellate court ruled that language in several Lloyd's policies required application of "all sums" allocation to environmental contamination damages spanning multiple policy periods. *Doe Run Resources Corp. v. Certain Underwriters at Lloyd's London*, 2013 WL 1614613 (Mo. Ct. App. Apr. 16, 2013).

Doe Run, a mining and smelting company, sought coverage for environmental remediation costs under excess policies issued by Lloyd's. In the coverage litigation that ensued, a Missouri trial court ruled that the policies were governed by New York law, under which insured losses should be allocated across policies on a pro rata basis. A jury subsequently found Lloyd's liable for approximately $62 million in environmental response costs. The trial court reduced the award to approximately $5 million based on pro rata allocation. The trial court also ruled that there was one "occurrence" per site. On appeal, Doe Run argued that Missouri law applied, that damages should be allocated on an "all sums" basis, and that the trial court erred in finding that each site constituted no more than one occurrence. The Missouri appellate court agreed.



The appellate court held that the insurance policies were governed by Missouri law because Missouri was the principal place of the insured risk. In addition, the court ruled that policy language required an "all sums" allocation. In particular, the court focused on a provision requiring Lloyd's to indemnify Doe Run for "all sums which the Assured shall be obligated to pay by reason of the liability … for damages … on account of property damage, caused by or arising out of each occurrence happening during the policy period." The court reasoned that this language did not limit Lloyd's indemnity obligation to damages "during the policy period."

The appellate court also reversed the trial court's one occurrence per site ruling, finding "that the undisputed evidence at trial proved that each chat pile, tailings pond, and active operation was a separate cause of alleged contamination constituting separate occurrences under the policies as a matter of law." Specifically, the court noted that the chat piles and tailings ponds were physically distinct entities with different migration profiles, subject to different remediation programs. As such, the court concluded that each site in active operation during the policy period gave rise to three

occurrences (active operations, chat piles, and tailings ponds) and that each inoperative site gave rise to two occurrences (chat pilings and tailings ponds).

Notwithstanding the *Doe Run* ruling, the status of Missouri allocation law is unsettled. The Missouri Supreme Court has yet to rule on the issue, and the *Doe Run* court avoided "the issue of whether Missouri law requires an all sums approach or a pro rata approach" by basing its ruling on the specific policy language presented. Last year, a Missouri trial court, interpreting similar policy language, concluded that damages should be allocated on a pro rata basis. *Mallinckrodt Inc. v. Continental Ins. Co.*, No. 05CC-001214 (Mo. Cir. Ct. Nov. 9, 2012).

Reinsurance Alert:

Follow the Settlements Clause Does Not Preclude Reinsurer's Discovery Requests, Says Connecticut Court

A "follow the settlements" provision generally precludes a reinsurer from second-guessing a ceding insurer's good faith, reasonable settlement decisions in court. In light of this contract language, disputes often arise in reinsurance litigation as to whether discovery relating to the ceding insurer's settlement and allocation decisions is appropriate. Rulings in this context are highly fact-dependent, frequently turning on the nature of the reinsurer's discovery requests and the bases upon which the reinsurer has disputed its obligations.

Last month, a federal district court in Connecticut ruled that a reinsurer was entitled to discover the ceding insurer's post-settlement allocation decisions, notwithstanding the deference owed to a ceding insurer's settlement decisions pursuant to a follow the settlements clause. *Travelers Indem. Co. v. Excalibur Reinsurance Corp.*, 2013 WL 1409889 (D. Conn. Apr. 8, 2013).

Travelers issued errors and omissions policies to various businesses and then reinsured certain of those policies through treaties with Excalibur. After settling claims under the E&O policies, Travelers sought to collect reinsurance from Excalibur. Excalibur refused to pay, arguing that Travelers had unfairly allocated the settlements to policy periods during which Excalibur provided reinsurance. In the dispute that followed, Excalibur moved to compel the production of documents relating to the settlement of the underlying E&O claims. The crux of the dispute was whether the follow the settlements clause precluded Excalibur from challenging and seeking discovery related to: (1) the reasonableness of Travelers' settlement allocation, and (2) whether the underlying E&O claims were covered by the reinsurance treaties.

The court ruled that notwithstanding the follow the settlements clause, Excalibur was entitled "to challenge the reasonableness of Travelers' post-settlement allocation decision, and to argue that the economic consequences of that allocation violates or disregards provisions in the reinsurance contract." In particular, the court noted that discovery relating to, among other things, the timeliness of notice of claims under the claims-made E&O policies, was relevant to Excalibur's challenges and could lead to the discovery of admissible evidence. Significantly, the ruling only addressed Travelers' relevance-based objection to the discovery requests. The court emphasized that certain

materials may ultimately be non-discoverable on the basis of privilege and/or confidentiality.

D&O Alert:

Sixth Circuit Rules That FTC Investigative Actions Do Not Constitute a "Claim" Under Directors & Officers Policy

Reversing an Ohio district court, the Sixth Circuit ruled that various investigative measures taken by the Federal Trade Commission do not constitute a "claim" for purposes of triggering coverage under a D&O policy. Rather, the court held that a "claim" arises, if at all, when a formal administrative complaint is filed against the policyholder. *Employers Fire Ins. Co. v. Promedica Health Sys., Inc.*, 2013 WL 1798978 (6th Cir. Apr. 30, 2013).

ProMedica, a non-profit health care system, entered into an agreement to acquire a hospital. In July 2010, the FTC notified ProMedica that it was investigating whether the acquisition was anticompetitive and in violation of federal law. In July and August 2010, the FTC issued document requests and held meetings with ProMedica. The FTC then transitioned its investigation to "full-phase" and issued a resolution authorizing the use of compulsory processes. During this phase of its investigation, the FTC issued subpoenas and civil investigative demands, and requested that ProMedica agree to the terms of "Hold Separate Agreement" under which the integration of the hospital and ProMedica would be limited. In January 2011, the FTC commenced an administrative action against ProMedica, asserting Clayton Act violations.

In litigation between ProMedica and its insurer, the parties disputed when a "claim" against ProMedica had been made for purposes of insurance coverage. The claims-made policies defined "claim" as:

> (1) a written demand for monetary, non-monetary or injunctive relief (including any request to toll or waive any statute of limitations); or
>
> (2) a civil, criminal, administrative, regulatory or arbitration proceeding for monetary, non-monetary or injunctive relief commenced by:
>
> (a) the service of a complaint or similar pleading; ….
>
> (c) the filing of a notice of charges, formal investigative order or similar document, against an Insured for a Wrongful Act….

Under the policies, "Wrongful Act" was defined to include "any actual or alleged … violation of [federal statutory law]."

OneBeacon argued that a claim arose when the FTC began to investigate ProMedica's acquisition of the hospital. If a claim arose at that time, ProMedica's notice to OneBeacon would have been untimely, resulting in a forfeiture of coverage. In contrast, ProMedica argued that a claim did not arise until the filing of a formal complaint. Under this scenario, notice to OneBeacon was within the policy period. The district court concluded that a claim arose when the FTC's investigation began and that ProMedica's failure to notify OneBeacon of the claim within the policy period precluded coverage. The Sixth Circuit reversed.

The Sixth Circuit ruled that the FTC's August 2010

actions did not constitute a claim because none sought relief for a "Wrongful Act." More specifically, the court reasoned that the FTC did not, in its August 2010 correspondence, "allege" a violation of law, as required by the policy language. The court reasoned that all of the August 2010 actions constituted investigations of *whether* a federal violation had occurred (or would occur), rather than an actual accusation of wrongdoing. The court reached this conclusion notwithstanding that: (1) the statute authorizing the FTC's August 2010 investigation provided that all demands "shall state the nature of the conduct constituting the *alleged* violation"; and (2) the FTC Operation Manual stated that full-phase investigations may involve inquiries into "*alleged* violations of [ ] law." Other courts have ruled that the issuance of a formal investigation order and/or subpoenas constitute allegations of a "Wrongful Act." However, the Sixth Circuit deemed those decisions not controlling under Ohio law.

Finally, the court ruled that even if the August 2010 actions did allege wrongdoing (*i.e.*, seek relief for a "Wrongful Act"), there was still no "claim" because none of the actions sought "relief." The appellate court rejected the notion that ProMedica's execution of the Hold Separate Agreement constituted a form of injunctive relief—a position endorsed by the Ohio district court.

Whether an agency's investigative actions constitute a "claim" turns primarily on applicable policy language. In cases involving policies that do not define "claim" or define it differently than the OneBeacon policy, courts have found that an investigation, including the issuance of subpoenas, gave rise to a "claim" under D&O policies.

Bad Faith/Discovery Alert:

Louisiana Court Rules on Scope of Expert Discovery in Bad Faith Action

In a recent decision, a Louisiana court addressed the admissibility of expert testimony in connection with a bad faith claim. *Versai Mgmt. Corp. v. Landmark American Ins. Corp.*, 2013 WL 681902 (E.D. La. Feb. 22, 2103).

The dispute arose out of a series of fires that damaged several buildings. The property management company sought coverage under an all risk commercial property policy and ultimately sued its insurer, alleging a failure to timely adjust claims and tender the amount of the buildings' value. In support of these claims, the policyholder submitted expert reports that asserted three main points: (1) that Louisiana statutory law regarding property valuation applied to the policy; (2) that an endorsement to the policy was ambiguous; and (3) that the insurer acted in bad faith in adjusting the claims. The insurer moved to exclude the expert testimony.

Expert testimony is generally inadmissible if it provides conclusions as to issues of law. However, expert testimony on issues of fact may be admitted if it is deemed reliable and relevant. Fed. R. Evid. 702, 704. Applying these standards, the court ruled that expert testimony offered by the policyholder related to conclusions of law and was thus inadmissible. However, the court allowed expert testimony as to generally accepted insurance practices, reasoning that

it related to disputed issues of fact and that expert testimony was justified in light of the complex nature of the case.

CERCLA Alert:

Texas Court Rules That Administrative Agency Actions Do Not Constitute a "Suit" Under General Liability Policy

Courts have reached differing conclusions as to whether administrative agency actions, including the issuance of a potentially responsible party ("PRP") letter, constitute a "suit" under a general liability policy so as to trigger defense obligations. While some courts have adopted a "bright line" test to conclude that only the initiation of court-based litigation constitutes a "suit," others have conducted a fact-driven analysis based on whether the administrative actions are the functional equivalent of adversarial litigation.

A Texas court recently weighed in on this issue, concluding that the undefined term "suit" in general liability policies did not encompass unilateral administrative actions and orders. *McGinnes Indus. Maintenance Corp. v. Phoenix Ins. Co.*, No. 4:2011-CV-04000 (S.D. Tex. Apr. 18, 2013). There, the policyholder received PRP letters from the Environmental Protection Agency regarding environmental contamination. In addition, the EPA demanded information from the policyholder and threatened financial penalties for non-compliance. The EPA also ordered the policyholder to pay nearly $400,000 in costs and for future studies, again, at the risk of incurring steep penalties for failure to comply. The court held that despite the coercive nature of these actions and the severe consequences of non-compliance, there was no suit and thus no duty to defend. The court stated, "[t]he policies covered the risks of lawsuits, but not those of a virulent administrative state."

Estoppel Alert:

New York Appellate Court Rules That Delayed Reservation of Rights Does Not Necessarily Estop Denial of Coverage

Reversing a trial court decision, a New York appellate court ruled that an insurer is not automatically estopped from denying coverage by virtue of an untimely reservation of rights. *206-208 Main Street Assocs., Inc. v. Arch Ins. Co.*, 2013 WL 1831452 (N.Y. App. Div. 1st Dep't May 2, 2013).

H&H Builders managed a construction project in New York. During construction, the foundation of an adjacent building collapsed, causing damage to neighboring properties. H&H notified Arch, its general liability insurer, of the incident and forwarded documentation indicating that the damage was caused by a collapse of several structures. H&H was named as a defendant in several lawsuits, which Arch agreed to defend under a general reservation of rights. More than two years later, Arch informed H&H that coverage for the claims may be barred by an earth movement exclusion in the policy and reserved its right to disclaim coverage on this basis. However, Arch continued to provide a defense in the underlying litigation. In ensuing coverage litigation, H&H argued that Arch was equitably estopped from denying coverage on the basis of the exclusion because of its ongoing control over the defense of the underlying actions. The trial court granted H&H's summary judgment motion on this issue, finding that regardless of whether the exclusion applied, Arch was equitably estopped from disclaiming coverage. The appellate court reversed.

The appellate court held that although Arch's disclaimer notice was unreasonably late, the doctrine of equitable estoppel did not automatically preclude Arch's denial of coverage. The court recognized that equitable estoppel applies only "where, by the time the insurer attempted to avoid liability under the policy, the underlying litigation against the insured had reached

a point where the course of the litigation had been fully charted." The court explained that under those circumstances, a denial of coverage would likely result in prejudice to the policyholder. However, the appellate court rejected the notion "that control of an insured's defense for any substantial length of time is inherently prejudicial." Because the underlying litigation against H&H was still in its "early phase," the court concluded that prejudice had not been established as a matter of law. The appellate court remanded the matter for a determination of whether H&H could establish prejudice "by some factor other than the posture of the litigation at the time Arch issued its reservation of rights."

"Occurrence" Alert:

Continued Disagreement Among Courts as to Whether and When Faulty Workmanship Constitutes an Occurrence

Previous Alerts have discussed conflicting decisions relating to whether and under what circumstances general liability policies provide coverage for construction defect claims. In recent weeks, several courts construing identical "occurrence" policy language (defined as "an accident") employed different reasoning to determine whether faulty workmanship claims are covered occurrences. The resulting opinions both reject and endorse consideration of the following factors: applicable policy language, including the presence of a "your work" exclusion and/or a "sub-contractor" exception; whether the conduct giving rise to the claim was akin to an "accident;" and whether the damage was limited to the insured's own work or extended to other property.

In *K&L Homes, Inc. v. American Family Mutual Ins. Co.*, 2013 WL 1364704 (N.D. Apr. 5, 2013), the Supreme Court of North Dakota ruled that whether construction defect claims are covered under a general liability policy turns on two discrete analyses: (1) whether there was an "occurrence" and (2) whether there was covered "property damage." With respect to the first issue, the court held that "faulty workmanship may constitute an 'occurrence' if the faulty work was 'unexpected' and not intended by the insured, and the property damage was not anticipated or intentional, so that neither the cause nor the harm was anticipated, intended or expected." Emphasizing that the occurrence analysis turns only on whether the construction claim was based on an "accident," the court rejected the premise (endorsed by numerous other courts), that the occurrence analysis relates to whether property damage was limited to the insured's own work or whether it caused harm to collateral property. With respect to the second issue, the court noted that when negligent work results in property damage, a "your work" exclusion precludes coverage if the damage is limited to the insured's own work. However, the court held that a "sub-contractor" exception to the "your work" exclusion may reinstate coverage where the faulty work was performed by a sub-contractor. The court held that the "sub-contractor" exception would restore coverage even if the sub-contractor's negligence results in damage only to the insured's own work. The court remanded the matter for factual development of these issues.

Three New York courts also issued rulings in this context, all of which appear to run counter to the reasoning set forth in *K&L Homes*.

In two decisions, the courts' occurrence analysis

was based primarily on whether there was damage to collateral property. In *Rosewood Home Builders, LLC v. National Fire & Marine Ins. Co.*, 2013 WL 1336594 (N.D.N.Y. Mar. 29, 2013), a federal district court held that faulty workmanship did not constitute an occurrence because it damaged only the insured's work. The court reasoned that in order for faulty workmanship to constitute an occurrence, damage must be inflicted upon collateral property. A similar analysis was applied in *I.J. White Corp. v. Columbia Casualty Co.*, 2013 WL 1577714 (N.Y. App. Div. 1st Dep't Apr. 16, 2013). There, a New York appellate court ruled that because the policyholder's faulty workmanship caused damage to "something other than the [insured's] work product," it constituted an occurrence under a general liability policy. The court did not address whether the faulty workmanship claims constituted an "accident" or whether the harm was unexpected, unintended and/or a foreseeable result of the insured's actions.

In *Scottsdale Ins. Co. v. R.I. Pools Inc.*, 710 F.3d 488 (2d Cir. 2013), the Second Circuit based its occurrence analysis on the presence of a "sub-contractor" exception. Bypassing any analysis of whether the claims were accidental (*i.e.*, unexpected, unintended or unforeseeable), the court reasoned that the inclusion of a "sub-contractor" exception to a "your work" exclusion indicated an intention to provide coverage for defects in the insured's own work. The court stated: "As coverage is limited by the policy to 'occurrences' and defects in the insured's own work in some instances are covered, these policies … unmistakably include defects in the insured's own work within the category of an occurrence." Notably, the Second Circuit previously held that faulty workmanship does not constitute an occurrence where the policy defines "occurrence" as "an accident." *Jakobson Shipyard, Inc. v. Aetna Cas. & Sur. Co.*, 961 F.2d 387 (2d Cir. 1992). The *Scottsdale* court distinguished *Jakobson* on the basis that the policy there did not contain a "your work" exclusion or a "sub-contractor" exception. The reasoning set forth in *Scottsdale* appears to contradict the basic rule of insurance policy interpretation that "an exception to an exclusion cannot create coverage where the policy's initial grant of coverage does not provide that type of coverage." *Wadzinski v. Auto-Owners Ins. Co.*, 342 Wis. 2d 311 (Wis. 2012).

Finally, in *Allied Roofing, Inc. v. Western Reserve Grp.*, 2013 WL 1749707 (Ohio Ct. App. Apr. 23, 2013), an Ohio appellate court ruled, as a matter of law, that claims for defective construction are not within the meaning of an "occurrence" under a general liability policy. Citing to Ohio precedent, the court focused on the accident-based nature of liability insurance, stating that "a central concept in the realm of insurance coverage [is] the doctrine of fortuity and that idea that commercial general liability policies cover truly accidental property damage, not damages arising from processes controlled by the insured and that could be anticipated." The court reached this conclusion without addressing the fact that the faulty workmanship at issue resulted in damage to collateral property.

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Barry R. Ostrager
(212) 455-2655
bostrager@stblaw.com

Mary Kay Vyskocil
(212) 455-3093
mvyskocil@stblaw.com

Andrew S. Amer
(212) 455-2953
aamer@stblaw.com

David J. Woll
(212) 455-3136
dwoll@stblaw.com

Mary Beth Forshaw
(212) 455-2846
mforshaw@stblaw.com

Andrew T. Frankel
(212) 455-3073
afrankel@stblaw.com

Lynn K. Neuner
(212) 455-2696
lneuner@stblaw.com

Chet A. Kronenberg
(310) 407-7557
ckronenberg@stblaw.com

Linda H. Martin
(212) 455-7722
lmartin@stblaw.com

Bryce L. Friedman
(212) 455-2235
bfriedman@stblaw.com

Michael D. Kibler
(310) 407-7515
mkibler@stblaw.com

Michael J. Garvey
(212) 455-7358
mgarvey@stblaw.com

Tyler B. Robinson
+44-(0)20-7275-6118
trobinson@stblaw.com

George S. Wang
(212) 455-2228
gwang@stblaw.com

Deborah L. Stein
(310) 407-7525
dstein@stblaw.com

Elisa Alcabes
(212) 455-3133
ealcabes@stblaw.com

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UNITED STATES

New York
425 Lexington Avenue
New York, NY 10017
+1-212-455-2000

Houston
2 Houston Center
909 Fannin Street
Houston, TX 77010
+1-713-821-5650

Los Angeles
1999 Avenue of the Stars
Los Angeles, CA 90067
+1-310-407-7500

Palo Alto
2475 Hanover Street
Palo Alto, CA 94304
+1-650-251-5000

Washington, D.C.
1155 F Street, N.W.
Washington, D.C. 20004
+1-202-636-5500

EUROPE

London
CityPoint
One Ropemaker Street
London EC2Y 9HU
England
+44-(0)20-7275-6500

ASIA

Beijing
3919 China World Tower
1 Jian Guo Men Wai Avenue
Beijing 100004
China
+86-10-5965-2999

Hong Kong
ICBC Tower
3 Garden Road, Central
Hong Kong
+852-2514-7600

Seoul
West Tower, Mirae Asset Center 1
26 Eulji-ro 5-gil, Jung-gu
Seoul 100-210
Korea
+82-2-6030-3800

Tokyo
Ark Hills Sengokuyama Mori Tower
9-10, Roppongi 1-Chome
Minato-Ku, Tokyo 106-0032
Japan
+81-3-5562-6200

SOUTH AMERICA

São Paulo
Av. Presidente Juscelino Kubitschek, 1455
São Paulo, SP 04543-011
Brazil
+55-11-3546-1000