Simpson Thacher

Insurance Law Alert

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"The Simpson Thacher team is smart, practical, trustworthy and experienced. They are highly sophisticated lawyers and have handled the most complex insurance matters out there."

– *Chambers USA* 2026 (quoting a client)

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A Maryland federal district court denied an insurer's motion for summary judgment, holding that a potential claim was first brought to the insureds' attention during the policy period and that, under Maryland's notice-prejudice statute, the insurer could not deny coverage based on the insureds' failure to report the potential claim during the policy period absent a showing of actual prejudice. *Aspen Specialty Ins. Co. v. Dormu*, 2026 U.S. Dist. LEXIS 145327 (D. Md. June 30, 2026). (Click here for full article)

Missouri Joins Jurisdictions Holding That Products Exclusions Bar Coverage For Claims Arising From Unbranded Marketing Of Opioids

The Missouri Court of Appeals affirmed summary judgment for insurers, holding that claims alleging deceptive marketing of opioids fall within a products exclusion, even where the marketing is not alleged to specifically reference the insured's products. *Opioid Master Disbursement Tr. II v. ACE Am. Ins.,* 2026 Mo. App. LEXIS 561 (Mo. Ct. App. July 21, 2026). (Click here for full article)

Illinois Appellate Court Affirms That Vacancy Exclusion Bars Coverage For Water Damage; Rejects Waiver And Estoppel

An Illinois appellate court affirmed that a vacancy exclusion barred coverage for water damage to a commercial property that had remained vacant for more than 60 consecutive days before the loss. The court rejected the insured's argument that the insurer was on notice that the property was vacant when it issued the policy and therefore waived the exclusion or was estopped from relying on it. *Argus Inv., Inc. v. W. Bend Mut. Ins. Co.*, 2026 Ill. App. LEXIS 291 (Ill. App. Ct. July 28, 2026). (Click here for full article)

Sixth Circuit Holds That Food Manufacturer's Alleged Salmonella Outbreak Was A Single "Occurrence" Under CGL Policies

In a decision applying Ohio law, the Sixth Circuit affirmed summary judgment for food manufacturer J.M. Smucker Company ("Smucker"), on the ground that thousands of claims arising from an alleged salmonella outbreak constituted a single "occurrence" under Smucker's commercial general liability policies. The court further held that the policies' Lot Endorsement was ambiguous and therefore did not require the claims to be treated as separate occurrences based on the production lots from which the allegedly contaminated products originated. *The J.M. Smucker Co. v. ACE Am. Ins. Co.,* 179 F.4th 1038 (6th Cir. 2026). (Click here for full article)

English Commercial Court Holds War Exclusion Bars Coverage For Nord Stream Pipeline Sabotage

The English Commercial Court held that the September 2022 sabotage of the Nord Stream 1 pipelines fell within the policies' war exclusion because the Russia-Ukraine war was a significant cause of the loss, regardless of whether the sabotage was carried out by Russia, Ukraine or a Ukrainian sub-state actor, or the United States. *Nord Stream AG v. Lloyd's Ins. Co. SA & Anor* [2026] EWHC 1685 (Comm). (Click here for full article)

English Commercial Court Enforces Insurance Arbitration Clause Through Anti-Suit Injunction And Awards Insurer Damages

The English Commercial Court granted a final anti-suit injunction restraining US-based hospitality companies from pursuing Louisiana litigation against Chubb Bermuda Insurance Ltd, in breach of a London-seated arbitration agreement and awarded Chubb damages arising from the companies' breach of that agreement. *Chubb Bermuda Ins. Ltd v. Fertitta Ent., Inc., et al.* [2026] EWHC 1392 (Comm). (Click here for full article)

English Commercial Court Rejects Rectification Of Global Insurance Policy, Leaving COVID-19 Losses Uncovered

The English Commercial Court dismissed a claim by CP Holdings and other hospitality companies seeking rectification (an equitable remedy by which the court can correct mistakes made in recording agreements in writing) of their 2019 global insurance policy with Assicurazioni Generali SpA, holding that pre-contractual communications established only a willingness in principle to consider such a clause, not a binding agreement on the term the insured later sought to add. *CP Holdings Ltd., et al. v. Assicurazioni Generali SpA, et al.* [2026] EWHC 1520 (Comm). (Click here for full article)

Client Alert: Policyholders Developing AI-Based Bad Faith Claims

Policyholders are actively developing breach of contract and "bad faith" claims based on the alleged use of artificial intelligence by insurers. For instance, a policyholder may argue that an insurance policy or insurer marketing material expressly or implicitly indicated that underwriting, coverage or valuation determinations would be made by human professionals (*e.g.*, doctors, actuaries, claims handlers), and that the insurer has improperly delegated the determinations to AI. Additionally, policyholders may argue that the AI model being used to assist the insurer in its coverage or valuation determinations inappropriately advantages the insurer over policyholder interests. Policyholders attempt to develop these theories in discovery by seeking insurer documents regarding the determination to use AI and any associated cost-benefit analysis; the development of the AI including training sets; and documents concerning the ongoing usage of the AI. Insurers are advised to consider the potential for these claims when developing, rolling out, and utilizing AI models to assist in underwriting and claims-handling. Careful planning and documenting by insurers can help minimize exposure to this new litigation tactic.

California Supreme Court Holds That Exhaustion Of Underlying Insurance Is Not Required To Pursue Relief Against Excess Insurers

HOLDING

The California Supreme Court held that an insured need not establish or plead prior exhaustion of all underlying insurance to pursue relief against an excess insurer. For declaratory relief, however, the insured must adequately allege covered losses sufficient to create a "reasonable likelihood" that the excess policy's attachment point will be reached. For bad faith, the insured must allege facts showing that the excess policy will attach or would have attached but for the insurer's alleged misconduct, and that the misconduct has impaired the insured's recovery of policy benefits. *Fox Paine & Co., LLC v. Twin City Fire Ins. Co.*, 2026 Cal. LEXIS 3943 (Cal. July 27, 2026).

BACKGROUND

This dispute arose from litigation between co-founders of investment firm Fox Paine & Company, LLC ("FPC"). FPC and related insureds were covered under a $50 million insurance program consisting of a $10 million primary policy and four $10 million "follow form" excess policies. Each excess policy conditioned payment on exhaustion of the underlying insurance.

After a business dispute between FPC's principals generated extensive litigation, the primary insurer paid its $10 million limit to one group of insureds, and two excess insurers later paid an additional $9 million in settlement. The plaintiffs, who were a different group of insureds and received none of the payments, subsequently sought coverage for their own litigation-related losses. They alleged that the excess insurers' failure to pay them policy benefits and other conduct by excess insurers that allegedly favored another group of insureds violated the implied covenant of good faith and fair dealing. The plaintiffs alleged that they had incurred more than $43 million in covered loss and recoverable interest arising from the underlying litigation, and they sued the excess insurers for breach of contract, declaratory relief, bad faith, and aiding and abetting breaches of fiduciary duties.

The trial court concluded that the plaintiffs adequately alleged exhaustion of the $10 million primary policy based on the primary insurer's payment of its full limit to the competing group of insureds and therefore allowed the plaintiffs' claims against the first excess layer to proceed. The trial court dismissed the claims against the higher excess layers, however, because only approximately $6 million of the $10 million first-excess limit had been paid and, accordingly, the insurance underlying those higher layers had not been exhausted. The Court of Appeal affirmed, holding that the higher-layer insurers could not be liable for breach of contract because their policies had not yet attached, that the plaintiffs had not adequately alleged an actual controversy supporting declaratory relief because they had not sufficiently alleged covered losses reaching the higher excess layers, and that their inability to allege exhaustion was fatal to their bad faith claims. The plaintiffs sought review of the latter two rulings.

DECISION

The California Supreme Court reversed. As to declaratory relief, the court rejected a categorical rule requiring exhaustion of all underlying insurance before an insured may obtain a declaration concerning coverage under an excess policy. Although declaratory relief requires an "actual controversy" rather than a dispute dependent on hypothetical future events, the court explained that the existence of future contingencies does not necessarily make a coverage dispute too speculative for adjudication and that courts should instead consider the practical likelihood that those contingencies will occur. Applying those principles, the court held that the fact that underlying insurance has not yet been exhausted does not, by itself, preclude an actual controversy concerning an excess insurer's future coverage obligations. The court further reasoned that requiring sequential exhaustion of each underlying layer before permitting declaratory relief could force insureds to pursue multiple lawsuits against successive excess insurers and create a risk of inconsistent rulings.

The court emphasized, however, that an insured must adequately allege covered losses sufficient to reach an excess policy's attachment point. If the amount of losses covered is uncertain, the allegations must establish a "reasonable likelihood" that the policy's attachment point will be reached; a mere theoretical possibility is insufficient. The court also concluded that the plaintiffs' allegation of more than $43 million in "covered Loss and recoverable interest" improperly combined covered loss with prejudgment interest, which does not count toward exhaustion. The court therefore remanded for consideration of whether the complaint adequately alleged a covered loss, excluding interest, sufficient to create a reasonable likelihood that the higher-layer policies would be reached.

As to bad faith, the court held that prior exhaustion is not required to state a claim against an excess insurer for breach of the implied covenant of good faith and fair dealing. The court held that the implied covenant exists from the inception of the policy and that it may be breached even before the insurer's contractual payment obligation has matured. The court further held that an insured may state a bad faith claim by alleging facts that, taken as true, show that "the excess policy *will* attach—or that it would attach, if not for the excess insurer's bad-faith conduct—and that the insurer's misconduct has impaired the insured's recovery of benefits owed to it under the policy." The court therefore rejected the Court of Appeal's conclusion that the plaintiffs' failure to allege exhaustion was, by itself, fatal to their bad faith claims.

COMMENTS

The court observed that numerous courts, including the Second Circuit in *E.R. Squibb & Sons, Inc. v. Lloyd's & Companies*, 241 F.3d 154 (2d Cir. 2001), have already applied a "reasonable likelihood" standard in determining whether an insured may pursue declaratory relief against an excess insurer before exhaustion. The court therefore concluded that adopting that standard would not disrupt insurers' settled expectations or destabilize the excess insurance market. The decision does not alter exhaustion requirements as conditions to payment.

Pennsylvania Supreme Court Rules That Public Policy Does Not Abrogate Insurers' Duty To Defend Or Indemnify Policyholders Alleged To Have Enabled Or Profited From Sex Trafficking

HOLDING

The Pennsylvania Supreme Court held that Pennsylvania's public policy against sex trafficking does not, standing alone, abrogate an insurer's contractual duty to defend or indemnify an insured alleged to have enabled or profited from sex trafficking. *Samsung Fire and Marine Ins. Co., Ltd (U.S. Branch) v. RI Settlement Tr.*, 2026 Pa. LEXIS 1276 (Pa. July 21, 2026).

BACKGROUND

The case arose from four lawsuits alleging that minors were victims of sex trafficking at a Philadelphia hotel. The plaintiffs sued the hotel's owners, operators, and managers (collectively, "Policyholders") alleging that the Policyholders negligently failed to prevent the trafficking. The Policyholders' commercial general liability insurers initially defended the lawsuits subject to reservations of rights.

An insurer subsequently commenced a declaratory judgment action seeking a declaration that it had no duty to defend or indemnify the Policyholders. After the Policyholders filed a Third-Party Complaint seeking a declaration that the insurers had a duty to defend, the insurers argued, among other grounds, that coverage would violate public policy because the allegations, if proven, would establish conduct prohibited by Pennsylvania's Human Trafficking Law, 18 Pa.C.S. § 3011. The district court granted judgment for the insurers without reaching their policy-language defenses. Relying on *Minnesota Fire & Casualty Co. v. Greenfield*, 855 A.2d 854 (Pa. 2004), a federal district court concluded that public policy barred a defense or indemnity because the policyholders allegedly had, at minimum, acted with reckless disregard of the trafficking occurring at the hotel.

On appeal, the Third Circuit certified to the Pennsylvania Supreme Court the question of whether Pennsylvania has an overriding public policy against sex trafficking that abrogates an insurer's duty to defend or indemnify an insured alleged to have enabled or profited from trafficking.

DECISION

The Pennsylvania Supreme Court answered the certified question in the negative.

Because the district court had not reached the insurers' policy-language defenses, the court assumed, without deciding, that the policies otherwise imposed a duty to defend and considered only whether public policy could override those contractual obligations.

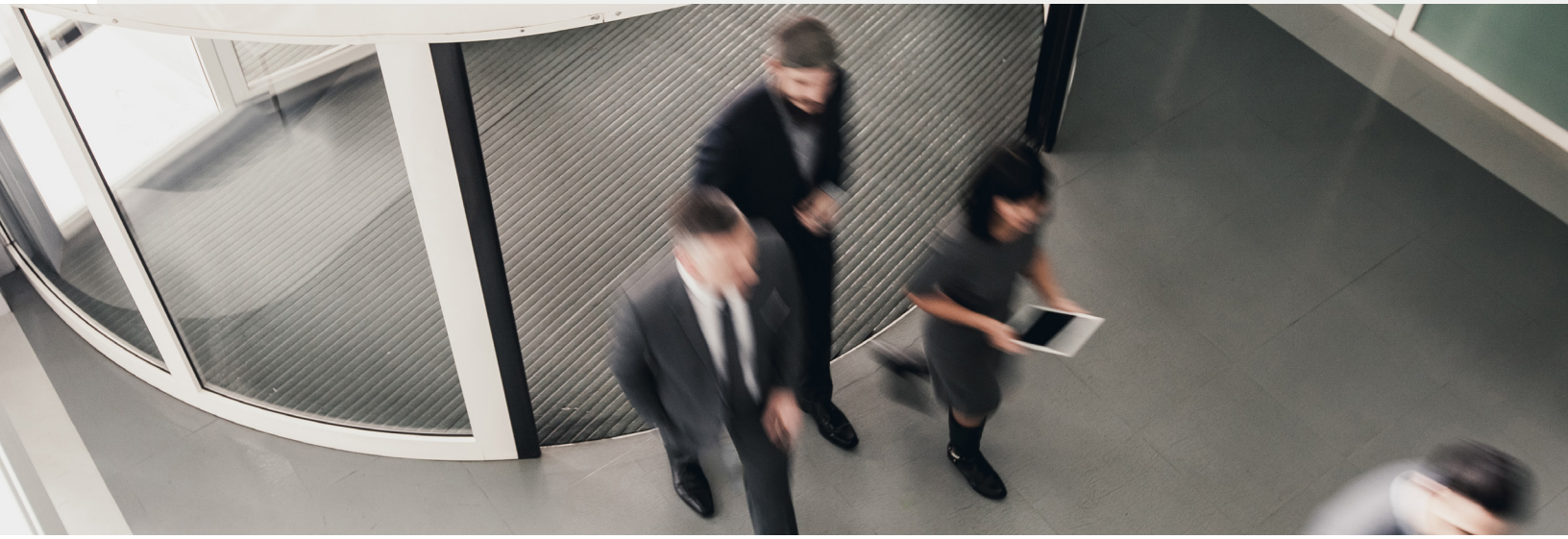
The court first rejected the premise that *Greenfield* established a controlling public policy exception. *Greenfield* was a nonprecedential plurality decision involving an insured who had pleaded guilty to criminal conduct involving heroin, and the plurality expressly limited its reasoning to criminal acts involving Schedule I controlled substances. The court declined both to adopt that reasoning and to extend it to sex trafficking.

The court further reasoned that Pennsylvania's anti-trafficking statute, standing alone, does not establish a public policy bar to otherwise available insurance coverage. In reaching that conclusion, the court emphasized that the duty to defend ordinarily should be resolved by reference to the policy language and the allegations of the underlying complaint, rather than through judicially created exclusions based on criminal statutes. The court noted that insurers remain free to address such risks through appropriate policy language and exclusions.

Accordingly, the court held that neither the duty to defend nor the duty to indemnify is abrogated on public policy grounds merely because the insured is alleged to have enabled or profited from sex trafficking. The court did not determine whether the underlying claims actually fall within coverage or are barred by any policy exclusion.

COMMENTS

The decision limits the availability of public policy as an independent basis for denying coverage under Pennsylvania law and underscores the importance of addressing criminal and other intentional conduct through express policy language. In concurrence, Justice Wecht criticized *Greenfield*'s public policy analysis more broadly, concluding that courts should not use public policy to rewrite insurance contracts.



Maryland Court Rules Insurer Must Show Actual Prejudice To Deny Coverage Based On Late Notice Under Claims-Made-And-Reported Policy

HOLDING

A Maryland federal district court denied an insurer's motion for summary judgment, holding that a potential claim was first brought to the insureds' attention during the policy period and that, under Maryland's notice-prejudice statute, the insurer could not deny coverage based on the insureds' failure to report the potential claim during the policy period absent a showing of actual prejudice. *Aspen Specialty Ins. Co. v. Dormu*, 2026 U.S. Dist. LEXIS 145327 (D. Md. June 30, 2026).

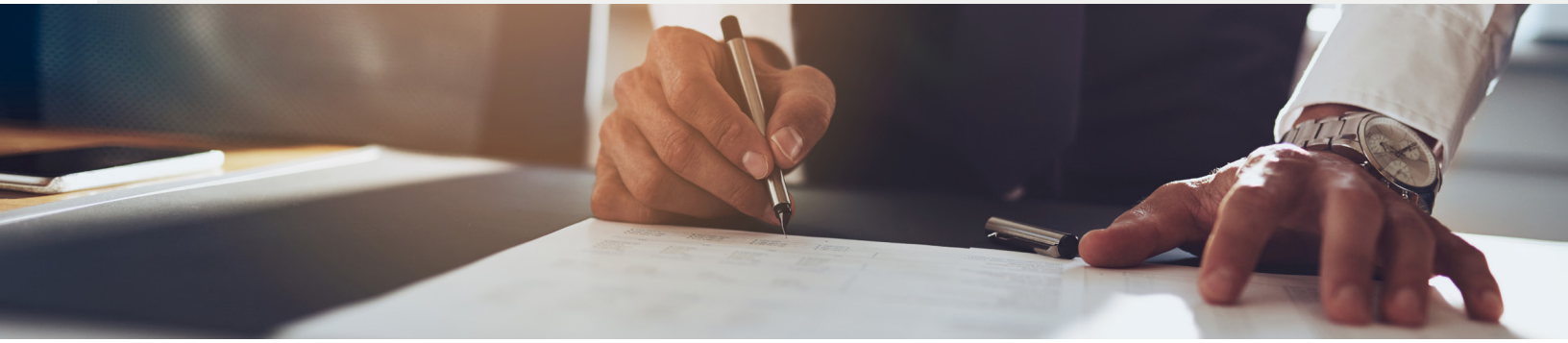
BACKGROUND

This insurance dispute arose out of a medical malpractice claim against a surgeon and his medical practice. The insureds were covered under professional liability policies issued by the Medical Protective Company ("MedPro") for the period October 9, 2020 to October 9, 2021.

The policies provided coverage for "any claim first made, or potential claim first brought to the Insured's attention, during the term of this policy." A "potential claim" was defined as "an incident which the Insured reasonably believes will result in a claim for damages." The policies also required that potential claims be reported to MedPro during the policy period.

In August 2021, a former patient's estate filed a medical malpractice claim with the Maryland Health Care Alternative Dispute Resolution Office ("HCADRO"), a statutory prerequisite to pursuing a medical malpractice claim in court. In September 2021, HCADRO mailed the insureds an Order of Transfer and accompanying cover letter identifying the malpractice proceeding and stating that it was being transferred to a federal or state court. HCADRO did not send the underlying Statement of Claim or Certificate of Merit.

The claimant subsequently filed a civil complaint against the insureds. The insureds received the complaint after the MedPro policies expired and reported it to MedPro on October 19, 2021, ten days after expiration. MedPro denied coverage and a coverage action was commenced. MedPro moved for summary judgment, arguing that the requirements for coverage under its claims-made-and-reported policies had not been satisfied.



DECISION

The court denied MedPro's motion for summary judgment. The court first held that the HCADRO Order of Transfer constituted notice of a "potential claim" during the policy period. Although the insureds had not received the underlying Statement of Claim, the Order of Transfer and accompanying cover letter identified the formal medical malpractice proceeding, identified the parties, and stated that the matter was being transferred to state or federal court. The court therefore concluded that the documents concerned an incident that the insureds reasonably would have believed would result in a claim for damages.

The court further held that the potential claim was first discovered or brought to the Insureds' attention during the policy period. HCADRO mailed the Order of Transfer to the insureds in September 2021, before the policies expired on October 9, and the court applied Maryland's presumption that a properly mailed document was received by its addressee.

The court then addressed the insureds' failure to report the potential claim to MedPro during the policy period. Applying Maryland Insurance Code § 19-110, the court held that MedPro could disclaim coverage based on that failure only if it established by a preponderance of the evidence that the late notice caused actual prejudice. The court explained that Maryland's notice-prejudice rule applies to claims-made-and-reported policies where the event triggering coverage occurs during the policy period but the insured fails to comply with the policy's reporting requirement.

The court concluded that MedPro failed to establish actual prejudice. MedPro received notice only ten days after the policy expired and five days after the civil complaint was formally served. The record contained no evidence that the delay impaired MedPro's ability to investigate or defend the claim, participate in settlement, present potentially outcome-determinative evidence, or otherwise protect its interests. Accordingly, the court held that MedPro could not disclaim coverage based on the insureds' failure to report the potential claim during the policy period.

COMMENTS

The decision illustrates the potentially significant effect of Maryland's notice-prejudice rule on claims-made-and-reported coverage. Where the event triggering coverage occurs during the policy period, an insured's failure to satisfy a requirement that the matter also be reported during that period may be treated as a breach of a notice provision rather than a failure of a condition necessary to create coverage. In that circumstance, the court held that § 19-110 requires the insurer to establish actual prejudice before disclaiming coverage based on late notice.

Missouri Joins Jurisdictions Holding That Products Exclusions Bar Coverage For Claims Arising From Unbranded Marketing Of Opioids

HOLDING

The Missouri Court of Appeals affirmed summary judgment for insurers, holding that claims alleging deceptive marketing of opioids fall within a products exclusion, even where the marketing is not alleged to specifically reference the insured's products. *Opioid Master Disbursement Tr. II v. ACE Am. Ins.,* 2026 Mo. App. LEXIS 561 (Mo. Ct. App. July 21, 2026).

BACKGROUND

Mallinckrodt and its related entities manufactured and sold opioids and ingredients used to manufacture opioid products. After facing more than 3,000 opioid-related lawsuits, Mallinckrodt and its related entities filed for bankruptcy in 2020. As part of the bankruptcy proceeding, Mallinckrodt's insurance coverage rights were transferred to a trust established to administer opioid-related claims.

Mallinckrodt selected eleven exemplar lawsuits to illustrate its pre-bankruptcy liability. The suits alleged, among other things, that Mallinckrodt engaged in allegedly misleading "unbranded marketing"—promotion of opioids in general without reference to a particular brand—that understated the risks of opioid use, encouraged overprescribing, and contributed to opioid-related bodily injuries.

Mallinckrodt sought coverage under primary policies that contained a products exclusion for injury "arising out of" the insured's "product." "Product" was defined to include warranties, representations and failures to provide warnings or instructions concerning the product. The trust argued that because certain of the marketing was alleged to be of opioids in general, rather than Mallinckrodt's opioids in particular, the products exclusion did not eliminate coverage. The trial court granted summary judgment to the insurers, and Mallinckrodt appealed.

DECISION

The Missouri Court of Appeals affirmed. The court explained that under Missouri law, "arising out of" is a broad and unambiguous term requiring only a causal connection—not direct or proximate cause—between the injury and the subject of the exclusion.

The court concluded that exemplar suits alleged a sufficient causal connection between Mallinckrodt's products and the claimed injuries. The complaints alleged that Mallinckrodt (i) falsely represented that opioids were non-addictive, safe for chronic pain, and effective at high doses; (ii) disseminated those representations through physicians, publications, and patient advocacy groups; and (iii) thereby increased opioid use and sales of Mallinckrodt's opioids and active pharmaceutical ingredients. The court therefore held that the alleged injuries "arise out of, flow from, or have origins in" Mallinckrodt's marketing conduct and fell within the products exclusion.

The court found persuasive decisions applying substantially similar products exclusions to preclude coverage for opioid claims in *The Travelers Property Casualty Co. of America v. Actavis, Inc.*, 225 Cal. Rptr. 3d 5 (Cal. Ct. App. 2017) and *Dundon v. ACE Property & Casualty Ins. Co.*, 2026 U.S. Dist. LEXIS 27567 (E.D. Pa. Feb. 10, 2026).

COMMENTS

This decision adds Missouri to the jurisdictions applying products exclusions to bar coverage for claims based on alleged marketing of products, even where the allegations concern the marketing of the product generally and not just the marketing of the insured's branded product in particular. The decision also reinforces the breadth Missouri courts give to "arising out of" language in exclusions: only a causal connection, rather than proximate causation, is required to preclude coverage.

Illinois Appellate Court Affirms That Vacancy Exclusion Bars Coverage For Water Damage; Rejects Waiver And Estoppel

HOLDING

An Illinois appellate court affirmed that a vacancy exclusion barred coverage for water damage to a commercial property that had remained vacant for more than 60 consecutive days before the loss. The court rejected the insured's argument that the insurer was on notice that the property was vacant when it issued the policy and therefore waived the exclusion or was estopped from relying on it. *Argus Inv., Inc. v. W. Bend Mut. Ins. Co.*, 2026 Ill. App. LEXIS 291 (Ill. App. Ct. July 28, 2026).

BACKGROUND

Plaintiff Argus Investment, Inc. operated a brewery at the insured property. Argus was insured by West Bend under a CGL policy containing a "vacancy exclusion," which provides that "[i]f the building where loss or damage occurs has been vacant for more than 60 consecutive days before that loss or damage occurs . . . We will not pay for any loss or damage caused by . . . [w]ater damage."

Argus ceased operations at the property in March 2020. Argus's CGL insurance policy from West Bend covering the property was renewed automatically in 2021. In January 2022, the property sustained water damage from flooding, and Argus submitted a claim to West Bend. West Bend denied coverage based on the vacancy exclusion. Argus then sued for breach of contract and alleged bad faith under section 155 of the Illinois Insurance Code. West Bend counterclaimed for a declaration that it owed no coverage because the vacancy exclusion applied. The trial court granted summary judgment to West Bend, concluding that the exclusion was unambiguous, applied to the loss, and had not been waived.

DECISION

The appellate court affirmed. The court first emphasized that the insured "bears the burden of knowing the content of its insurance policies" and that an insurer "has no duty to review the adequacy of the insured's coverage." The court noted that Argus did not dispute that the vacancy exclusion was unambiguous or that the property was vacant when the policy renewed in June 2021.

Argus argued that West Bend waived the vacancy exclusion because it knew, or should have known, that the property was vacant based on a third-party audit of Argus's worker's compensation policy. The audit disclosed that the brewery was closed and that Argus had no employees other than an office manager. The property insurance policy was not audited, and it was renewed automatically in 2021. The court rejected Argus's argument, holding that the worker's compensation audit did not establish that West Bend knew the property was vacant. The audit reflected only that the brewery had ceased operations and reduced its workforce; it did not communicate that Argus was requesting a change to its property coverage or that the building met the policy's definition of "vacant."

The court also rejected Argus's estoppel argument. The court held that West Bend was not estopped from relying on the vacancy exclusion because Argus failed to establish any misleading act or statement by West Bend. Specifically, the court held that Argus could not show that West Bend misled it into believing coverage would apply if the property remained vacant, that Argus never sought to alter its coverage to reflect a change in status prior to renewal, and that an insurer has no duty to review the adequacy of the insured's coverage. The court further noted that the onus was on Argus and its employees to read the policy and familiarize themselves with its exclusions, and that Argus could not rely on its own failure to review the policy to establish estoppel.

COMMENTS

The decision relies on several important principles of insurance law, including that insureds are presumed to know the contents of their policies, that insurers generally have no duty to advise insureds regarding the adequacy of their coverage, and that policy renewals incorporate existing policy terms absent modification.

Sixth Circuit Holds That Food Manufacturer's Alleged Salmonella Outbreak Was A Single "Occurrence" Under CGL Policies

HOLDING

In a decision applying Ohio law, the Sixth Circuit affirmed summary judgment for food manufacturer J.M. Smucker Company ("Smucker"), on the ground that thousands of claims arising from an alleged salmonella outbreak constituted a single "occurrence" under Smucker's commercial general liability policies. The court further held that the policies' Lot Endorsement was ambiguous and therefore did not require the claims to be treated as separate occurrences based on the production lots from which the allegedly contaminated products originated. *The J.M. Smucker Co. v. ACE Am. Ins. Co.*, 179 F.4th 1038 (6th Cir. 2026).

BACKGROUND

This insurance dispute arose from Smucker's 2022 recall of peanut butter products that were potentially contaminated with salmonella at its production facility. The recall was followed by thousands of claims against Smucker. ACE denied coverage because Smucker had not satisfied a separate retained limit for each occurrence. Because the policies contained a retained limit of $250,000 per "occurrence," ACE maintained that Smucker was responsible for satisfying the retained limit for each of the 225 occurrences before ACE's coverage obligations attached.

The district court granted summary judgment to Smucker, reasoning that the salmonella contamination constituted a single occurrence and that the Lot Endorsement was ambiguous.

DECISION

The Sixth Circuit affirmed. The court first examined the policies' definition of "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." Because the policies did not define "accident," the court applied Ohio law, under which the relevant inquiry focuses on the insured's perspective and "what the insured did unintentionally that exposed it to liability." Applying that standard, the court concluded that the alleged salmonella outbreak—and not each claimant's consumption of peanut butter—was the "only identifiable" accident that gave rise to the actions against Smucker.

The court explained that "the number of occurrences is determined by reference to the cause or causes of the damage or injury, rather than by the number of individual claims." The Sixth Circuit therefore rejected ACE's argument that each claimant's exposure constituted a separate occurrence, concluding that such an approach was inconsistent with Ohio's cause-based analysis.

The court separately addressed the Lot Endorsement and concluded that it was ambiguous. First, the court noted that, unlike other endorsements in the policies, the Lot Endorsement "does not specify that it is replacing the definition of 'occurrence.'" Second, the court held that the phrase "[a]rises out of any one 'lot'" was ambiguous because it could be interpreted either as (i) a limitation, applying where multiple injuries resulting from the same condition within a single lot

constitute one occurrence; or as (ii) an aggregation provision, grouping injuries by production lot. Because Ohio law requires ambiguities to be construed against the insurer, the court concluded that the Lot Endorsement did not alter the result dictated by the policies' occurrence definition.

The court also rejected ACE's argument that Smucker's interpretation rendered the Lot Endorsement superfluous. The court accepted as plausible Smucker's alternative theory that the Lot Endorsement served a "timing function" by determining the policy year in which an occurrence involving a single lot is deemed to occur. Under that interpretation, when injuries arising from a single lot span multiple policy periods, Smucker would be required to satisfy the retained limit for only one policy year rather than multiple policy years.

COMMENTS

The practical significance of a single-occurrence finding depends on the terms of the policy and the interests of the parties in the particular coverage dispute. A finding of one occurrence is not necessarily favorable to a policyholder in every case. Where a policy contains substantial per-occurrence retentions or deductibles, a policyholder may prefer a single occurrence to avoid multiple retentions. By contrast, where a policy provides per-occurrence limits, a policyholder may seek to establish multiple occurrences to maximize available coverage.

The decision highlights the fact-specific nature of occurrence disputes and the importance of clear policy language addressing how claims arising from a common cause, lot, batch, or other related event should be treated. Because the Sixth Circuit's analysis was grounded in Ohio law, the decision's broader impact will depend in part on how other jurisdictions approach similar occurrence questions.

English Commercial Court Holds War Exclusion Bars Coverage For Nord Stream Pipeline Sabotage

HOLDING

The English Commercial Court held that the September 2022 sabotage of the Nord Stream 1 pipelines fell within the policies' war exclusion because the Russia-Ukraine war was a significant cause of the loss, regardless of whether the sabotage was carried out by Russia, Ukraine or a Ukrainian sub-state actor, or the United States. *Nord Stream AG v. Lloyd's Ins. Co. SA & Anor* [2026] EWHC 1685 (Comm).

BACKGROUND

After explosions rendered two natural gas pipelines in the Baltic Sea inoperable, their Swiss operator, Nord Stream AG, sought coverage under offshore operating all risks policies. The insurers declined coverage based on the policies' war exclusion. It was common ground that the Russia-Ukraine conflict, which began on 24 February 2022, constituted a "war" within the meaning of the policies, and that the only possible perpetrators were Ukraine (including sub-state actors), Russia, or the United States. Nord Stream argued, among other things, that the sabotage lacked a sufficient causal connection to the war to trigger the war exclusion.

DECISION

The court held that the war was a significant cause of the sabotage under each of the possible perpetrator scenarios. If Ukraine was responsible, the war provided both a motive to retaliate against Russia and removed the prior restraint imposed by the risk of escalation. If Russia was responsible, the war had altered Germany's relationship with Russia giving Russia a motive to punish or coerce Germany into reversing its support for Ukraine. If the United States was responsible, the invasion removed the prior concern that sabotaging the pipelines might provoke Russia and made such an action a "*conceivable act*."

The court held that these connections satisfied the broad requirement that the loss be "*directly or indirectly occasioned by, happening through, or in consequence of war*." That language did not require the war to be a proximate or effective cause; it was sufficient that there be an "*indirect*" link, *i.e.*, that the war be a "*significant*" contributing factor in the sense of being "*noticeable*" or "*specifically accountable*" as a cause. To the extent there were several causes, the war need not have "*some higher degree of comparative causal contribution*." Because the war exclusion applied under each of the possible perpetrator scenarios, it was unnecessary to determine who actually carried out the sabotage.

COMMENTS

This decision is a significant ruling on the application of a war exclusion to an act of sabotage occurring outside the immediate theater of armed conflict. The judgment is notable for its broad approach to indirect causation under the "*directly or indirectly occasioned by*" language, confirming that the causal test is substantially less demanding than proximate cause and that the chain of causation need not be direct. The decision also confirms that an insurer need not necessarily establish the identity of the actor responsible for a loss to satisfy the causal standard.

English Commercial Court Enforces Insurance Arbitration Clause Through Anti-Suit Injunction And Awards Insurer Damages

HOLDING

The English Commercial Court granted a final anti-suit injunction restraining US-based hospitality companies from pursuing Louisiana litigation against Chubb Bermuda Insurance Ltd, in breach of a London-seated arbitration agreement and awarded Chubb damages arising from the companies' breach of that agreement. *Chubb Bermuda Ins. Ltd v. Fertitta Ent., Inc., et al.* [2026] EWHC 1392 (Comm).

BACKGROUND

Fertitta held USD 200 million in excess coverage issued by Chubb for the 2019–2020 policy year. Following alleged COVID-19 business interruption losses, Fertitta commenced litigation against its insurers in Louisiana and ultimately sought to pursue claims against Chubb there, despite the Chubb policy's London-seated arbitration clause. Chubb acted quickly and obtained an interim anti-suit injunction ("ASI") restraining Fertitta from pursuing its claims in Louisiana. After Fertitta repeatedly breached that injunction, the Commercial Court had to determine whether to make the anti-suit injunction final.

Fertitta did not appear in the English proceedings, but maintained that (i) the London arbitration clause was invalid under Louisiana law; (ii) the dispute had no connection to England as the policies covered only U.S. risks and the losses were suffered in the United States; and (iii) Louisiana was the most suitable forum given that the parties, witnesses, and evidence were located in the United States.

DECISION

The court granted Chubb a permanent anti-suit injunction. It held that there was a valid arbitration agreement and that Louisiana law was irrelevant to determining the validity of the arbitration agreement given it was governed by English law. As there was a valid arbitration agreement, it was also irrelevant whether the dispute had any connection to England or whether Louisiana might have been a more suitable forum. The court also awarded Chubb damages for the costs of the U.S. proceedings, costs in the English proceedings, and an indemnity for costs incurred in any future U.S. proceedings brought by Fertitta.

COMMENTS

The decision further demonstrates the readiness of English courts to enforce arbitration agreements in insurance policies through anti-suit relief. It also illustrates the potential consequences of pursuing litigation in breach of an arbitration agreement; the breaching party may be required not only to discontinue the foreign proceedings but also to compensate the counterparty for the resulting costs associated with that exercise in England (irrespective of the cost-sharing rules, or lack thereof, in the parallel jurisdiction).

English Commercial Court Rejects Rectification Of Global Insurance Policy, Leaving COVID-19 Losses Uncovered

HOLDING

The English Commercial Court dismissed a claim by CP Holdings and other hospitality companies seeking rectification (an equitable remedy by which the court can correct mistakes made in recording agreements in writing) of their 2019 global insurance policy with Assicurazioni Generali SpA, holding that pre-contractual communications established only a willingness in principle to consider such a clause, not a binding agreement on the term the insured later sought to add. *CP Holdings Ltd., et al. v. Assicurazioni Generali SpA, et al.* [2026] EWHC 1520 (Comm).

BACKGROUND

CP Holdings operated hotels, workspaces, and restaurants across the UK, Czechia, Romania, Slovakia, and Hungary under a long-standing global insurance program underwritten by Generali. During the 2019 renewal, Generali required CP Holdings to move to a new policy wording at short notice. CP Holdings' broker proposed including a "conformity clause," under which the terms of the preceding year's policy would prevail if the new wording disadvantaged the insured. Generali's underwriter responded that Generali was "*able to include a Conformity Clause (wording to be agreed)*," but the parties never agreed on specific wording.

Following the COVID-19 pandemic, the 2019 Global Policy excluded CP Holdings' business interruption losses under an infectious diseases exclusion. CP Holdings sought rectification of the 2019 policy to add a general conformity clause that would permit it to rely on the arguably more favorable 2018 policy wording. The claim depended on establishing that such a term had in fact been agreed at the time of renewal.

DECISION

The court rejected the rectification claim. Analyzing the pre-renewal correspondence, the court held that Generali's underwriter's statement that it was "*able to include*" a conformity clause, subject to "*wording to be agreed*" reflected only a "*willingness in principle*" to negotiate such a provision. An objective reading of the pre-contractual correspondence did not establish that the parties had reached a binding agreement to include the particular term that CP Holdings sought through rectification.

COMMENTS

The decision underscores the importance of ensuring that agreement on key terms is recorded unambiguously. Without a clear contemporaneous written record, it will be very difficult to prevail in establishing that such a term was agreed, or in a claim for rectification.

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** In April 2026, Simpson Thacher announced plans to expand its presence in Asia with an office in Singapore.*
*** In August 2026, Simpson Thacher announced plans to expand its presence in the U.S. with an office in Chicago.*

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