11-1651

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IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

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CATHY S. GATSON, CLERK
KANAWHA COUNTY CIRCUIT COURT

RONNIE SMITH, et al. Plaintiffs v. RICHARD D. LINDSAY, et al. Defendants/Third-Party Plaintiffs v. ATTORNEYS LIABILITY PROTECTION SOCIETY, INC., et al. Third-Party Defendants	CIVIL ACTION NO. 08-C-75 Honorable Charles E. King, Judge

ORDER GRANTING THIRD-PARTY DEFENDANT ATTORNEYS LIABILITY PROTECTION SOCIETY, INC.'S MOTION FOR SUMMARY JUDGMENT

On the 25th day of August, came the Third-Party Defendant Attorneys Liability Protection Society, Inc., ("ALPS"), by and through counsel, Marc E. Williams, and further came the Third-Party Plaintiffs Richard D. Lindsay and Pamela Tabor Lindsay, d/b/a Tabor Lindsay & Associates' ("TL&A"), by and through counsel, James A. Varner, Sr. and Jeffrey Van Volkenberg, for a Hearing on ALPS's Motion for Summary Judgment and TL&A's Motion for Summary Judgment on Claims for Insurance Coverage. Also before the Court on August 25, 2011, was the Plaintiff Ronnie Smith, by and through counsel Andy MacQueen and Timothy Barber.

This Court having reviewed the pleadings and submissions of the parties, heard the arguments of counsel, reviewed applicable legal authority and being otherwise sufficiently informed and advised, hereby **ORDERS** that ALPS' Motion for Summary Judgment is

GRANTED and that TL&A's Motion for Summary Judgment on Claims for Insurance Coverage is **DENIED** for the following reasons:

FINDINGS OF FACT

1. Richard D. Lindsay and Pamela Tabor Lindsay maintain a law practice specializing in medical malpractice in Charleston. The law firm, Tabor Lindsay & Associates, is organized as a professional limited liability company. Ms. Tabor Lindsay is the sole member and her husband, Richard Lindsay, is an employee.

2. In 1990, the plaintiff, Ronnie Smith, and his former wife, Nancy Smith, retained Rudolph L. DiTrapano and his law firm, DiTrapano, Barrett & DiPerio (formerly known as DeTrapano & Jackson) to represent them in a medical malpractice action.

3. Attorney DiTrapano, acting on behalf of the Smiths, enlisted TL&A to litigate the Smith's medical malpractice case due to their expertise in handling such cases.

4. The medical malpractice action was settled in 1995 and the Nancy E. Smith Irrevocable Trust (the "Trust") was established at United National Bank to receive the proceeds of the settlement. Ms. Smith subsequently passed away in 1998.

5. On January 10, 2008, Mr. Smith filed a complaint *pro se* against TL&A individually and in his capacity as administrator of Ms. Smith's estate. In the complaint, Mr. Smith asserted that Attorney Tabor Lindsay had wrongfully caused a check to be issued *in her name* from the Trust account in the amount of $290,000. Mr. Smith sought recovery against TL&A for compensatory and punitive damages. Return receipts attached to the complaint indicate that it was served upon TL&A on February 11, 2008.

6. ALPS had previously issued a claims-made-and-reported lawyers professional liability insurance policy to TL&A with a policy period from March 24, 2007 through March

2008 (the "2007 Policy"). TL&A did not report Mr. Smith's claim to ALPS during that policy period.

7. Instead, TL&A retained defense counsel on its own, and on February 20, 2008, filed an answer to Mr. Smith's complaint.

8. Mr. Smith subsequently retained his own counsel and filed an amended complaint in which he expanded his allegations against TL&A for improper handling of trust account funds. Among other things, Mr. Smith asserted that Attorney Tabor Lindsay had wrongfully endorsed his name on a check, and that she failed to deposit certain funds paid over to her from the settlement proceeds into the Trust. Mr. Smith again sought recovery of the allegedly missing funds as well as punitive damages for TL&A's allegedly willful and wanton conduct. Mr. Smith also alleged that TL&A had failed to provide an accounting for the allegedly missing funds. TL&A answered the amended complaint on June 8, 2008.

9. At the expiration of the 2007 Policy, ALPS issued to TL&A a subsequent claims-made lawyers professional liability policy with a policy period from March 24, 2008 to March 24, 2009 (the "2008 Policy"). At the expiration of the 2008 Policy, ALPS issued to TL&A another claims-made lawyers professional liability policy with a policy period from March 24, 2009 through March 24, 2010 (the "2009 Policy"). TL&A did not report Mr. Smith's claim during the policy period of either of these policies.

10. In applying for the 2008 and 2009 Policies, TL&A completed and executed application forms that each asked if any claims had been asserted against the firm or any of its members during the past five years and whether TL&A was aware of any circumstances that could give rise to a claim. In each instance, TL&A responded to this question by checking the box for "No."

11. Finally, on May 20, 2010, TL&A provided notice to ALPS of Mr. Smith's claim and enclosed a copy of the amended complaint. In its cover letter, TL&A stated that Mr. Smith's suit had been filed "in 2008 from *alleged negligent conduct* in 1995" (emphasis supplied). TL&A conceded that it had not reported the case to ALPS earlier because the firm "looked upon this as a nuisance case—nothing was done for almost a year." TL&A then attempted to minimize its failure to report the case previously by claiming that there was no prejudice to ALPS because TL&A had been represented by an attorney throughout the intervening two years. TL&A requested that ALPS defend and indemnify the firm in connection with Mr. Smith's claim.

12. By letter dated May 25, 2010, ALPS claims attorney Jim Mickelson acknowledged receipt of TL&A's report of the Smith claim. Mr. Mickelson also confirmed an earlier telephone conversation with Attorney Richard Lindsay in which Attorney Lindsay again conceded that TL&A had received the Smith claim in 2008, but had not reported it until 2010 due to its belief that it was a nuisance suit that would not be pursued. Mr. Mickelson indicated that the matter was under review, but that ALPS was presently disputing coverage based upon TL&A's failure to timely report the Smith claim and because the allegations amounted to a claim for conversion.

13. The ALPS policy in effect at the time when TL&A reported the Smith claim had an effective date of March 24, 2010 and an expiration date of March 24, 2011 (the "2010 Policy").

14. By correspondence dated June 23, 2010, ALPS denied TL&A's request for coverage. Among other things, ALPS's denial was based upon the fact that Mr. Smith's claim was first asserted in 2008, over two years before the inception of the 2010 Policy, and, therefore,

it was not "first made" during the policy period as required under the insuring clause. The denial was also based upon the fact that Mr. Smith's amended complaint did not seek damages within the meaning of the 2010 Policy and also fell within an exclusion for claims arising out of the mishandling of client funds.

15. After an additional exchange of correspondence between ALPS and TL&A in which ALPS reiterated its denial, TL&A submitted through counsel on October 1, 2010, a "second amended complaint" that had recently been filed by Mr. Smith. The second amended complaint consisted of two paragraphs in which Mr. Smith incorporated all of his factual allegations contained in the earlier amended complaint (which was attached) and then asserted that the foregoing "actions, behaviors, omissions, or violations of duty on the part of the defendants were occasioned by their negligence." These were the very same actions, behaviors and omissions that had served as the basis for Mr. Smith's earlier amended complaint.

16. In his October 1 correspondence, TL&A's counsel asserted to ALPS that "this is your insured's first notice of a negligence claim," and demanded that ALPS assume the defense of the Lindsays. In fact, however, TL&A itself had previously characterized Mr. Smith's claim as based in alleged negligence.

17. TL&A's counsel further explained that "[o]bviously, ALPS raised a concern about the late notice. In response to that, *defense counsel approached* the Court and *opposing counsel with a motion* to continue the trial date and *permit the amendment of the pleadings*." (emphasis supplied).

18. ALPS subsequently renewed its denial of coverage, and TL&A filed a third-party complaint naming ALPS and others as third-party defendants. In its third-party complaint, TL&A seeks a declaration as to "the rights and obligations of ALPS" under the 2010 Policy.

19. The declarations pages for the 2007, 2008, 2009, and 2010 Policies each state, "NOTICE: This is a Claims Made and Reported policy. Except to such extent as may otherwise be provided herein, the coverage afforded under this policy is limited generally to liability for only those claims that are first made against the Insured and first reported to the Company while this policy is in force."

20. The 2007, 2008, 2009, and 2010 Policies each utilize the same policy form, PLP002a (2/15/2007). The first page of this policy form prominently states that coverage is provided on a "Claims Made And Reported" basis and that the insured must immediately report any claim during the policy period, otherwise there will be no coverage.

21. The basic Insuring Agreement provides:

> Subject to the limit of liability, exclusions, conditions, and other terms of this policy, the **Company** agrees to pay on behalf of the **Insured** all sums (in excess of the **deductible** amount) that the Insured becomes legally obligated to pay as **damages**, arising from or in connection with A **CLAIM** FIRST MADE AGAINST THE **INSURED** AND FIRST REPORTED TO THE **COMPANY** DURING THE **POLICY PERIOD**, provided that the **claim** arises from an act, error, omission or personal injury that happened on or after the **loss inclusion date** and the **retroactive coverage date** set forth in Items 2 and 3 of the Declarations, and that the claim arises from or is in connection with:
>
> 1.1.1 an act error or omission in professional services that were or should have been rendered by the insured . . . .
>
> and further provided that at the **effective date** of this policy, no **Insured** knew or reasonably should have known or foreseen that the act, error, omission or personal injury might be the basis of a **claim**.

22. A **Claim** is defined as "a demand for money or services, including but not limited to the service of suit or institution of arbitration proceedings against the Insured."

23. **Damages** are defined to include "any monetary award by way of judgment or final arbitration, or any settlement" but do not include "*restitution*, reduction, disgorgement or set-off of any fees, costs, consideration, or expenses paid to or charged by an Insured, *or any*

other funds or property presently or formerly held by an Insured." **Damages** also expressly excludes "punitive, multiple or exemplary damages" or "injunctive, declaratory, or other equitable relief, or costs or fees incident thereto."

24. The policy form also contains an Exclusions section, which provides:

> 3.1 THIS POLICY DOES NOT APPLY TO ANY CLAIM ARISING FROM OR IN CONNECTION WITH: . . .
>
> 3.1.13 Any conversion, misappropriation or improper commingling by any person of client or trust account funds or property, or funds or property of any person held or controlled by an **Insured** in any capacity or under any authority, including any loss or reduction in value of such funds or property.

25. The policy form also contains a Conditions section, which provides:

> 4.2.5 Neither the making of one or more **claims** against more than one **Insured**, nor the making of one or more **claims** by more than one claimant, shall operate to increase the **limit of liability**. All **claims** that arise out of the same or **related professional services**, whenever made and without regard to the number of **claims**, claimants or **Insureds**, shall be considered together as a single **claim** and shall be subject to the same single "each claim" **limit of liability**, "aggregate" **limit of liability**, and **claim expense allowance**.
>
> 4.6.4 In the event an **Insured** fails to give written notice to the **Company** of a **claim,** prior to the end of the **policy period** in which the **claim** is made . . . then no coverage for any such **claim** shall be afforded to the **Insured** under any future policy issued by the **Company**.

CONCLUSIONS OF LAW

1. Generally, "[d]etermination of the proper coverage of an insurance contract when the facts are not in dispute is a question of law." *Moore v. CNA Ins. Co.*, 215 W.Va. 286, 289-90, (2004) (citing *Tennant v. Smallwood,* 211 W.Va. 703 (2002)). I find that the relevant facts necessary to adjudicate the insurance coverage issue presented are not in dispute.

2. West Virginia courts routinely decide issues of insurance coverage, including whether an insurer owes a duty to defend its insured, on summary judgment. *See, e.g., Mylan Labs. Inc. v. American Motorists Ins. Co.*, 226 W.VA 307 (2010) (affirming grant of summary

judgment in favor of insurer on duty to defend issue); *Moore v. CNA Ins. Co.*, 215 W.Va. 286, 294 (2004) (same).

3. It is the insured's burden to establish a *prima facie* case of loss within the coverage of the policy, and it is not until the insured has met this burden that the burden shifts to the insurer to demonstrate that the loss at issue is one for which it is not liable because of an exclusion or some other policy provision. *See Camden-Clark Memorial Hosp. Ass'n v. St. Paul Fire and Marine Ins. Co.*, 224 W.Va. 228, 236, (2009); *Jarvis v. Pennsylvania Cas. Co.*, 129 W.Va. 291, 296-97 (1946).

4. "Where the provisions of an insurance policy contract are clear and unambiguous they are not subject to judicial construction or interpretation, but full effect will be given to the plain meaning intended." *Payne v. Weston*, 195 W.Va. 502, 506-07 (1995) (citing *Keffer v. Prudential Ins. Co.*, 153 W.Va. 813, (1970)).

5. The determination of whether an ambiguity exists in an insurance policy is a question of law for the Court. *Canal Ins. Co. v. Blankenship*, 129 F. Supp.2d 950, 953 (S.D. W.Va. 2001).

6. An ambiguity exists only where the policy language is "reasonably susceptible of two different meanings" or is "of such doubtful meaning that reasonable minds might be uncertain or disagree as to its meaning[.]" *Payne*, 195 W.Va. at 507 (citing *Shamblin v. Nationwide Mut. Ins. Co.*, 175 W.Va. 337 (1985)).

7. In considering the issue, the Court must read the policy provisions so as to avoid ambiguities, and it should not torture the language of the policy in order to create them. *See id.*

Claims-Made Coverage

8. The professional liability policies at issue in this case are what is known as claims-made policies. "Claims-made" insurance policies have been accepted and enforced by the Supreme Court of Appeals. *See Soliva v. Shand, Morahan & Co., Inc.*, 176 W.Va. 430, 433 (1986); *Auber v. Jellen*, 196 W.Va. 168, 174 (1996).

9. The policies at issue also require that a claim be "first reported" during the policy period. This a common and enforced requirement of claims-made coverage. *See, e.g., Gargano v. Liberty Intern. Underwriters, Inc.*, 572 F.3d 45, 49 (1st Cir. 2009); *Employers Reins. Corp. v. Sarris*, 746 F. Supp. 560, 563 (E.D. Pa. 1990).

10. The majority rule with respect to claims-made coverage is that the reporting requirement cannot be relaxed or extended, as this unfairly extends coverage under the policy for the insured and exposes the insurer to risks beyond those it agreed to insure against. Because the reporting requirements in a claims-made policy define the scope of coverage afforded, they are strictly enforced, and the failure to report a claim within the policy period cannot be excused by any alleged lack of prejudice to the insurer. *See, e.g., Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. 551 N.E.2d 28, 30 (Mass. 1990); *Hasbrouck v. St. Paul Fire and Marine Ins. Co.*, 511 N.W.2d 364, 366-69 (Iowa 1993); *Zuckerman v. National Union Fire Insurance Co.*, 495 A.2d 395, 406 (N.J. 1985); *Gulf Ins. Co. v. Dolan, Fertig and Curtis*, 433 So.2d 512, 515 (Fla. 1983).

11. TL&A has asserted that the Court should adopt the minority rule, which requires the insurer to show prejudice where the notice provisions of a claims-made insurance policy are breached. I do not find that the cases cited by TL&A, which are all from other jurisdictions, are persuasive.

12. I find that the adoption of a prejudice requirement would be contrary to the plain language of the ALPS insurance policies, which unambiguously requires that a claim be both "first made" and "first reported" within the same policy period in order to qualify for coverage. Moreover, I conclude that the adoption of a rule requiring prejudice would undermine claims-made coverage and would therefore conflict with the decisions of the Supreme Court of Appeals enforcing such coverage. *See Soliva v. Shand, Morahan & Co., Inc.*, 176 W.Va. 430, 433 (1986); *Auber v. Jellen*, 196 W.Va. 168, 174 (1996).

13. To the extent that TL&A has suggested that enforcing a claims-made reporting requirement could result in unfairness to an insured who might receive a claim minutes before the policy expires and therefore be unable to timely report it, that situation is not presently before the Court, as the evidence shows that TL&A had ample time to report Mr. Smiths' claim but waited *several years* to do so.

14. I rule that summary judgment should enter in favor of ALPS in this case because Mr. Smith's claim against TL&A was not "first reported" within the policy period in which it was "first made," as required by the insuring clause. The undisputed evidence demonstrates that Mr. Smith first asserted his claim during the 2007 Policy period and that TL&A did not report it until nearly *two years later*, during the 2010 Policy period. I further find that Mr. Smith's recent "amendment" of his complaint (by the addition of a paragraph characterizing the conduct recited in his prior complaints as negligent) does not create a "new" claim, or otherwise cure TL&A's failure to report the claim in the 2007 Policy period.

Estoppel

15. TL&A asserted at the hearing for the first time that ALPS is barred from denying coverage under the insurance policies at issue under the doctrine of estoppel. TL&A argues that

correspondence that accompanied the ALPS insurance policies stated that the company merely "encouraged" insureds to report potential claims instead of requiring that insureds do so. TL&A further argues that the *pro se* complaint served by Mr. Smith in 2008 alleged solely intentional conduct and, because of this, TL&A viewed the complaint as a "potential claim" and not a "claim."

16. Estoppel applies when a party is induced to act or to refrain from acting to her detriment because of her reasonable reliance on another party's misrepresentation or concealment of a material fact. Syllabus Point 2, in part, *Ara v. Erie Ins. Co.,* 182 W.Va. 266, 387 S.E.2d 320 (1989).

17. When an insured is wrongfully lulled by a statement of the insurer into a belief that no coverage exists, the doctrine of equitable estoppel will preclude the insurer from later denying coverage based upon the insured's failure to comply with notice or reporting requirements.. *See id.,* Syllabus Point 3.

18. The upshot of the *Ara* decision is that in order to establish the factual predicate for a finding of coverage by estoppel, there must be evidence of a misrepresentation of a material fact by the insurer and detrimental reliance by the insured on that material misrepresentation. To apply to the factual scenario involving ALPS and TL&A, there would have be evidence of a factual misrepresentation by ALPS that convinced TL&A that it did not need to report the *Smith* claim at the time that the original Complaint was filed.

19. TL&A has failed to meet is burden of coming forward with competent evidence to show a misrepresentation on the part of ALPS that could have led it to believe that it did not have to report the *Smith* claim when it was received. Rather, the record establishes that the decision not to report the Smith claim was a conscious decision of TL&A because the Lindsays

believed that the Complaint was a "nuisance claim." It is important to note that the misrepresentation of material fact must occur at the time that notice should have been made. There is no evidence anywhere in the record of a statement by ALPS to TL&A that the firm did not need to report the *Smith* claim (or any other claim) in a timely fashion. The ALPS Policies repeatedly state that an insured is required to report claims in a timely manner. Every document produced in discovery is consistent with the policy language: report claims immediately when they are made and if you have any questions, call ALPS. TL&A's failure to report the claim to ALPS for more than two years after being sued precludes a finding of coverage for the Smith claim.

20. Nor can there be any estoppel based upon the correspondence enclosing the ALPS insurance policies and TL&A's alleged belief that Mr. Smith's *pro se* complaint was a "potential claim" that did not need to be reported in a timely manner. As an initial matter, TL&A has offered no competent evidence that it was actually misled by this correspondence into delaying its report of the *Smith* complaint. Indeed, as noted above, the only evidence before the Court is that the delay in reporting was due to TL&A's belief that the *Smith* claim was a "nuisance" suit.

21. Moreover, Mr. Smith's *pro se* complaint clearly constitutes a "claim" against TL&A within the meaning of the ALPS policies, regardless of TL&A's alleged beliefs about the availability of coverage under the ALPS policies. The ALPS policies define a claim as "a demand for money or services, including but not limited to *the service of suit* or institution of arbitration proceedings against the Insured." Because Mr. Smith's service of his *pro se* complaint clearly constituted an actual claim, as opposed to a potential claim, and the correspondence at issue does not make any representations about the reporting of actual claims, it cannot serve as the basis for an estoppel against ALPS.

22. In light of the absence of any facts to support the argument of coverage by estoppel, the Court finds TLA's arguments on this issue unpersuasive and rules that ALPS is not estopped from denying coverage to TL&A for Mr. Smith's claim.

Remaining Coverage Issues

23. Pursuant to the foregoing, the Court finds that ALPS owes no duty to defend or indemnify TL&A in connection with Mr. Smith's claim and, therefore, ALPS' Motion for Summary Judgment is **GRANTED.**

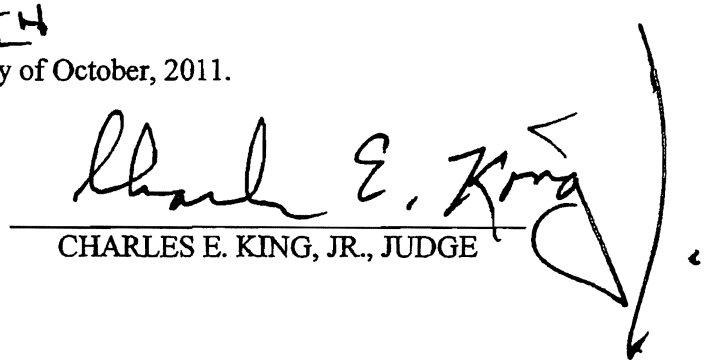
24. The Court notes the objections and exceptions of the parties to this Court's rulings.

25. The entry of this Order does not impair the rights of any remaining parties.

WHEREFORE, it is hereby **ORDERED** that ALPS's Motion for Summary Judgment is **GRANTED.**

The Court does further **ORDER** that a certified copy of this Order be sent to all parties or counsel of record.

Entered this 26th day of October, 2011.



CHARLES E. KING, JR., JUDGE

STATE OF WEST VIRGINIA
COUNTY OF KANAWHA, SS
I, CATHY S. GATSON, CLERK OF THE CIRCUIT COURT OF SAID COUNTY AND IN SAID STATE, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE COPY FROM THE RECORDS OF SAID COURT
GIVEN UNDER MY HAND AND SEAL OF SAID COURT THIS 3rd DAY OF November 2011
Cathy S. Gatson CLERK
CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

11-3-11
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IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

RONNIE SMITH, Administrator of the Estate of Nancy Smith, deceased; and, RONNIE SMITH, individually,

Plaintiffs,

v.

Civil Action No. 08-C-75
Judge Charles E. King, Jr.

RICHARD D. LINDSAY and PAMELA LINDSAY, d/b/a TABOR LINDSAY & ASSOCIATES,

Defendants/Third-Party Plaintiffs,

v.

DITRAPANO, BARRETT & DIPERIO, PLLC, formerly known as DITRAPANO & JACKSON,

and

UNITED NATIONAL BANK, formally known as UNITED BANK,

Third-Party Defendants,

and

ATTORNEYS LIABILITY PROTECTION SOCIETY, INC.

Third-Party Defendants.

CERTIFICATE OF SERVICE

This is to certify that on this 28th day of November, 2011, the undersigned counsel served the foregoing ***"Notice of Appeal"*** upon the Circuit Clerk of Kanawha County and all counsel of record by facsimile and/or depositing true copies in the United States Mail, postage prepaid, in envelopes addressed as follows:

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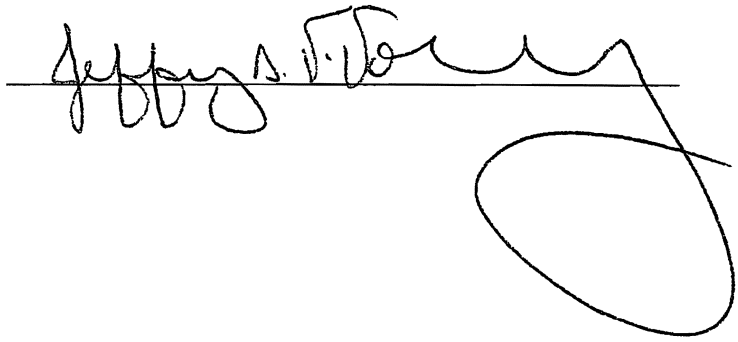
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