

Insurance Law Alert

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– *Chambers USA 2026*
(quoting a client)

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Delaware Superior Court Applies Bump-Up Provisions To Settlements Of Shareholder Actions Challenging Merger Consideration

In two recent decisions, the Delaware Superior Court ruled that bump-up provisions in Directors and Officers (D&O) insurance policies precluded coverage for settlements of shareholder actions challenging the adequacy of merger consideration. In each case, the court concluded that the settlement represented an effective increase in deal consideration, and that the bump-up provision therefore applied. The decisions are *MSG Networks Inc. v. Fed. Ins. Co.*, 2026 WL 1822345 (Del. Super. Ct. June 24, 2026) and *Zayo Grp. Holdings, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 2026 WL 2254784 (Del. Super. Ct. Aug. 5, 2026).

MSG Networks Inc. v. Fed. Ins. Co., 2026 WL 1822345 (Del. Super. Ct. June 24, 2026)

BACKGROUND

The coverage dispute arose from a 2021 reverse triangular merger in which Madison Square Garden Entertainment Corp. (“MSGE”) acquired Madison Square Garden Networks Inc. (“MSGN”). Before the merger, the Dolan Family Group controlled both companies. One stated purpose for the transaction was for MSGE to use MSGN’s cash to fund MSGE projects, including the Sphere in Las Vegas.

After the merger, MSGN Class A shareholders filed suit in the Delaware Court of Chancery, alleging an unfair merger process and that their stock had been undervalued. The shareholders’ expert calculated approximately \$371 million in damages and alternatively calculated \$44.9 million in damages relating to undisclosed increases in Sphere cost projections. The parties settled for \$48.5 million after extensive discovery and shortly before trial. The settlement represented an 8.8 percent increase over the merger’s cash value at closing.

MSGN sought coverage for the settlement under its D&O policies. XL Specialty Insurance Company and National Union Fire Insurance Company each advanced \$10 million toward the settlement under agreements permitting them to recoup those amounts if the policies did not provide coverage. MSGN filed suit seeking declaratory relief, and the insurers counterclaimed for a declaration that the settlement was precluded from coverage under the policies’ bump-up provision. The provision provides in relevant part that the policies’ definition of “Loss” does not include any:

amount that represents, or is substantially equivalent to, an increase in the consideration paid (or proposed to be paid) in an acquisition (or proposed acquisition) of more than 50% of the outstanding securities or other ownership interest of an entity[.]

DECISION

The Delaware Superior Court granted summary judgment for the insurers, determining that the bump-up provision precluded coverage for the \$48.5 million settlement.

The underlying suit alleged that MSGN Class A Shareholders received inadequate merger consideration because, among other things, the exchange ratio undervalued their shares and MSGE had failed to disclose to MSGN's special committee increased cost projections for the Sphere project in Las Vegas. In determining that the settlement "represents" increased consideration, the court applied the factors discussed in *Ill. Nat'l Ins. Co. v. Harman Int'l Indus., Inc.*, 360 A.3d 240 (Del. 2026) ("*Harman III*"), including: (i) the settlement language; (ii) whether the settlement compensated shareholders for an allegedly inadequate deal price; (iii) the stage of litigation at the time of the settlement; and (iv) composition of the settlement class.

Although the settlement agreement stated that the insured settled to avoid the expense and burden of litigation costs, the court found more compelling evidence that the settlement "represents" an increase in consideration based on other factors, including: (i) the settlement directly increased the value received by the Class A shareholders and represented an 8.8 percent premium to the merger price; (ii) the settlement closely corresponded to the shareholders' expert's damages estimate relating to the Sphere cost projections; (iii) the shareholders' claims were based on undervaluation of their stock, and the settlement provided direct per-share payments to shareholders who had received merger consideration; and (iv) the parties settled only after extensive discovery and shortly before trial, which the court viewed as evidence that the payment reflected resolution of the alleged valuation shortfall rather than merely avoidance of litigation costs.

The court further determined that, not only did the settlement "represent" an actual increase in consideration, it also was "substantially equivalent to" an increase in consideration under the bump-up clause.

The court rejected MSGN's argument that the transaction was not an "acquisition" under the bump-up clause because the Dolan Family Group controlled both companies before and after the merger. The court held that the policies' plain language did not require a change in ultimate control, noting that MSGE held no voting securities in MSGN before the merger and 100 percent after.

The court further concluded that the bump-up provision applied to the attorneys' fees and costs paid from the common settlement fund. Applying the common fund doctrine, the court reasoned that the expense award was "fused into the Settlement" because the entire fund benefitted the shareholder class and therefore enhanced the consideration received by the shareholders.

The court therefore held that the bump-up provision barred coverage for the entire settlement amount, including the fee and expense payment. The court accordingly held that XL Specialty and National Union were each entitled to recoup their \$10 million advances.

Zayo Grp. Holdings, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA, 2026 WL 2254784 (Del. Super. Ct. Aug. 5, 2026)

BACKGROUND

The coverage dispute arose from a 2019 reverse triangular merger in which Digital Colony Partners and the EQT Infrastructure IV Fund, referred to as “Consortium B,” acquired Zayo Group Holdings, Inc. (“Zayo”), a global provider of communications infrastructure. Zayo’s shareholders received \$35 in cash per share of common stock.

Former Zayo shareholders sued Zayo’s CEO, Dan Caruso, in the Delaware Court of Chancery, alleging that he breached his fiduciary duties in connection with the acquisition. The Court of Chancery dismissed all claims except the shareholders’ claim that Caruso breached his duty of care by failing to disclose a conversation showing that Consortium B was willing to pay a price above \$35 per share. The parties ultimately settled for \$27,125,000. Zayo sought coverage under its D&O policies.

DECISION

The Delaware Superior Court granted the insurers’ motion for summary judgment, holding that the bump-up provision barred coverage for the settlement.

The court first placed its analysis in the context of *Harman III and Towers Watson & Co. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 138 F.4th 786 (4th Cir. 2025) (“*Towers Watson II*”), both of which involved bump-up provisions with the same operative language as Zayo’s policy. (These opinions were discussed in our [February 2026](#) and [June 2025](#) alerts, respectively.) In *Towers Watson II*, the Fourth Circuit held that the bump-up provision barred coverage for the settlement of a shareholder action challenging the adequacy of merger consideration. In *Harman III*, however, the Delaware Supreme Court held that the same provision did not bar coverage on the facts before it.

Against that backdrop, the court considered whether the requirements for application of the bump-up provision were satisfied. The court first found that the underlying action alleged inadequate deal consideration in the acquisition of the insured entity because the shareholders sought damages for “unfair Merger consideration” and the alleged conduct purportedly caused them to receive an unfair price.

The court then determined that the settlement represented an effective increase in consideration. The court identified several “strong indicators” supporting that conclusion: Caruso paid the settlement amount to the plaintiff shareholders on a per-share basis, and only to those who held stock at closing; additionally, the parties settled after a year of discovery, which the court found supported the conclusion that the settlement represents an increase in consideration rather than merely an effort to avoid litigation costs.

The court placed particular weight on the fact that the settlement amount went only to the shareholders who had received consideration in the acquisition, describing this factor as “largely determinative” and finding that it carried more weight than the insured’s argument that the settlement represented litigation costs. The court also found significant the fact that, although Caruso denied wrongdoing, he did not stipulate that he settled solely to avoid continued litigation costs—unlike the defendant in *Harman III*. The court ultimately concluded that “the Caruso Action and the Settlement are far more aligned with the facts in *Towers Watson II*” than with those in *Harman III*.

The court also rejected Zayo’s argument that the Larger Settlement Rule required allocation between covered and uncovered portions of the settlement. The court noted that it had previously declined to extend the rule beyond the allocation situation involving indemnifiable and non-indemnifiable parties, and in any event concluded that the entire settlement represented an increase in consideration, leaving no allocation issue.

Finally, the court granted the insurers summary judgment on Zayo’s bad-faith claim, holding that because the bump-up clause excluded coverage, the insurers did not breach the policy by declining coverage. Without an underlying breach of the policy, the insured could not maintain its bad-faith claim.

COMMENTS

MSG Networks and *Zayo* shed further light on the application of bump-up provisions following the Fourth Circuit’s opinion in *Towers Watson II* and the Delaware Supreme Court’s decision in *Harman III*. While *Harman III* held that the bump-up provision did not apply on the record before it, subsequent decisions suggest that case-specific differences in the settlement record can produce a different result. In particular, the decisions highlight settlement pricing, structure, timing, and the composition of the class receiving the settlement as potentially significant considerations.

Both cases have been appealed to the Delaware Supreme Court.



Ohio Federal Court Holds Occupational Disease Exclusion Bars Coverage For PFAS Claims By Non-Employees

HOLDING

An Ohio federal district court granted summary judgment to an insurer, holding that an occupational disease exclusion in commercial general liability policies barred coverage for PFAS-related personal injury claims brought by firefighters who were not employees of the insured. *Fire-Dex, LLC v. Admiral Ins. Co.*, 2026 U.S. Dist. LEXIS 199844 (N.D. Ohio Sept. 3, 2026).

BACKGROUND

Fire-Dex, an Ohio-based manufacturer of personal protective equipment for firefighters, was named as a defendant in lawsuits alleging that firefighters developed cancer from exposure to per- and polyfluoroalkyl substances (“PFAS”) in Fire-Dex turnout gear. The plaintiffs alleged that they were repeatedly exposed to PFAS while wearing the gear in the course of their firefighting duties.

Fire-Dex sought defense and indemnity under CGL policies issued by Admiral Insurance Company. Admiral denied coverage based on an occupational disease exclusion, which provided “there is no coverage . . . for any ‘bodily injury’ to any individual resulting from any occupational or environmental disease arising out of any insured’s operations, completed operations or products.” Fire-Dex sued, seeking a declaration of coverage and asserting claims for breach of contract and bad faith.

DECISION

The United States District Court for the Northern District of Ohio first denied Fire-Dex’s motion to certify a question to the Ohio Supreme Court regarding whether the occupational disease exclusion applies only to claims by an insured’s own employees or also to claims by non-employees. The court agreed that the issue was one of “first impression” under Ohio law, but concluded that existing Ohio authority provided “a reasonably clear and principled course” for resolving it.

Turning to the merits, the court held that the occupational disease exclusion unambiguously barred coverage.

Because the policies did not define “occupational disease,” the court considered Ohio case law, Ohio’s statutory definition of the term, and dictionary definitions. The court concluded that an occupational disease is one contracted during and as a result of employment, where the conditions causing the illness are not ones to which the general public is exposed. The underlying allegations satisfied that definition because the firefighters allegedly developed cancer from PFAS exposure while wearing turnout gear required as part of their employment.

The court rejected Fire-Dex’s argument that the exclusion applied only to claims by Fire-Dex’s own employees. Fire-Dex argued that “occupational disease” should be limited to diseases giving rise to workers’ compensation benefits and, on that basis, that the exclusion should apply only to claims by employees against their employers. The court disagreed. It reasoned that eligibility for workers’

compensation is a consequence of having an occupational disease, not part of the definition of occupational disease itself. And, even if workers' compensation were relevant, eligibility for workers' compensation does not depend on whom the worker sues—"it would be bizarre to say that an illness is an occupational disease when a plaintiff sues his employer but ceases to be an occupational disease when he sues someone else."

The court further ruled that the policy language itself established that the occupational disease exclusion was not limited to claims by Fire-Dex's employees. The exclusion applied to bodily injury sustained by "any individual," which the court held plainly encompasses both employees and non-employees. The court contrasted that language with another policy provision expressly referring to "any employee," reasoning that the difference in language required a difference in meaning. Accordingly, the exclusion applied to the underlying firefighters' claims, and Admiral had no duty to defend or indemnify Fire-Dex.

The court also granted Admiral summary judgment on Fire-Dex's breach of contract and bad faith claims. Because Admiral had no duty to defend or indemnify, there was no breach of contract or bad faith.

COMMENTS

This decision is notable because PFAS coverage litigation to date has frequently centered on pollution exclusions, while this decision illustrates that occupational disease exclusions may provide an independent basis for defeating coverage for PFAS and other toxic-tort claims arising from workplace exposure.

The *Fire-Dex* court's reasoning is consistent with the Connecticut Supreme Court's decision in *R.T. Vanderbilt Co. v. Hartford Accident & Indem. Co.*, 333 Conn. 343 (2019), which addressed occupational disease exclusions in the context of asbestos and other toxic-exposure claims. There, the court likewise held that the exclusions were not limited to claims by the insured's own employees and applied to individuals who allegedly contracted an occupational disease while working for other employers. The *Fire-Dex* court relied on *Vanderbilt* in rejecting Fire-Dex's argument that the exclusion was limited to claims by its own employees.



New York District Court Awards Insured Attorney's Fees Against Excess Insurer Where Duty To Defend Was "Looming"

HOLDING

A federal district court in New York granted an insured's motion for attorney's fees incurred in successfully defending a declaratory judgment action brought by its excess insurer. The court held that, under New York's "Mighty Midgets" doctrine, the insured could recover its fees where the excess insurer's duty to defend was "looming" and "likely to be triggered." *GuideOne Nat'l Ins. Co. v. Sys. 2000 Plumbing Serv., Inc.*, 2026 U.S. Dist. LEXIS 195589 (S.D.N.Y. Aug. 31, 2026).

BACKGROUND

Systems 2000 Plumbing Service, Inc. ("Systems 2000") was insured under a \$2 million primary policy issued by Travelers and a \$4 million "follow form" excess policy issued by GuideOne. After a 2021 fire at an apartment building where Systems 2000 was performing work replacing valves, Travelers voluntarily reformed its policy to remove a residential exclusion. GuideOne declined to follow Travelers' reformation, maintaining that it had no obligation under its excess policy to cover the resulting claims.

GuideOne subsequently brought a declaratory judgment action seeking a determination that it had no obligation to defend or indemnify Systems 2000. Following a bench trial, the court ruled in favor of Systems 2000 on mutual mistake and illusory contract grounds. Systems 2000 then moved to recover the attorney's fees it had incurred in the coverage action.

DECISION

The United States District Court for the Southern District of New York granted Systems 2000's motion for attorney's fees under New York's "Mighty Midgets" doctrine, which permits an insured to recover fees under certain circumstances when "cast in a defensive posture by the legal steps an insurer takes in an effort to free itself from its policy obligations." *Mighty Midgets, Inc. v. Centennial Ins. Co.*, 47 N.Y.2d 12, 389 N.E.2d 1080, 1085 (N.Y. 1979). The court addressed the Second Circuit's decision in *Liberty Surplus Ins. Corp. v. Segal Co.*, 420 F.3d 65 (2d Cir. 2005), which reasoned that an excess insurer ordinarily should not be responsible for an insured's fees where its contingent duty to defend has not been triggered. The court found that *Liberty Surplus* left open the possibility of fee recovery where the excess insurer's duty to defend has not yet been triggered, but "likely will be," and the insurer brings a declaratory judgment action to avoid that "looming" obligation.

The court found that GuideOne's duty to defend fell within that scenario. The underlying claims exceeded \$15 million—more than seven times the \$2 million primary limit—and prelitigation correspondence suggested that GuideOne understood that the loss was likely to exceed the primary coverage before it commenced the declaratory judgment action. The court therefore concluded that GuideOne's duty to defend was "looming" and "likely" to be triggered.

In determining how the New York Court of Appeals would resolve this question, the court relied on *RLI Ins. Co. v. Smiedala*, 77 A.D.3d 1293 (4th Dep’t 2010). There, the Fourth Department held that an excess insurer was not insulated from fee-shifting merely because its duty to defend had not yet been triggered, reasoning that the insured nevertheless had been placed in a defensive posture by the insurer’s attempt to avoid its policy obligations. Based on *RLI Ins. Co.*, the court predicted that New York courts would permit fee recovery where an insured successfully defends itself against a declaratory judgment action brought by an excess insurer concerning the insurer’s looming, likely-to-be-triggered duty to defend.

COMMENTS

The general rule recognized by the Second Circuit in *Liberty Surplus* is that an excess insurer whose duty to defend has not been triggered is not responsible for the insured’s fees in coverage litigation. The *GuideOne* decision identifies a narrow exception. The result turned on the court’s finding that circumstances indicated exhaustion of the primary coverage—and thus *GuideOne*’s defense obligation—was not merely possible but likely. The decision therefore underscores the importance of evaluating the underlying exposure and exhaustion picture when an excess insurer considers pursuing declaratory relief against an insured.

The *GuideOne* decision also highlights the different standards governing the two potential bases for fee shifting under New York law. The court did not reach the insured’s alternative argument that a fee award was proper because *GuideOne* acted in bad faith in denying coverage. The court nevertheless expressed skepticism about that argument, observing that the complex coverage dispute reflected an “arguable difference of opinion” between insurer and insured.



Delaware Court Predicts That New York Law Prohibits Insurers From Recouping Settlement Payments Absent Express Policy Language Or Insured Consent

HOLDING

The Delaware Superior Court, applying New York law, held that an insurer cannot recoup settlement payments made under a reservation of rights where the policies contained no express recoupment provision and the insured had not agreed to reimbursement. The court predicted that the New York Court of Appeals would adopt the same rule. *Turner Corp. v. Lexington Ins. Co.*, 2026 WL 2227785 (Del. Super. Ct. Aug. 3, 2026).

BACKGROUND

This insurance dispute arose from a lawsuit brought by New York University (“NYU”) against Turner Construction following Hurricane Sandy in 2012. NYU alleged that Turner failed to properly secure a ventilation shaft at NYU Langone Medical Center, allowing millions of gallons of water to enter the facility and damage multiple buildings. NYU sought more than \$2.2 billion in property damage and business interruption losses.

Turner was insured under a \$25 million commercial umbrella liability policy issued by National Union and a \$25 million follow-form excess liability policy issued by Lexington. Neither policy contained a general provision allowing the insurers to recoup settlement payments, though both policies included endorsements expressly providing for recoupment of settlement advances in certain motorist-coverage situations.

Following years of litigation and an unsuccessful mediation—and with a trial date looming—NYU made a settlement demand in September 2022. NYU imposed an October 7 deadline for a response, and advised that this would be “Turner’s (and its insurers’) last opportunity to resolve NYU’s claims against it in an amount that does not exceed Turner’s available insurance coverage.” On October 7, the insurers agreed to contribute their full policy limits toward the settlement. The insurers expressly reserved their right to seek full recoupment, asserting that coverage was precluded by the policies’ non-cumulation and anti-stacking provisions. Turner acknowledged the insurers’ payment but expressly declined to consent to recoupment.

DECISION

The Delaware Superior Court granted summary judgment in Turner’s favor on the recoupment issue, concluding that the insurers had no right to recover their settlement payments under New York law.

Finding that the New York Court of Appeals had not addressed whether an insurer may recoup settlement payments based solely on a reservation of rights, the Delaware Superior Court examined New York precedent, decisions from other jurisdictions, and the Restatement of the Law of Liability Insurance to predict how New York’s highest court would resolve the issue.

The court first observed that New York’s intermediate appellate courts are divided on whether an insurer may recoup *defense costs* based on a reservation of rights. It noted that New York’s Appellate Division, First Department has permitted recoupment in those circumstances, while the Second Department reached the opposite conclusion in *Am. W. Home Ins. Co. v. Gjonaj Realty & Mgmt. Co.*, 138 N.Y.S.3d 626 (App. Div. 2020), holding that an insurer could not recoup defense costs absent an express policy provision authorizing reimbursement.

The court acknowledged that defense costs and settlement payments implicate different coverage obligations. It noted that, in *Arrow Lighter, Inc. v. N. Am. Capacity Ins. Co.*, 2025 WL 4353603 (E.D.N.Y. Dec. 22, 2025), a federal court applying New York law had distinguished *Gjonaj* on that basis when considering an insurer’s claim for recoupment of settlement payments. The Delaware Superior Court, however, did not consider that distinction dispositive.

The court also considered Section 25(2) of the Restatement, which provides that, unless otherwise stated in the policy or agreed to by the insured, an insurer may not settle a legal action and subsequently demand reimbursement on the grounds that the action was not covered. Although the court acknowledged the absence of a clear nationwide consensus, it found the Restatement’s approach consistent with New York’s principles of contract law.

Turning to the specific policies at issue, the court emphasized that both policies expressly authorized recoupment of settlement advances in certain motorist-coverage circumstances but contained no comparable provision applicable to the settlement at issue. The court reasoned that the omission of a broader recoupment provision must be presumed intentional. The court further emphasized that the insured had expressly declined to consent to recoupment. Accordingly, it found that the insurers’ reservation of rights to seek recoupment of the settlement payments could not create a contractual right that the parties had not agreed upon. Having determined that the insurers lacked a right to recoupment, the court declined to decide whether the policies’ non-cumulation and anti-stacking provisions precluded coverage for the settlement.

COMMENTS

Turner highlights the difficult position insurers may face when asked to fund a settlement while maintaining substantial coverage defenses. Here, the insurers contributed their full policy limits to protect their insured against a potential excess verdict, expressly reserving their right to seek reimbursement. Nevertheless, the court denied recoupment without reaching the merits of their coverage defenses. Although the decision represents a Delaware court’s prediction of New York law rather than binding New York precedent, it highlights the importance of considering recoupment rights when funding settlements involving disputed coverage.



English Commercial Court Upholds Avoidance Of Charterers' Liability Policy For Non-Disclosure Of Prior Cargo Fires

HOLDING

The English Commercial Court held that an insurer was entitled to avoid a charterers' liability policy because the insured, a Belgian scrap metal dealer, breached its duty of fair presentation under the Insurance Act 2015 by failing to disclose five fires involving its scrap metal cargoes in the period before the policy renewal. *Cometsambre SA v Lloyd's Ins. Co. SA* **HIG 5321** [2026] EWHC 1837 (Comm).

BACKGROUND

Cometsambre, a Belgian scrap metal dealer, held charterers' liability insurance that had been renewed annually since 2010. Cometsambre had presented its scrap metal cargoes as non-hazardous, implying a low risk of fire. Between May 2020 and October 2021, Cometsambre experienced five fires involving its scrap metal: three on board-chartered vessels during loading or discharge and two in quayside scrap stockpiles at Ghent. None of the fires was disclosed to the insurer before the policy renewal for 2022.

In June 2022, a fire occurred during loading of scrap metal onto the chartered vessel LOWLANDS MIMOSA. The fire caused significant damage to the vessel, giving rise to a substantial charterparty claim against Cometsambre. Cometsambre sought an indemnity from the insurer. The insurer contended that Cometsambre had breached its duty of fair presentation under the Insurance Act 2015 by failing to disclose the earlier fires. The court therefore had to decide (amongst other things) whether the fires were material circumstances that should have been disclosed, and whether the insurer would have entered into the policy had the earlier fires been disclosed.



DECISION

Butcher J held that the insurer was entitled to avoid the policy due to the insured's breach of the duty of fair presentation. The court held that, given the initial presentation of the risk to the insurers, a prudent underwriter would have expected a low risk of fire. Further, a prudent underwriter would want to take the fires into account in deciding whether to write the risk, as fires are a "paradigm example" of an incident capable of generating large claims—whether or not the fires in fact gave rise to a claim—and previous fires may speak to the nature of the cargo being shipped by the charterer. Moreover, a pattern of five fires after a long period without significant fire incidents was particularly material as this indicated a significant change in the underlying risk profile. The burden was on the insured to disclose the prior fires, whether or not the insurer raised specific questions about fire history.

Turning to whether the insurer would have renewed the policy had the fires been disclosed, the court acknowledged the well-known risk that underwriters may honestly but unreliably convince themselves, after the event, that they would have declined the risk. Applying a "healthy scepticism" to that evidence, the court nonetheless accepted the coverholder's testimony that it would not have renewed the policy in 2022 on any terms. The premium was too low relative to the fire exposure, and the pattern of five fires pointed to an altered risk profile.

COMMENTS

The decision illustrates that prior incidents may be material to underwriting even where they have not resulted in claims, particularly where a pattern of similar incidents indicates a change in underlying risk profile. It also reinforces that the insured's duty of fair presentation is not dependent on the insurer having specifically asked about the circumstances at issue.

The court's treatment of the question of whether the non-disclosure actually influenced the insurer's decision is also instructive: it applied a "healthy scepticism" to hypothetical underwriting evidence but was persuaded by the commercial logic that the premium was far too low to justify the fire risk that the insured had failed to disclose.



English Commercial Court Upholds D&O Defense Costs Cover Pending Proof Of Fraud

HOLDING

The English Commercial Court held that insurers could not avoid a D&O policy on the basis of alleged fraud in its placement. The policy required fraud to be established by a final court decision or formal written admission before avoidance was permitted; until then, the insurers were required to continue to advance defense costs. *Liberty Managing Agency Ltd v Chedid* [2026] EWHC 2354 (Comm).

BACKGROUND

The insurers issued a D&O policy to Petrofac Ltd. The defendants—former Petrofac officers facing criminal bribery charges to which they had pleaded not guilty—were insureds under the policy. The insurers purported to avoid the policy based on alleged fraudulent misrepresentation and non-disclosure in its placement. Those allegations materially relied on the prosecution’s case in the pending criminal trial and had not yet been proved.

The key issue was whether the insurers could avoid the policy on the strength of the fraud allegations alone, or instead had to await a final determination of the fraud. The defendants argued that Clause 8.2 prevented avoidance until fraud was established. That clause provided that the insurer could not avoid the policy for misrepresentation or non-disclosure unless such fraudulent conduct “is established by a final decision of a court, tribunal or regulator or by a formal written admission of the Insured.” The insurers argued that the clause was no more than “surplusage” reflecting “the ordinary position that an insurer who avoids must ultimately, in the event of dispute, establish its case at trial.” The insurers further argued that Clause 8.2 was unenforceable because it would protect the insureds from “the consequences of their own fraudulent wrongdoing,” contrary to public policy and the principle that “fraud unravels all.”



DECISION

The court held that the words “established by a final decision” in Clause 8.2 imposed a temporal requirement: the insurer could only avoid the policy once the fraudulent conduct had been established by a final decision of a court, tribunal or regulator or by a formal written admission. The court noted that this construction made “good commercial sense”—directors and officers would want their ongoing defense costs paid until there was an “objective resolution” of allegations that may otherwise permit avoidance of the policy, and D&O insurers would be willing to provide that protection to make their policies more attractive in a competitive market.

The court also rejected the argument that Clause 8.2 was contrary to public policy. The principle that parties should not benefit from their own willful wrongdoing applies to proven fraud. But there was no public policy bar to parties agreeing how unproven allegations of fraud would affect their contractual relationship. Clause 8.2 simply regulated the position while the alleged fraud remained unproven. If the insurers ultimately proved fraud in relation to the placement of the policy, the policy “will (in the usual way) be avoided *ab initio*, and any benefits received by Defendants (such as defense costs which have been advanced) will need to be returned.” Nor was there any public policy bar to an agreement to indemnify against the costs of defending allegations of criminal wrongdoing.

COMMENTS

Beyond the policy wording, the court was unwilling to endorse a result that could deprive the insureds of the ability to defend themselves and increase the chances of their defense failing. The counterbalance, as the court noted, is that if fraud is ultimately established and the policy avoided, the insureds must repay the defense costs advanced.

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