No. 11-1651

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

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SUPREME COURT OF APPEALS
OF WEST VIRGINIA

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

Defendants/Third-Party
Plaintiffs Below, Petitioners,

v.

(Circuit Court of Kanawha County
Civil Action No. 08-C-75)

ATTORNEYS LIABILITY
PROTECTION SOCIETY, Inc., et al.,

Third-Party Defendants
Below, Respondents.

BRIEF ON BEHALF OF PETITIONERS, RICHARD D. LINDSAY and PAMELA LINDSAY d/b/a TABOR LINDSAY & ASSOCIATES, IN SUPPORT OF THEIR PETITION FOR APPEAL

(re: Petitioners' Notice of Appeal from an Order of the Circuit Court of Kanawha County Entered on October 26, 2011)

Defendants/Third-Party Plaintiffs Below, Petitioners, RICHARD D. LINDSAY and PAMELA LINDSAY, d/b/a TABOR LINDSAY & ASSOCIATES, By Counsel:

James A. Varner, Sr. (WV State Bar #3853)
javarner@wvlawyers.com
James N. Riley (WV State Bar #3111)
jnriley@wvlawyers.com
Jeffrey D. Van Volkenburg (WV State Bar #10227)
(Counsel of Record)
jdvanvolkenburg@wvlawyers.com
Empire Building - 400 West Main Street
P. O. Drawer 2040
Clarksburg, WV 26302-2040
Telephone: (304) 626-1100
Facsimile: (304) 623-3035

McNeer, Highland, McMunn and Varner, L.C.
Of Counsel

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TO: THE HONORABLE JUSTICES OF THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

ASSIGNMENTS OF ERROR[1]

A.) The Circuit Court committed error when it granted summary judgment in favor of the Attorneys Liability Protection Society, Inc., (hereafter "ALPS" or "Respondent") thereby denying insurance coverage for Tabor Lindsay & Associates (hereafter, "TL&A" or "Petitioners") pursuant a "claims-made-claims-reported" policy of insurance based on the timing of TL&A's report of Plaintiff Smith's claims to ALPS.

B.) The Circuit Court erred by granting ALPS' Motion for Summary Judgment which was based, in part, on the timing of TL&A's report of Plaintiff Smith's claims, despite the clear lack of prejudice to ALPS in its duty to defend and indemnify TL&A.

C.) The Circuit Court committed error when it granted Summary Judgment in favor of ALPS, finding that there were no factual issues left for resolution despite the language of W. Va. Code § 55-13-9, settled case law and the materials sent from ALPS to Petitioners.

D.) The Circuit Court erred by not finding that ALPS had waived its right to rely on reporting requirements of the policy by sending communications to its insureds which informed insureds were "encouraged" to report "potential claims" under the facts of this case.

STATEMENT OF THE CASE

A.) History of TL&A's Representation of Plaintiff Ronnie Smith

Richard D. Lindsay and Pamela Lindsay practice with the law firm of TL&A in Charleston, West Virginia, a professional limited liability company. Plaintiff Ronnie Smith (Smith) and his now deceased wife, Nancy Smith, retained Rudolph DiTrapano and the law firm formerly known as DiTrapano & Jackson to prosecute certain claims sounding in medical malpractice and products liability (hereafter, "underlying suit"). *See*, *Transcript of Deposition of Ronnie Smith*, App., at 507:9-20. Attorney DiTrapano subsequently associated as co-counsel with Richard D. Lindsay and Pamela Lindsay to assist in the litigation of the Smiths' claims due to the Lindsays' expertise in

[1] Rule 10(c)(3) of the Rules of Appellate Procedure states, "[t]he assignments of error need not be identical to those contained in the notice of appeal." Pursuant to the authority provided in Rule 10(c)(3), Petitioners have made minor revisions to the wording of their assignments of error, which are reflected herein.

medical negligence claims. *Id.*, App. at pp. 235:22-236:4 (also App. at pp. 507-509; 648:22-649:4). In 1995, the claims of Ronnie and Nancy Smith were settled in what was, at the time, one of, if not the largest medical malpractice recoveries in West Virginia. The settlement was with numerous defendants and separate payments were made. It is not disputed that Plaintiff Ronnie Smith and his wife received significant settlement monies and utilized said settlements monies. *Id.*, App., pp. 237-238 (also App., pp. 652-653). Nancy Smith died in 1998.

Mr. Smith has acknowledged under oath that he was not aware of any document which indicated that any money was improperly taken by anyone associated with TL&A. *Id.*, App. at 742:3-8. Mr. Smith has testified that he had no evidence as to whether he actually received all of the money to which he was entitled. *Id.*, App., pp. 753-754.

B.) Claims Asserted in Plaintiff's Complaint, Amended Complaint and Second Amended Complaint

Plaintiffs' original *pro se* Complaint alleged that Pamela Lindsay had wrongfully caused a check to be issued in her name from a Trust account in the amount of Two Hundred Ninety Thousand Dollars ($290,000.00). Mr. Smith asserted that this money was taken from the settlements obtained on behalf of him and Nancy Smith. Mr. Smith sought recovery for compensatory and punitive damages. *See, Plaintiff's pro se Complaint*, App., pp. 1-3 (also App., pp. 61-69). Since the filing of the original *pro se* Complaint, Plaintiff's allegation of misappropriation of a $290,000 check has been withdrawn as it was baseless and easily refuted. The document which formed the basis of the original complaint was actually a deposit slip, not a withdrawal.[2] The original allegations in Plaintiff's pro se Complaint, since discredited, sounded in intentional conduct on the part of Pamela

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[2] During Plaintiff Smith's deposition, he acknowledged that the original *pro se* complaint asserting claims of intentional misappropriation against Pamela Lindsay was prepared with the assistance of attorney Rudolph DiTrapano after Mr. Smith contacted him about his purported concerns over the accounting related to his settlement funds from 1995. *See, Smith Transcript*, App., pp. 239-240 (also, App., pp. 543-544).

Lindsay. There was no mention of any negligent conduct on behalf of anyone associated with TL&A. *Plaintiff's pro se Complaint*, App., pp. 1-3.

Based on the claims of intentional conduct, TL&A hired personal counsel and filed an answer to Smith's *pro se* complaint. Plaintiff Smith subsequently retained counsel, and filed his First Amended Complaint on or about May 27, 2008. Again, the claims in the Amended Complaint sounded in intentional conduct. *See*, *Plaintiffs' Amended Complaint*, App., pp. 4-7 (also, App., pp. 44-47, 244-247.)

The Amended Complaint, while no longer alleging that Pamela Lindsay misappropriated a $290,000.00 check, did assert that Pamela Lindsay had wrongfully endorsed Plaintiff's name on a check and failed to deposit sums paid to Pamela Lindsay from the settlement funds into the Trust.[3] Smith again sought compensatory and punitive damages from TL&A for allegedly "willful and wanton" conduct. See, *Plaintiff's Amended Complaint*, *supra*. TL&A, represented by new counsel, provided notice of this complaint to ALPS on or about May 20, 2008, which denied coverage.[4] There was little activity in this case prior to ALPS' entry into this case due to a trial date continuance and the amendments to pleadings. The only discovery completed were the depositions of Richard Lindsay and Pamela Lindsay.

C.) TL&A's Request That ALPS Provide a Defense and Indemnification for Plaintiff Smith's Claims

On or about May 20, 2011, TL&A, through its employee, Richard D. Lindsay, wrote to ALPS requesting that ALPS provide a defense and indemnification to TL&A. *See*, *May 20, 2010 Correspondence from Richard D. Lindsay to ALPS*, App., p. 254. ALPS, without completing any factual investigation, informed TL&A that it challenged the request for insurance coverage for

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[3] The Amended Complaint alleged that there was approximately one million dollars ($1,000,000.00) unaccounted for from the settlement proceeds. Discovery completed after the undersigned's entry into this case has revealed that is not the case and that the records to track the remainder of said money are simply no longer in existence.

[4] The undersigned counsel served their notice of appearance in this civil action, on or about June 8, 2010, taking over the defense of TL&A. *See*, *Docket Sheet for Civil Action 08-C-75*, App., p. 415.

Plaintiff Smith's claims, via correspondence dated May 25, 2010, while reserving the right to make a formal coverage determination for Plaintiff Smith's claims. *See*, *Correspondence from Jim Mickelson to Richard Lindsay*, App., 208 (also, App., p. 255). The May 25, 2010 correspondence from ALPS noted that ALPS was challenging coverage based on the timing of the reporting *and because Plaintiff's allegations amounted to a claim for conversion*. App., p. 208 (also, App., p. 255). ALPS' May 25, 2010 correspondence does not mention any treatment by ALPS of the claim as a negligence based claim.[5] Specifically, Mickelson's correspondence stated: "[c]urrently, ALPS disputes coverage based upon the failure to timely provide notice *and based upon the allegations in the complaint which amount to a claim for conversion and demand for punitive damages*." *See*, App., p. 208 (also, App., p. 255) (emphasis added).

ALPS subsequently sent a June 23, 2010 correspondence to TL&A which denied TL&A's request for defense and indemnity for Plaintiff Smith's claim. *See*, App., pp. 172-190 (also, App., pp. 256-264). In the June 23, 2010 correspondence, ALPS' coverage counsel asserted that there was no coverage for the claims asserted by Plaintiff Smith against TL&A as a result of the claim being reported to ALPS on May 20, 2010. ALPS denied coverage, at least in part, because the claims were not "first made . . . and first reported" during the policy period. ALPS' correspondence then goes on to assert:

> Apart from this, the relief that Mr. Smith seeks, an accounting and repayment of amounts allegedly misappropriated by Pamela Tabor Lindsay, do not constitute damages within the meaning of the policy. In addition, Mr. Smith's claims appear to fall within the scope of the Policy's exclusions for claims based upon improper handling of funds, billing disputes, and intentional/dishonest conduct.

See, App., p. 172 (also, App., p. 256). The June 23, 2010 correspondence from ALPS goes on to reference the "claims-made-claims-reported" provision of the policy and further cited, at page four

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[5] As will be more fully demonstrated below, this is of critical importance when viewed in contrast with the deposition testimony of ALPS' Rule 30(b)(7) deponent, Robert Tameler. Mr. Tameler testified that ALPS viewed all three complaints filed by Plaintiff Smith as containing or potentially containing claims for negligence, despite asserting contrary positions in correspondence to TL&A.

(4), the exclusions dealing with "dishonest, fraudulent, criminal, malicious, or intentionally wrongful act, error or omission committed by . . . . an insured. *Id.*, App., p. 175 (also, App., p. 259).[6] The correspondence also cited to the provision of the policy addressing claims for "conversion, misappropriation or improper commingling by any person of client or trust account funds or property . . . ." *Id.*, App., p. 178 (also, App., p. 262). ALPS' correspondence further stated that any lack of prejudice to ALPS was irrelevant to the determination of coverage. *Id.*, App., p. 176 (also, App., p. 260). ALPS then represented that "the vast majority of jurisdictions have concluded that an insured under a claims-made-claims-reported policy, like the ALPS policy, cannot rely upon an alleged lack of prejudice to cure a failure to report during a policy a period, as this would inequitably expand the coverage of such a policy." *Id.*, App., p. 177 (also, App., p. 261). ALPS cited decisions from multiple jurisdictions, excluding West Virginia and the 4th Circuit Court of Appeals, concerning TL&A's assertion of a lack of prejudice to support a determination of coverage.[7]

ALPS also denied coverage based upon the allegations in the first amended complaint arising from the alleged mishandling of client funds, all of which have been denied by TL&A. Also important and discussed more fully below, is the information contained at footnote fourteen (14) of

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[6] TL&A vehemently disputes any assertion of intentional or other improper conduct in the handing of funds from Plaintiff Smith's settlements.

[7] It appears that the issue of "prejudice" as applied to an insurer denying coverage under a claims-made-claims-reported policy may be an issue of first impression in West Virginia and in the Fourth Circuit Court of Appeals leaving significant discretion to the Court to determine if the notice requirements may be excused when there is a finding that the insurer is not prejudiced. The insurer is under an obligation to provide the grounds for the denial of its coverage and in this instance, ALPS did not cite to any case law in the 4th Circuit Court of Appeals or in West Virginia to support the proposition that the lack of prejudice was not pertinent to deny coverage. In other areas of insurance coverage, West Virginia state and federal courts have chosen to adopt the minority position held by Courts across the United States. In the matter of *American Safety Indemnity Co. v. Stollings Trucking Co., Inc.*, 450 F.Supp.2d 639 (S.D. W. Va. 2006), the Federal District Court for the Southern District adopted the acknowledged minority position concerning the conflict between two excess insurance clauses, finding that they should be disregarded as mutually repugnant and analyzed *pro rata*. *Id.*, at 649.

ALPS' June 23, 2010 coverage denial letter. The footnote stated that the allegations in the Amended Complaint, filed in May of 2008 determine whether coverage exists.[8]

On or about September 24, 2010, Plaintiff filed a Second Amended Complaint, which for the first time, asserted a negligence claim against the TL&A Defendants. *See*, *Plaintiffs' Second Amended Complaint*, App., pp. 8-13 (also, App., pp. 248-253.) On or about October 1, 2010, TL&A, through counsel, forwarded Plaintiff Smith's Second Amended Complaint to coverage counsel for ALPS. The October 1, 2010 correspondence explicitly informed counsel for ALPS that this was the first allegation of negligence on the part of Plaintiff Smith in this litigation. *See*, *TL&A October 1, 2010 correspondence*, App., pp. 192-193 (also, App., pp. 265-266). In response to the October 1, 2010 correspondence, ALPS wrote TL&A's counsel on or about October 19, 2010. ALPS' October 19, 2010 correspondence (App., pp. 267-271), asserted that any third-party action that TL&A would be required to file to determine coverage obligations would be "frivolous." In response to the allegations of negligence in the Second Amended Complaint, ALPS, without a basis and without any investigation whatsoever as to what facts had changed, stated that this was not the first claim of negligence, and even if it were, there would still be no coverage for Plaintiff Smith's claims against TL&A. Subsequently, TL&A was forced to file a third-party complaint to determine its rights to coverage due and owing to them under the ALPS' policy of insurance. *See*, App., pp. 383-388.

After ALPS October 19, 2010 denial of TL&A's request for coverage, TL&A moved the Court to permit the amendment of their pleadings to assert a claim for declaratory judgment against ALPS requesting the circuit court make a determination as to whether ALPS was required to provide

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[8] This representation is a material fact, which was later contradicted by ALPS Rule 30(b)(7) deponent.

defense and indemnification to TL&A. *See, TL&A Third-Party Complaint*, App., pp. 201-206 (also, App., pp. 383-388).[9]

After ALPS entry into the litigation, the parties served and responded to written discovery and completed the deposition of Robert Tameler ("Tameler"), the Rule 30(b)(7) deponent designated by ALPS for certain areas related to insurance coverage. On or about July 8, 2011, ALPS served its Motion for Summary Judgment on TL&A's declaratory judgment claims. *See, ALPS' Motion for Summary Judgment and Accompanying Memorandum*, App., pp. 14-38 (hereafter, collectively *"ALPS' Motion for Summary Judgment"*). On or about August 9, 2011, TL&A served its Response to ALPS' Motion for Summary Judgment, App., pp. 209-231 (hereafter, *"TL&A Response"*). On or about August 23, 2011, ALPS served its reply in further support of its Motion for Summary Judgment, App., pp. 298-307 (hereafter, *"ALPS' Reply Brief"*). On August 18, 2011, TL&A filed a cross-motion for summary judgment incorporating those arguments contained in the TL&A Response. *See*, App., pp. 374-382. Oral arguments were heard by the circuit court on August 25, 2011. On October 26, 2011, the Circuit Court entered an Order granting ALPS' Motion for Summary Judgment. *See, Order Granting ALPS' Motion for Summary Judgment*, App., pp. 389-401 (hereafter, "Order"). TL&A appeals from entry of the circuit court's Order granting ALPS' Motion for Summary Judgment.

D.) The Circuit Court's Order Granting ALPS' Motion for Summary Judgment

There are multiple findings of fact and conclusions of law in the Court's order granting summary judgment that are relevant to the issues contained in the instant appeal, which demonstrates the circuit court's error in finding that no coverage existed for Plaintiff Smith's claims against TL&A.

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[9] TL&A also asserted third-party claims against the law firm of DiTrapano Barrett and DiPiero ("DBD") formerly known as DiTrapano and Jackson and United Bank. The claims against United Bank have since been resolved and United Bank has been dismissed from this civil action. The claims against DBD remain pending in the Circuit Court of Kanawha County, West Virginia as the time of filing this appeal brief.

The Order entered by the circuit court cited to TL&A's October 1, 2010 correspondence for the proposition that TL&A had notified ALPS for the first time that Plaintiff Smith had asserted a negligence claim. *See, Order,* at ¶ 16, App., p. 393. The Order then stated that "[i]n fact, however, TL&A itself had previously characterized Mr. Smith's claim as based in alleged negligence." *Id.* at ¶ 16, App., p. 393.[10] In the following paragraph of the Order, the circuit court found that TL&A's October 1, 2010 Correspondence to ALPS noted that TL&A had obtained a continuance in the pending trial date, thereby eliminating any prejudice that ALPS may claim from the timing of TL&A's notice to it.[11] *Id.* at ¶ 17, App., p. 393.

Paragraphs 19 through 25 in the section of the Order addressing "Findings of Fact" cite to specific provisions of the ALPS insurance policy, which is more fully addressed below. The factual findings of the order fail to address the testimony of Tameler, whose testimony contradicts the previous denial letters sent by counsel for ALPS, prior to TL&A's filing of the third-party complaint in this civil action. The Order also ignores the effect and significance of materials sent from ALPS to TL&A which state that insureds are "encouraged" to report "potential claims." *See, Order*, App., 386-387.

The circuit court's "conclusions of law" held that "'[c]laims-made insurance policies have been accepted and enforced by the Supreme Court of Appeals." In support of this proposition the Court could only cite to *Soliva v. Shand, Morahan & Co., Inc.*, 176 W. Va. 430, 433 (1986) and *Auber v. Jellen*, 196 W. Va. 168, 174 (1996). *See, Order, Conclusions of Law*, ¶ 8, App., p. 391. In support of its holding that claims-made claims-reported policies of insurance require a reporting during the policy period, the court relied exclusively upon foreign precedent to find that this was a

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[10] As will be demonstrated below, this finding of fact was erroneous based on the correspondences sent from ALPS to TL&A which denied coverage based the timing of the notice of claim as well as allegations of intentional conduct.

[11] ALPS' June 23, 2010 Correspondence noted prejudice was an issue that ALPS relied upon, at least in part, to deny TL&A's claim for insurance coverage pursuant to the policy of insurance. *See*, App., pp. 172-190 (also, App., pp. 256-264).

"common and enforced" requirement of claims made insurance. *Id.*, at ¶ 9, App., p. 391.[12] The circuit court, without the benefit of West Virginia Supreme Court of Appeals or West Virginia Federal District Court authority, adopted the majority position which holds that lack of prejudice to an insurer does not eliminate the enforceability of the strict and harsh notice requirements of the ALPS' policy. *Id.*, at ¶ 10, App., p. 391. The circuit court, at paragraph eleven (11) of its Order found that TL&A's arguments asserting that the minority position should control were not persuasive.

The circuit court's order additionally noted that the cases cited by TL&A were all from foreign jurisdictions.[13] The court held that if it adopted the minority position concerning prejudice it would conflict with this Court's holding in *Soliva v. Shand, Morahan & Co., Inc.*, 176 W. Va. 430, 433 (1986) and *Auber v. Jellen*, 196 W. Va. 168, 174 (1996). The circuit court's order did not explain the nature of the potential conflict. In its conclusions of law, the circuit court also summarily dismissed the effects of the filing of the Second Amended Complaint, which contained the first assertion of negligence, without analyzing the various representations contained in ALPS' correspondences and the deposition of Tameler, which contradict each other. *Id.*, at ¶¶ 13-14, App., 392-393.

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[12] The circuit court's order relied upon *Gargano v. Liberty Intern. Underwriters, Inc.*, 572 F.3d 45, 49 (1st Cir. 2009) and *Employers Reins. Corp. v. Sarris*, 746 F.Supp. 560, 563 (E.D. Pa. 1990). Each of these decisions is distinguishable from the facts of this appeal. In *Gargano*, the insured sought coverage, *after a judgment had been entered against him* from three separate insurance companies, each of which had issued a claims-made-claims reported policy of insurance to the insured. *Gargano*, at 47-48. None of the insurers had insurance in place when the claim was first made and first report. *Id.* In *Sarris*, the insured's cancelled their policy of insurance and did not renew it for subsequent renewal periods. *Sarris*, at 562-563. Here, TL&A maintained a policy of insurance through ALPS for all pertinent policy periods.

[13] The court's order also relied exclusively on cases from foreign jurisdictions to find that the majority position on prejudice should control.

The circuit court's order also found that the doctrines of estoppel and waiver did not apply to mandate coverage despite materials supplied to TL&A by ALPS which "encourage" insureds to report "potential claims."[14] *Id.*, at ¶¶ 15-22, App., pp. 393-394.

E.) The ALPS' Policy of Insurance Issued to TL&A

TL&A continuously maintained an ALPS' policy of insurance from 2007 through the reporting of the claims in 2010. The first pertinent policy period was from March 24, 2007 through March 2008. The policy obtained by TL&A was classified by ALPS as a "claims-made-and-claims reported" lawyers professional liability insurance policy by ALPS. It is not disputed that TL&A continuously renewed their policy through ALPS for the years 2008 through 2010. Pertinent to the instant dispute are several provisions of the applicable policy of insurance, which are stated in full below:

> 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 claims arises from an act, error, omission or personal injury that happened on or after the loss inclusion date and 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.

See, ALPS' Policy of Insurance, App., p. 284.

The pertinent exclusions, relied upon by ALPS to deny coverage in this policy of insurance state the following:

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[14] These term "potential claim" is not defined anywhere in the materials supplied by ALPS to its insureds.

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.

. . .

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.

See, *ALPS' Policy of Insurance*, App., pp. 290, 294.

F.) Other Materials Supplied By ALPS To TL&A Concerning Insurance Coverage Supplied Through Its Policies

In addition to the actual policy of insurance, ALPS supplied literature to its insureds. Correspondence directly received from ALPS advised Pamela Tabor-Lindsay "[w]e *encourage* firms to notify ALPS as soon as there *is a concern with a potential claim*." *See*, *March 24, 2010 Correspondence from Charles Reese, Underwriting*, App., p. 153 (also, App., p. 282) (emphasis added).[15]

G.) TL&A's Filing Of Its Petition for Appeal and the Selection of The Record for Appeal

Following entry of the order granting summary judgment to ALPS, TL&A timely filed its Notice of Appeal with this Honorable Court. Pursuant to the Order entered by the Court, TL&A timely forwarded its proposed appendix record to be utilized on appeal. ALPS submitted a response, requesting limited additional materials for purposes of the appendix record, which have been incorporated into the Appendix. TL&A has submitted this timely Brief, requesting the Court reverse

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[15] Tameler acknowledged ALPS does not define a "potential claim" anywhere in its policies of insurance. App., at pp. 281:17-19 (also, App., at pp. 739:17-19).

the circuit court's entry of an award of summary judgment and remand this matter to the circuit court, finding that (1) insurance coverage is present for the claims asserted by Plaintiff Smith in this civil action; or (2) that there exists issues of material fact which must be further developed by the circuit court in relation to whether insurance coverage exists for Plaintiff Smith's claims.

SUMMARY OF THE ARGUMENT

TL&A requests that this Court reverse the grant of summary judgment by the circuit court, due to the error of the circuit court in its determination of whether insurance coverage exists for TL&A pursuant to the ALPS' policy of insurance. By misapplying and not properly considering all pertinent evidence in a light most favorable to TL&A, reversal of the entry of the summary judgment order is required.

A.) The Circuit Court committed error when it granted summary judgment in favor of the Attorneys Liability Protection Society, Inc., (hereafter "ALPS" or "Respondent") thereby denying insurance coverage for Tabor Lindsay & Associates (hereafter, "TL&A" or "Petitioners") pursuant a "claims-made-claims-reported" policy of insurance based on the timing of TL&A's report of Plaintiff Smith's claims to ALPS.

The circuit court erred when it granted summary judgment in favor of ALPS on its motion for summary judgment concerning whether insurance coverage existed for the claims asserted by Plaintiff Smith against TL&A. Plaintiff Smith's original *pro se* Complaint contained only allegations of intentional conduct against TL&A. ALPS relied upon the intentional act allegations, in part, to deny insurance coverage to TL&A in their letters following the reporting of the claims in 2010. ALPS developed a circular argument whereby TL&A was required to report the claim upon the filing of the original complaint in 2008, however, ALPS has asserted that those same claims would have been denied on separate policy grounds. This renders the coverage ALPS provided to TL&A as illusory. Additionally, West Virginia Code § 33-6-14 does not permit insurance coverage to be denied under a claims-made-claims-reported policy of insurance, based on the specific facts of this case.

B.) The Circuit Court erred by granting ALPS' Motion for Summary Judgment which was based, in part, on the timing of TL&A's report of Plaintiff Smith's claims, despite the clear lack of prejudice to ALPS in its duty to defend and indemnify TL&A.

After the filing of the original complaint in early 2008, there was little discovery completed in this case. In fact, the only discovery completed prior to the reporting of the claim to ALPS in 2010 were the depositions of Richard and Pamela Lindsay. Based upon the original allegations of intentional conduct, the claim was not reported, and remained mostly dormant until the reporting in 2010. TL&A urges this Court to adopt the minority position with respect to the reporting of claims under a claims-made-claims-reported policy of insurance, which considers whether an insurer was prejudiced by potentially untimely reporting of claims pursuant to the ALPS' policy.

C.) The Circuit Court committed error when it granted Summary Judgment in favor of ALPS, finding that there were no factual issues left for resolution despite the language of W. Va. Code § 55-13-9, settled case law and the materials sent from Petitioners.

In addition to the arguments stated above, ALPS documents sent to TL&A referenced that insureds were "encouraged" to report "potential claims." The ALPS policy of insurance does not define what a "potential claims" constitutes. Language informing insureds that they were "encouraged" to report these undefined potential claims is expressly contradicted by ALPS reliance on the very strict and harsh "claims-made, claims-reported" language in the policy. These discrepancies become even more critical in consideration of Plaintiff Smith's later decision to amend his complaint to expressly assert a claim of negligence against TL&A. Collectively, these facts render the insurance policy ambiguous, defeating the reasonable expectations of the insured. A reasonable policy holder would interpret the language "encouraging" policy holders to report a "potential claim" as not imposing any form of mandatory duty to report an intentional act based claim, for which there likely was not coverage.

Pursuant to West Virginia Code § 55-13-9, and settled case law, there are, at the very least, additional issues left for resolution before the circuit court. These uncontroverted facts, including

the deposition testimony of Tameler , mandates that this Court find that circuit court's ruling granting summary judgment was in error.

D.) The Circuit Court erred by not finding that ALPS had waived its right to rely on reporting requirements of the policy by sending communications to its insureds which informed insureds were "encouraged" to report "potential claims" under the facts of this case.

This Court has previously held that "[t]he doctrine of waiver focuses on the conduct of the party against whom waiver is sought and requires that party to have intentionally relinquished a known right. There is no requirement of prejudice or detrimental reliance by the party asserting waiver." *Potesta v. USF&G*, 202 W. Va. 308, 315-316, 504 S.E.2d 135, 142-143 (1998), *citing Waller v. Truck Ins. Exchange*, 11 Cal. 4th 1, 31, 44 Cal. Rptr. 2d 370, 387, 900 P.2d 619, 636 (1995). By sending materials to an insured, which states that insureds are "encouraged" to report "potential claims" and at the same time disavowing coverage for intentional acts, ALPS has waived the right to strictly rely on the "claims-made, claims-reported" portions of their insurance policy, especially after the amendment of Plaintiff Smith's complaint to assert a claim for negligence.

Collectively, the ambiguous literature accompanying ALPS' policies of insurance, the lack of prejudice to ALPS coupled with Plaintiff's assertion of a negligence claim after factual development in this case warrants a finding that the lower court was in error through its award of ALPS' Motion for Summary Judgment, finding that there was no insurance coverage for Plaintiff Smith's claims and that there were no factual issues for further development in this case.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Pursuant to Rules 10(c)(6) and 18 of the Rules of Appellate Procedure, TL&A renews its request that this Court grant the opportunity to present oral argument on the issues addressed in

Petitioner's brief. Oral argument is necessary, pursuant to the requirements listed in Rule 18(a) of the Rules of Appellate Procedure for the following reasons and those apparent to the Court:[16]

The parties have not waived oral argument. W. Va. R.A.P. 18(a)(1). The issues presented in this appeal are clearly not frivolous, as the determination of whether insurance coverage exists for the claims in the underlying litigation present important issues not only to the parties, but also to policy holders and insurers that enter into insurance contracts which constitute claims-made, claims reported policies of insurance. As more fully described in this brief, case law interpreting claims-made, claims-reported policies of insurance is limited in West Virginia and this Court's clarification of the application of the notice requirements contained in said policies, as applied to subsequent versions of complaints, containing differing factual allegations is of critical importance to both this Court and the Federal District Courts of West Virginia. *See*, W. Va. R.A.P. 18(a)(2).

The issue of the application of the notice requirements contained in claims-made, claims-reported policies of insurance has not been authoritatively decided in West Virginia. The development of clear and unequivocal guidelines that insurers and policy holders can operate under will serve to reduce potential future litigation and reduce the heavy burden placed on this Court and the Circuit Courts of West Virginia. Additionally, because of the lack of clear authority in the Federal District Court's of West Virginia, oral argument and a subsequent decision from this Court will provide guidance for the West Virginia Federal District Courts in the event that they are faced with issues similar or identical to those issues presented though this appeal. W. Va. R.A.P. 18(a)(3).

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[16] Rule 18(a) of the Rules of Appellate Procedure states the following:

(a) Criteria for oral argument.-- Oral argument is unnecessary when:
(1) all of the parties have waived oral argument; or
(2) the appeal is frivolous; or
(3) the dispositive issue or issues have been authoritatively decided; or
(4) the facts and legal arguments are adequately presented in the briefs and record on appeal, and the decisional process would not be significantly aided by oral argument.

While the issues and documentary evidence are fully presented in this brief, the decisional process will necessarily be aided by oral argument. It is anticipated that the Court may have specific questions concerning the factual development of the case before the Circuit Court of Kanawha County. While the various versions of the complaints filed in this civil action, and the correspondences sent from TL&A and ALPS are included for the Court's reference, TL&A requests the opportunity to fully explain the specific factual development of this case, as this information is critical for the Court's determination. For these reasons, TL&A respectfully requests the opportunity present oral argument on the issues in this appeal to this Honorable Court.

ARGUMENT

Standard of Review

Rule 56 of the West Virginia Rules of Civil Procedure governs the resolution of motions for summary judgment and provided the standard by which the circuit court considered ALPS' Motion for Summary Judgment.

> The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment, as a matter of law. A summary judgment, interlocutory in character, may be rendered on the issue of liability alone although there is a genuine issue as to the amount of damages.

W. Va. R. Civ. P. 56(c).

This Court has repeatedly held that "[a] motion for summary judgment should be granted only when it is clear that there *is no genuine issue of fact to be tried and inquiry concerning the facts is not desirable to clarify the application of the law.*" *Aetna Casualty & Surety Co. v. Federal Insurance Co. of New York*, 148 W. Va. 160, 171, 133 S.E.2d 770, 777 (1963), *citing Shafer v. Reo Motors, Inc.*, 108 F. Supp. 659, 1952 U.S. Dist. LEXIS 2339 (1952), affirmed, 205 F.2d 685 (3rd Cir. 1952); *Clark v. Montgomery Ward and Company,* 298 F.2d 346 (4th Cir. 1961) (emphasis added). A "genuine issue" for the purposes of a summary judgment motion made pursuant to Rule 56(c) of the West Virginia Rules of Civil Procedure is "simply one half of a trial worthy issue, and a genuine issue does

not arise unless there is sufficient evidence favoring the non-moving party for a reasonable jury to return a verdict for that party. The opposing half of a trial worthy issue is present where the non-moving party can point to one or more disputed 'material' facts." Syl. pt. 5, *Jividen v. Law*, 194 W. Va. 705, 461 S.E.2d 451 (1995). *Any fact that has the capacity to sway the outcome of the pending litigation under applicable law is a "material fact." Id.* (emphasis added).

The determination of 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, 599 S.E.2d 709 (2004), *citing Tennant v. Smallwood*, 211 W. Va. 703 (2002) (emphasis added). If facts are in dispute a finder of fact is needed to resolve those issues. TL&A's third-party complaint filed against ALPS requested a judicial declaration of insurance coverage pursuant to West Virginia Code § 55-1-1, *et seq.* ("Uniform Declaratory Judgment Act"). Under the West Virginia Declaratory Judgment Act, issues of fact may be tried by a fact finder pursuant to West Virginia Code § 55-13-9, which holds:

> When a proceeding under this article involves the determination of an issue of fact, such issue may be tried and determined in the same manner as issues of fact are tried and determined in other civil actions in the court in which the proceeding is pending.

See, W. Va. Code § 55-13-9. If the lower court determined that the interpretation of the insurance policy at issue constituted an issue of law for the court, it was first required to determine whether the policy language was clear and unambiguous. *Payne v. Weston*, 195 W. Va. 502, 506-507, 466 S.E.2d 161, 165-166 (1995). The determination of whether an ambiguity exists in the policy in question would then be a determination for the Court. *Canal Ins. Co. v. Blankenship*, 129 F.Supp.2d 950, 953 (S.D. W. Va. 2001). An "ambiguity" for purposes of the interpretation of an insurance policy is present 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*, at 507, *citing Shamblin v. Nationwide Mut. Ins. Co.*, 175 W. Va. 337 (1985). Additionally, the Court must be mindful that "[w]here the policy language is exclusionary, it will be strictly construed against the insurer in order that the purpose of providing indemnity not be defeated." Syl. Pt. 5, *National*

Mut. Ins. Co. v. McMahon & Sons, Inc., 177 W. Va. 734, 356 S.E.2d 488 (1987) (overruled on other grounds); *Potesta v. United States Fid. & Guar. Co.*, 202 W. Va. 308, 314, 504 S.E.2d 135, 141 (1998).

On appeal, the standard of review applicable to the circuit court's entry of an order granting summary judgment, is the *de novo* standard of review. *See*, Syl. Pt. 1, *Painter v. Peavy*, 192 W. Va. 189, 451 S.E.2d 755 (1994).

A.) The Circuit Court committed error when it granted summary judgment in favor of ALPS thereby denying insurance coverage for TL&A through a "claims-made-claims-reported" policy of insurance based on the timing of TL&A's report of the claim to ALPS.

1.) ALPS' Position Concerning Reporting Requirements Created Illusory Coverage for TL&A

ALPS' position in this litigation, in part, has been that TL&A was required to report Plaintiff Smith's claim during the original 2008 reporting period, and because the claim was not reported until a later policy period, coverage did not exist. The circuit court erred by accepting this assertion despite several critical factors which should have resulted in a denial of ALPS' Motion for Summary Judgment. Initially, it should be noted that ALPS maintained coverage for TL&A for all pertinent policy periods, including the time period when the claim was reported. ALPS' Motion for Summary Judgment, as well as its correspondences denying insurance coverage assert that TL&A's failure to report the Smith's claim in 2008 violated the "claims-made-claims-reported" provisions of the ALPS policy of insurance. *See*, *ALPS' Motion for Summary Judgment*, App., pp. 28-31. Correspondence provided by ALPS after it received notice of Plaintiff Smith's claims also contended that separate grounds for the denial of coverage exist. *See*, *June 23, 2010 correspondence from ALPS Coverage Counsel, to Pamela Tabor Lindsay*, App., pp. 172-190 (also, App., pp. 256-264).[17] Through its

[17] ALPS June 23, 2010 correspondence noted the following: (1) "Unfortunately, coverage is not available for Mr. Smith's claims because, *among other things*, they were not 'first made . . . and first reported' during the effective policy period . . ." (2) ". . . Mr. Smith seeks an accounting and repayment of amounts *allegedly misappropriated* by you . ." (3) " . . . Mr. Smith's claims appear to fall within the scope of the Policy's exclusions for claims based on *improper handling* . . ." *See*, *June 23, 2010 ALPS Correspondence*, App., p. 172 (also, App., p. 256) (emphasis added).

simultaneous assertion of a denial of coverage through the strict requirements of the "claims-made-claims-reported" provisions of the ALPS insurance policy and for claims premised upon intentional conduct, ALPS has provided coverage that is illusory in consideration of Plaintiff Smith's subsequent assertion of a negligence claim in 2010 and the discovery obtained in the underlying action.

Under ALPS' theory denying coverage, whether TL&A had reported this claim in 2008 is irrelevant as ALPS maintained that there were entirely separate grounds for the denial of coverage for TL&A in 2008,[18] premised on allegations of intentional conduct. Consequently, any reporting of the claim by TL&A in 2008 would have resulted in the same denial of coverage that ALPS obtained from the circuit court after the claim was reported in May 2010.

Because the original complaint sounded in intentional conduct, there were no set of circumstances where ALPS would have provided coverage to TL&A after the filing of the original complaint, which rendered any coverage illusory in nature.[19] This Court has previously addressed what constitutes "illusory" coverage, holding:

> Provisions in an insurance policy, which are unambiguous when read in the policy as a whole, but in effect, provide only illusory coverage, should be enforced to satisfy the reasonable expectations of the insured. Since [the insured] could have **reasonably expected** [the insurer] to defend him in an action brought by Hardin against him, in part, for malicious prosecution and slander, [the insurer] should have to provide a defense for him . . . .(emphasis added).

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[18] "Illusory" insurance coverage has been previously noted by this Court as coverage that is "worthless." *See*, generally, *Pristavec v. Westfield Ins. Co.*, 184 W. Va. 331, 335, 400 S.E.2d 575, 579 (1990).

[19] TL&A concedes that based on the unsupported and now discredited allegations in the original complaint, ALPS likely had coverage defenses which it could have asserted to limit or deny coverage to TL&A. The problems in ALPS' position arose when it failed to take into account the later factual development in this case, which changed the nature of the theories of recovery asserted by Plaintiff Smith and discovery revealed the lack of evidence supporting an intentional act theory of recovery.

Boggs v. Camden-Clarke Memorial Hospital, 225 W. Va. 300, 693 S.E.2d 53 (2010), *citing Davidson v. Cincinnati Ins.*, 572 N.E.2d 502, 508 (Ind. Ct. App. 1991).[20] Because the coverage provided by ALPS was illusory, it frustrated TL&A's reasonable expectations for insurance coverage. Premised on these grounds alone, this Court should reverse the award of Summary Judgment to ALPS.

Plaintiff Smith's assertion of a negligence claim against TL&A in 2010 put ALPS on notice as to the potential for a claim for which coverage would have to be provided until, at the very least, ALPS conducted a reasonable investigation of the claims and defenses pursuant to its duties to its insured. ALPS' denial of coverage, including letters sent to TL&A after the demand for coverage, demonstrate that ALPS relied exclusively on the cold pleadings to deny coverage, which only served to support their denial of coverage. Had ALPS undertaken an investigation and further considered the discovery in this case, which included Tameler's deposition, coverage should have been found.

The unintended consequence of the circuit court's ruling requires an insured to report a claim, despite the strong possibility that no coverage existed, based on the cold pleadings. The law does not require the doing of a futile act. *State v. James Edward S.*, 184 W. Va. 408, 413, 400 S.E.2d 843, 848 (1990) (overruled on other grounds by *State ex rel Humphries v. McBride*, 220 W. Va. 362, 647 S.E.2d 798 (2007)), *quoting Ohio v. Roberts*, 448 U.S. 56, 74, 100 S. Ct. 2531, 2543, 65 L.Ed. 2d 597, 613 (1980), *opinion clarified on other grounds by United States v. Inadi*, 475 U.S. 387, 106 S. Ct. 1121, 89 L.Ed. 2d 390 (1986), modified on other grounds by *State v. Kennedy*, 205 W. Va. 224, 517 S.E.2d 457 (1999).[21] The reporting of this claim in 2008, without the benefit of discovery, would have resulted in a likely denial of coverage.

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[20] The Court in *Boggs* found that the holding in *Davidson* was not applicable to the facts of that case. Additionally, TL&A does not concede that the terms of this insurance policy are unambiguous when the policy is read as a whole.

[21] While equitable principals are not wholly applicable to the instant dispute, it is also well-settled that equity abhors forfeitures. ("But be that as it may, equity will continue to look 'with disfavor upon forfeitures and will not be quick, active, or alert to see or declare or enforce them.'" *McCartney v. Campbell*, 114 W. Va. 332, 333, 171 S.E. 821, 822 (1933), *citing Hukill v. Myers*, 36 W. Va. 639, 645, 15 S.E. 151, 152 (1891).

Tameler's deposition testimony demonstrated that there were significant issues as to how ALPS applies its claims-made claims-reported policies. Tameler testified if you are one second late in reporting, you have no coverage, yet he proceeded to testify that if there are sequential coverage periods, the strict requirement that claims be reported during the coverage period in which they were made is relaxed. *See*, *Transcript of Deposition of Robert Tameler*, App., at 734:5-735:7. TL&A maintained a policy from 2007 through 2010 covering the time period of the filing of the original *pro se* Complaint through the filing of the Second Amended Complaint. The policy materials supplied by ALPS to TL&A do not discuss the potential relaxing of the reporting requirements if successive policies of insurance are in place. Based on these undefined ambiguities in the potential reporting requirements for TL&A, ALPS has selectively enforced the claims-made, claims-reported provisions of their policy, which is further evidence of the illusory coverage provided by ALPS.

Additionally, the circuit court's Order ignored the reality that ALPS simply chose to ignore the assertion of a negligence claim, while an ALPS' policy was in effect. Under this unique set of facts, the circuit court erred by granting ALPS' Motion for Summary Judgment and the circuit court's order must be reversed.

As previously noted, ALPS maintained contradictory positions, which are illustrated by ALPS' June 23, 2010 correspondence to TL&A, in which ALPS references the ALPS' policy of insurance in effect from March 24, 2010 to March 24, 2011, (hereafter, "2010 Policy") which was used to evaluate coverage for TL&A. *See*, App., p. 174 (also, App., p. 258). Because ALPS used the 2010 Policy to evaluate coverage for TL&A, **ALPS was bound to review the applicable claims during the 2010 Policy period**. Plaintiff Smith's Second Amended Complaint was served, on September 24, 2010, within the 2010 Policy period. The Court's Order granting ALPS' Motion for Summary Judgment, to the extent that it is reliant on ALPS' utilization of the 2010 ALPS' policy for TL&A is clearly in error. Based on the application of the 2010 Policy, the denial of coverage, even after the assertion of a negligence claim frustrated the "reasonable expectations" of TL&A. The doctrine of

reasonable expectations has been explained by the West Virginia Supreme Court of Appeals as follows:

> In West Virginia, the doctrine of reasonable expectations is limited to those instances, such as the present case, in which the policy language is ambiguous. *Soliva,* W. Va. at , 345 S.E. 2d at 36; *contra Estrin, 612 S.W.2d 413; Corgatelli v. Globe Life & Accident Insurance Co.,* 96 Idaho 616, 533 P.2d 737 (1975). Where ambiguous policy provisions would largely nullify the purpose of indemnifying the insured, the application of those provisions will be severely restricted. *Linden Motor Freight Co., v. Travelers Insurance Co.*, 40 N.J. 511, 193 A.2d 217 (1963); see *Keeton* 83 Harv. L. Rev. At 976. An exclusion in a general liability policy should not be so construed as to "strip the insured of protection against risks incurred in the normal operation of the business," especially when the insurer was aware of the nature of the insured's normal operations when the policy was sold. *Chemtec Midwest Services, Inc. v. Insurance Company of North America*, 279 F. Supp. 539 (W.D. Wis. 1968), see *Boswell*, 38 N.J. Super. 599, 610, 120 A.2d 250.

National Mut. Ins. Co. v. McMahon & Sons, Inc., 177 W. Va. 734, 742, 356 S.E.2d 488, 496 (1987) (overruled on other grounds). Based on this application of the 2010 policy, there is ambiguity in the policy and its interpretation, which should have been resolved in favor of a finding of coverage for TL&A. The Order awarding summary judgment in favor of ALPS was erroneous and based on the above referenced information,. Consequently, this Court should reverse the circuit court's grant of summary judgment, as there is evidence sufficient to find coverage in favor of TL&A by a jury. *Jividen, supra.*

During his deposition, Tameler was also asked if there was anything in the claims file that memorializes the coverage review that identified the initial submission to ALPS as a negligence claim:

> Q: Are you telling me though that if it weren't for the notice provision in ALPS' decision would have been different on the first, second or third Complaint if they'd been what you concede to be timely reported?
>
> A: Only the first one can be timely reported. The rest of them all relate to the same cause of action which they started back in 2008. So the actions would had to have been reported when they were served with the complaint pursuant to the policy which clearly states that they have to provide us copies of the complaint immediately upon receipt, and it also tells them if they knew about it beforehand they have to provide us about facts and circumstances which may give rise to a claim.

See *Tameler Transcript*, App. F-10, also G-1(S), at 89:17-24, 90:1-7. The testimony of Tameler and ALPS' coverage letter of June 23, 2010 contradict each other insomuch as the coverage letter states that the allegations in the amended complaint determine whether coverage exists, while Tameler's deposition testimony states that the coverage determination is premised upon the time of filing of the original complaint.[22] These contradictions, when viewed in the context of ALPS' reliance on the 2010 policy to evaluate coverage provides ample evidence demonstrating that the circuit court's determination that there were no issues of fact left for resolution to be clearly in error, warranting this court to reverse the circuit court's summary judgment order. The opposing half of a trial worthy issue is present where the non-moving party can point to one or more disputed 'material' facts." Syl. pt. 5, *Jividen v. Law*, 194 W. Va. 705, 461 S.E.2d 451 (1995). *Any fact that has the capacity to sway the outcome of the pending litigation under applicable law is a "material fact." Id.* (emphasis added). The shifting foundation upon which ALPS' premised its denial of coverage, which amounts to an ambiguous policy, constituted evidence or facts which had "the capacity to sway the outcome of the pending litigation." *Id.*

ALPS' reliance on the Amended Complaint, filed during a subsequent coverage period, to deny coverage to TL&A, as stated in ALPS' June 23, 2010 correspondence demonstrates additional ambiguities as to the interpretation of the policy, which should have warranted denial of ALPS' Motion for Summary Judgment and a finding of coverage for TL&A. Furthermore, handling this as it did, there is a strong argument that ALPS has waived any attempted reliance on the "claims-made-

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[22] The Amended Complaint was filed on or about May 27, 2008. *See*, *Docket Sheet*, App., p. 415. The ALPS' policy of insurance in effect during the filing of the original complaint ran through March 24, 2008. Consequently, the Amended Complaint was filed during a subsequent policy period (March 24, 2008 through March 24, 2009).

claims-reported" portion of the applicable policy due to the timing of the filing of the amended complaint.[23]

2.) *West Virginia Code § 33-6-14 Prevents the Strict Application of the ALPS Policy of Insurance*

In its Response Brief to ALPS' Motion for Summary Judgment, TL&A asserted that West Virginia Code § 33-6-14 would also preclude the Court from the strict application of the "claims-made-claims-reported" provisions of the ALPS' policy of insurance. *See*, *TL&A Response*, App., pp. 225-227. West Virginia Code § 33-6-14 states the following:

> *No policy delivered or issued for delivery in West Virginia* and covering a subject of insurance resident, located, or to be performed in West Virginia, shall contain any condition, stipulation or agreement requiring such policy to be construed according to the laws of any other state or country, except as necessary to meet the requirements of the motor vehicle financial responsibility laws or compulsory disability benefit laws of such other state or country, or preventing the bringing of such an action against any such insurer for more than six months after the cause of action accrues, *or limiting the time within which an action may be brought to a period of less than two years from the time the cause of action accrues in connection with all insurances other than marine insurances*; in marine policies such time shall not be limited to less than one year from the date of occurrence of the event resulting in the loss. *Any such condition, stipulation or agreement shall be void, but such voidance shall not affect the validity of the other provisions of the policy.* This section shall not apply to the standard fire insurance policy.

See, W. Va. Code § 33-6-14 (emphasis added). The pertinent language of this code section clearly provides that a policy of insurance may not limit " . . . the time within which an action may be brought to a period of less than two years from the time the cause of action accrues . . ." *Id.*

In *Soliva* v. *Shand, Morahand & Co., Inc.,* 176 W. Va. 430(1986), this Court examined the application of West Virginia Code § 33-6-14 to a "claims-made" policy of insurance. In *Soliva*, a physician purchased a "claims made" policy of insurance for a period of one year beginning on May

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[23] Tameler, testified that he viewed all three complaints filed by Plaintiff as containing allegations of negligence. If this testimony is to be believed, the substantive analysis for the denial of coverage should have remained uniform while evaluating the three different complaints. Because ALPS' coverage counsel has determined the second amended complaint controls the analysis, as between the first and second complaint, there is a clear difference of opinion as to the proper analysis to utilize. If ALPS' coverage counsel's opinion is correct, the filing of the amended complaint would also negate ALPS' contention that the claims-made-claims reported provision controls the instant analysis. The fact that coverage counsel utilized the 2010 Policy while relying an amended complaint filed during the 2008 policy period demonstrates the ambiguities that should have resulted in denial of ALPS' Motion for Summary Judgment.

25, 1980 running until May 25, 1981. *Id*, at 431. The insured did not renew the policy and instead purchased an occurrence based policy beginning on June 1, 1981. On June 12, 1982 the insured was sued for medical negligence which allegedly occurred between August 8, 1980, and November 24, 1980. The claims made insurer denied the action because it was not filed prior to May 25, 1981. *Id.* The carrier providing the "occurrence" based policy denied coverage because the alleged malpractice occurred before the effective date of the policy. The insured claimed that the "claims made" policy violated West Virginia Code § 33-6-14 (1982) on grounds that insurance policies without a tail provision of at least two years are prohibited by the statute. *Id.*, at 433.

While this Court denied coverage in *Soliva*, this case is significantly different. The policy at issue in this case defines a claim to include "a demand for money or services, including but not limited to the service of suit or institution of arbitration proceedings against the insured." *See*, *ALPS Policy of Insurance*, at p. 4 of 14, App., p. 286. If the Court utilizes ALPS' reliance on the Amended Complaint as the basis for its denial of coverage as stated in the June 23, 2010 denial of coverage letter, TL&A correctly notified ALPS of its request for defense and indemnification within two (2) years following the filing of the Amended Complaint and thus coverage should be provided under the holding in *Soliva*.

Additionally, in *Soliva*, the "claim" for insurance coverage was made after the expiration of the applicable claims-made policy, in clear violation of the policy. Here, TL&A maintained a policy of insurance with ALPS from the time of the filing of the Complaint, through the filing of the Amended Complaint and the Second Amended Complaint, which clearly differentiates the instant analysis from that applied by the Court in *Soliva*. Consequently, in consideration of Tameler's testimony that a claim reported after the expiration of a policy term may still be provided coverage, West Virginia Code § 33-6-14 is applicable and coverage should exist. The circuit court's order granting ALPS' Motion for Summary Judgment did not specifically address the potential application of West Virginia

Code § 33-6-14 to TL&A's request for coverage.[24] TL&A requests that this Court apply the referenced provisions of West Virginia Code § 33-6-14 and determine that coverage exists pursuant to its provisions or remand this matter to the circuit court for a formal determination on this issue.

B.) The Circuit Court erred by granting ALPS' Motion for Summary Judgment which was based, in part, on the timing of TL&A's report of Plaintiff Smith's claims, despite the clear lack of prejudice to ALPS in its duty to defend and indemnify TL&A.

1.) This Court Should Adopt the Minority Position With Respect to Examining Prejudice In the Context of Claims-Made Policies

The impact of prejudice, or lack thereof, as a factor to be considered by West Virginia Courts in the determination of whether insurance coverage should exist pursuant to a claims-made-claims-reported policy appears to be an issue of first impression for this Court. In its Motion for Summary Judgment, ALPS could not cite any West Virginia or 4th Circuit Court of Appeals case law which supported of the position that the strict application of claims-made provisions in an insurance policy should not be excused where there is no prejudice to the insurer. *See, ALPS' Motion for Summary Judgment and Reply Brief in Support of Motion for Summary Judgment.* The circuit court's order additionally did not cite any West Virginia or 4th Circuit Court of Appeals case law, which addressed West Virginia's position concerning whether potential prejudice to an insurer should be considered in the context of the strict application of a claims-made-claims-reported policy of insurance. *See, Order Granting Summary Judgment to ALPS', Conclusions of Law*, at ¶ 10, App., p. 391.

As noted by TL&A in its Response to ALPS' Motion for Summary Judgment, a minority of courts have taken the position that an insurer must demonstrate prejudice to relieve itself of coverage pursuant to a notice provision in a policy of insurance. In *Cooperative Fire Insurance Assc. of*

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[24] TL&A further notes that the policy language at issue in *Soliva* differs from the applicable policy language at issue in this appeal. Based on the language cited in the *Soliva* opinion, it appears that the policy only covered those claims that were first made during the policy period ("claims-made" policy), without regard to when they were reported to the insurer. Consequently, applying the language of the policy at issue, including the fact that the ALPS' policy was renewed and in effect during the subsequent policy periods when the claim was reported, there are clear differences between the matter *sub judice* and the matter in *Soliva*.

Vermont v. White Caps, Inc., 166 Vt. 355, 694 A.2d 34 (1997), the Supreme Court of Vermont found that an insurer which seeks to be relieved of its obligations under a liability policy on the ground that the notice provision was breached must prove that the breach resulted in substantial prejudice to its position in the underlying action.[25] *Id.*, at 356. Finding that insurance law in Vermont had evolved from the "strict contractual approach" reflected in its previous ruling, the court cited with approval to other jurisdictions which have held that an insurer must demonstrate prejudice from late notice in order to escape liability. Among the cases cited by the Vermont Supreme Court decision was this Court's decision in *State Auto. Mut. Ins. Co. v. Youler,* 183 W. Va. 556, 396 S.E.2d 737 (W. Va. 1990).[26] In *Youler*, this Court was presented with a situation in which it was required to interpret the notice requirements in an automobile policy of insurance for purposes of invoking uninsured and underinsured motorists coverage. This Court held that "[a] notice provision in an automobile insurance policy requiring the insured to give 'prompt' notice or notice 'as soon as practicable' to the insurer of an accident means that the notice must be given within a reasonable period of time." *Youler*, at 562, *citing* Syl. *Ragland v. Nationwide Mutual Ins. Co.*, 146 W. Va. 403, 120 S.E.2d 482 (1961); Syl. Pt. 3, *Black & White Cab Co. v. New York Indemnity Co.*, 108 W. Va. 93, 105 S.E. 521 (1929), *as modified on denial of reh'g.*

The Court went on to note that "[t]he particular language used in the automobile insurance policy as to the time in which notice must be given is not controlling; regardless of the language used, whether 'immediate,' 'prompt,' forthwith,' 'as soon as practicable' or words of similar import, the courts are generally in agreement that reasonable notice is sufficient." *Youler, supra, citing Ragland* at 409. This Court also noted that "[g]enerally, whether notice has been given to an automobile

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[25] The court in *Cooperative Fire Ins.*, did not decide the question of whether to extend its holding to "claims made" policies and expressed no opinion concerning that question.

[26] The decision in *Youler* has been distinguished, on separate grounds, by several subsequent West Virginia decisions addressing the stacking of insurance policies: *See, e.g., Trent v. Cook*, 198 W. Va. 601, 482 S.E.2d 218 (1996) (also modified on other grounds); *Imgrund v. Yarborough*, 199 W. Va. 187, 483 S.E.2d 533 (1997);

insurer within a reasonable period of time is an issue to be resolved by the fact finder." *Youler, supra, citing State Farm Fire & Casualty Co. v. Scott*, 236 Va. 116, 120, 372 S.E.2d 383, 385 (1988); *State Farm Mutual Automobile Ins. Co. v. Milam*, 438 F.Supp. 227, 232 (S.D. W. Va. 1977), *citing Willey v. Travelers Indemnity Co.*, 156 W. Va. 398, 193 S.E.2d 555, 558-559 (1972) (anticipating West Virginia law and holding that an insurer must show prejudice to avoid coverage under a "lack of notice defense").

The Court in *Youler* further considered three separate approaches in considering the potential effects of prejudice on an insurer when provided potentially untimely notice by an insured. The Court noted that some jurisdictions held the presence of prejudice, or lack thereof, to the investigative interests of the insurer, due to the delayed notice of the accident was immaterial on the ground that lack of timely notice was a breach of the condition precedent of the insurance contract justifying, by itself a denial of coverage. *Youler*, at 562, *citing State Farm Mutual Automobile Insurance Co. v. Tarantino*, 114 Ariz. 420, 423-425, 561 P.2d 744, 747-49 (1977) (prejudice presumed, after delay of four and one-half years). This Court noted a second, middle road, in which some courts held that prejudice to the insurer from delayed notice of an accident is a factor to be considered, but they held that there is a rebuttable presumption of prejudice and require the insured to show that the insurer was not prejudiced by the delay. *Youler, supra*, referencing *Klein v. Allstate Insurance Co.*, 367 So. 1085, 1086 (Fla. Dist. Ct. App. 1979).

Finally, this Court noted that "[t]he majority of the precedents, however, do not allow a denial of uninsured or underinsured motorist coverage for delayed notice of the accident to the insurer unless the delay was unreasonable, considering, among other things, whether the insurer was prejudiced, and the insurer bears the burden of proving prejudice." *Youler, supra.*, referencing, *State Farm Mutual Automobile Insurance Co. v. Burgess*, 474 So.2d 634, 636-638 (Ala. 1985).

TL&A willingly concedes that there are differences between automobile policies of insurance and the claims-made-claims-reported policy at issue in this litigation. However, the underlying policy

considerations for refusing to apply a strict and unyielding notice requirement are constant through the analysis of both types of insurance policies. This Court has firmly held that "[w]here the policy language is exclusionary, it will be strictly construed against the insurer in order that the purpose of providing indemnity not be defeated." Syl. Pt. 5, *National Mut. Ins. Co. v. McMahon & Sons, Inc.*,177 W. Va. 734, 356 S.E.2d 488 (1987) (overruled on other grounds); *Potesta v. United States Fid. & Guar. Co.*, 202 W. Va. 308, 314, 504 S.E.2d 135, 141 (1998).

ALPS itself references prejudice in its coverage counsel's letters. While stating that prejudice, or lack thereof, was "irrelevant" ALPS stated the following in a June 23, 2010 correspondence from John G. O'Neil to Pamela Tabor Lindsay:

> In any event, the assertion that ALPS has not been prejudiced appears to be contrary to the facts as we understand them. ALPS has essentially been prevented from participating in the most critical events in this case, including the depositions of you and Mr. Lindsay, and the filing of the defendant's motion for summary judgment. To say that there has been no prejudice ignores the fact that ALPS, as the entity that is being called upon to answer for the claims of Mr. Smith, is entitled to minimize its potential exposure. Your delay in reporting Mr. Smith's claims has essentially deprived ALPS of an opportunity to do so, and it simply cannot be said that there is no prejudice. Accordingly and notwithstanding any alleged lack of prejudice, the extended delay in reporting Mr. Smith's claims precludes coverage under the Policy.

See, App., p. 177 (also, App., p. 261). Initially, any prejudice was cured by acts taken by TL&A seeking and obtaining a continuance to the trial date. To the extent ALPS disagrees, that is a significant material fact or facts in issue, as are the questions of the effect of sequential coverage periods, reasonable expectations and contradictory and ambiguous language within the policy as well as associated "explanatory" communications. In this instance, and based on the specific facts at issue in this litigation, TL&A encourages this Court to move from the "strict contractual approach" reflected in the lower court's ruling and require that an insurer demonstrate prejudice wherein it denies coverage under a "claims-made-claims-reported" policy of insurance that was renewed during all pertinent time periods and reporting periods, and there is a late amendment of a complaint, during an applicable policy period, including a claim for negligence against the insured. To hold otherwise negates the insured's reasonable expectations under the applicable policy of insurance, creates illusory

insurance coverage and permits an insurer to ignore factual developments in a case, that it would provide coverage under a then-existing applicable policy.

2.) The Issue of Whether "Prejudice" Exists Is a Determination For a Finder of Fact

The circuit court accepted the majority position in denying the potential applicability of "prejudice" to determine whether insurance coverage exists for purposes of the reporting requirements in a claims-made-claims-reported policy of insurance. However, if this Court determines that the minority position is the accepted analysis to be applied in West Virginia, the issue of whether prejudice exists in the context of the timing of reporting of claims is an issue for the finder of fact, per established West Virginia case law. *See*, *Youler*, at 563. (In an underinsured or insured motorist case, if the insurer presents evidence of prejudice, the reasonableness of the notice ordinarily becomes a question of fact for the fact finder to decide). In *Dairyland Ins. Co. v. Voshel*, 189 W. Va. 121, 428 S.E.2d 542 (1993), this Court analyzed what constituted prejudice to an insurer due to a delay in reporting a claim in the context of a liability policy of insurance. Citing *Youler*, the Court noted that "regardless of the language used (in the policy), whether 'immediate,' 'prompt,' 'forthwith,' 'as soon as is practicable' or words of similar import, the courts are generally in agreement that reasonable notice is sufficient." *Voshel*, at 124. In *Voshel* there was an approximately two (2) year delay between the loss and the notification to the insurer of the claim. *Id.* The lower court in *Voshel* found that the two-year delay was unreasonable and this Court affirmed the lower court ruling on the specific facts of the case.[27]

Important for purposes of the analysis of potential prejudice in this case is this Court's determination of the factors that a court should consider when determining whether prejudice exists

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[27] In upholding the denial of the coverage in *Voshel*, this Court noted that there was no explanation which would make a two year before reporting the claim seem reasonable. The insurer presented evidence of the prejudice it suffered as a result of the delay. The Court noted that the chain of title of the subject automobile could not be established, which was critical to establish whether the automobile was an "insured" vehicle under the applicable policy. A critical witness was deceased by the time of the reporting of the claim and another critical witness could not be located. *Voshel*, at 125, 546. In the present case, there are reasonable explanations explaining this delay in reporting.

to warrant a denial of coverage. TL&A acknowledges in *Voshel* that this Court specifically held a liability insurer is more likely to experience prejudice due to a delay in reporting a claim (versus an underinsured or uninsured policy provision) because there is no other insurance carrier which would undertake an investigation. *Id.*, at 124-125. However, the Court provided a specific set of factors that should be examined for prejudice in the liability insurance context:

> In cases which involve liability claims against an insurer, several factors must be considered before the Court can determine if the delay in notifying the insurance company will bar the claim against the insurer. The length of the delay in notifying the insurer must be considered along with the reasonableness of the delay. If the delay appears reasonable in light of the insured's explanation, the burden shifts to the insurance company to show that the delay in notification prejudiced their investigation and defense of the claim. If the insurer can produce evidence of prejudice, then the insured will be held to the letter of the policy and the insured barred from making a claim against the insurance company. If, however, the insurer cannot point to any prejudice caused by the delay in notification, then the claim is not barred by the insured's failure to notify.

Syl. Pt. 2, *Voshel, supra.* As applied to the facts of the case before the circuit court, the only evidence submitted concerning the reasons for the delay is contained in the affidavit of Richard Lindsay, in which he noted that he had been continually insured by ALPS with no interruptions in insurance coverage since 2007; that at the time of the filing of the second amended complaint, it was his belief that Mr. Smith had asserted a claim for negligence for the first time, which was timely submitted to ALPS; that he believed that the claims contained in the Complaint and Amended Complaint were alleged intentional conduct and he therefore did not believe them to be covered; that he had reviewed correspondences received from coverage counsel for ALPS after requesting coverage and ALPS did not assert that the Complaint and Amended Complaint were being treated as negligence claims; that coverage counsel for ALPS referenced the prejudice it purportedly suffered by alleged late notice. *See*, *Affidavit of Richard D. Lindsay*, App., pp. 272-275.[28]

It is not disputed that prior to the notification of ALPS of this claim, only limited discovery had transpired, which included the depositions of Richard D. Lindsay and Pamela Lindsay. The deposition

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[28] ALPS did not attempt to take the depositions of Richard D. Lindsay or Pamela Lindsay during the discovery period prior to the filing of its motion for summary judgment.

of Plaintiff, Ronnie Smith was not completed until after ALPS had entered its appearance in this case. In his deposition, Plaintiff Smith testified that he did not know whether there was even money missing whether someone had made an innocent mistake and misplaced his funds, or whether someone improperly took his money. *See*, *Smith Transcript*, App., at 242:12-243:16 (also, App., at 612:12-613:16).[29] ALPS was present at the most critical discovery even for purposes of coverage, and any assertion of prejudice is completely negated by that fact.

The effect of the filing of the Second Amended Complaint, combined with discovery completed after ALPS entry into this litigation, including the deposition testimony of Plaintiff Smith mandates that the issue of "prejudice" must be considered by this Court and that the minority position should adopted to negate the possibility of insured's being forced to proceed without insurance coverage that should cover these claims. The fact that TL&A continued to maintain and pay for its ALPS' policy of insurance from the time of the filing of the original complaint through the filing of the Second Amended Complaint further demonstrates that if TL&A were denied coverage through the ALPS policy of insurance, the reasonable expectations of the insured would be frustrated.

For these reasons, TL&A respectfully requests that this Court adopt the minority position requiring an examination of the prejudice an insurer may experience if there is a delay in reporting a potential claim. Specifically, TL&A urges this Court to adopt an analysis which permits the consideration of potential prejudice in a determination of coverage in those limited instances where an insured has purchased a claims-made, claims-reported policy of insurance that was renewed

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[29] As the Court will note, ALPS had counsel present at Mr. Smith's deposition, which was completed on April 7, 2011. *See*, *Smith Transcript*, App., p. 493. Despite Mr. Smith's inability to produce any evidence of missing funds, let alone an intentional act by TL&A, ALPS did not attempt to modify their coverage position in light of this new evidence. By way of further explanation, the "paper" that Mr. Smith referenced at the conclusion of the quoted deposition testimony was the deposit slip which formed the basis for Mr. Smith's original complaint. In the original *pro se* complaint, Mr. Smith asserted that Pamela Lindsay wrote a check to herself in the amount of Two Hundred Ninety Thousand Dollars ($290,000.00). *See*, *Original Complaint*, App., pp. 1-3 (also, App., pp. 61-69). This assertion has been completely negated and not included in the Amended Complaint as it has been established that the $290,000.00 "check" was actually a deposit slip for the account into which settlement proceeds were deposited on behalf of Mr. Smith and his now deceased wife. *Smith Transcript*, App., at 551:2-552:10).

continuously for subsequent policy periods, and evidence discovered after the filing of the original complaint, and after the initial policy period, demonstrates that insurance coverage should be present.

3.) Because a Duty to Defend is Broader than the Duty to Indemnify, ALPS, at the Very Least Must Defend the Claims Against the Defendants

In its response to ALPS' Motion for Summary Judgment, TL&A correctly noted that West Virginia follows the majority of courts that hold that a duty to defend is broader than the duty to indemnify. See, *Aetna Casualty & Property Company v. Pitrolo*, 176 W. Va. 190, 194, 342 S.E.2d 156, 160 (1986). It is also well-established that an insurer's duty to defend is tested by whether the allegations in the plaintiff's complaint are "reasonable susceptible of an interpretation that the claim may be covered by the terms of the insurance policy. *Camden-Clark Memorial Hospital Association v. St. Paul Fire and Marine Insurance Co.*, 224 W. Va. 228, 682 S.E.2d 566 (2009). In this case, the Plaintiff Smith's allegation of negligence in the Second Amended Complaint clearly triggered a duty to defend. First and foremost, there were no factual allegations against Richard Lindsay of any intentional wrongdoing; therefore, ALPS, at the very least, had a duty to defend him. With respect to Richard Lindsay, Plaintiff's claims of negligence, should be covered. However, ALPS conducted absolutely no investigation of what conduct could be deemed negligent. Prior to making its coverage determination, ALPS did not know what Plaintiff Smith was alleging that was negligent because it summarily denied coverage with no additional investigation. Based on the foregoing, ALPS, at the very least, must defend the interests of its insureds in this action.

C.) The Circuit Court Committed Error When It Granted Summary Judgment in Favor of ALPS, Finding That There Were No Factual Issues Left for Resolution Despite the Language of West Virginia Code § 55-13-9, Settled Case Law and the Materials Sent From ALPS to Petitioners.

1.) ALPS' Reliance on The Amended Complaint in Its June 23, 2010 to Deny Coverage Renders Its Policy of Insurance Ambiguous

Based on the evidence previously described in this Brief, the circuit court missed several clear discrepancies, which, at the very least, demonstrated issues which rendered the coverage provided by its policies of insurance ambiguous, leaving issues of fact to be resolved pursuant to West Virginia

Code § 55-13-9. Additionally, ALPS' attempt to use West Virginia's notice pleading requirement to ignore the later assertion of a negligence claim, creates additional factual issues, which should have required the circuit court to deny ALPS' Motion for Summary Judgment. In ALPS' June 23, 2010 correspondence, which denied coverage to TL&A, ALPS stated the following:

> While ALPS is obviously not in a position to determine the veracity of Mr. Smith's claims, it is his allegations in the amended complaint that determine whether coverage exists. *See*, *West Virginia Fire & Cas. Co. v. Stanley*, 216 W. Va. 40, 47 (2004), *citing State Auto. Ins. v. Alpha Engineering Serv.*, 208 W. Va. 713, 716 (2000).

See, fn. 14, App., p. 178 (also, App., p. 262). During the deposition of Mr. Tameler, he testified as follows:

> Q: You were aware that there was an original Complaint, and Amended Complaint, and a Second Amended Complaint; correct?
>
> A: Correct.
>
> Q: So that I'm clear on what you're telling me the policy you referenced you believe was in connection with the Amended Complaint which would be number two in the string of three?
>
> A: That is my understanding, yes.
>
> Q: Okay. Is it the one that referenced "negligence?"
>
> A: They all referenced negligence.
>
> Q: Your testimony is that you have read all three of the Complaints starting with the hand written initial Complaint [pro se Complaint], the second filing and the third, and it's your belief and testimony that they all contain negligence claims?

See, App., at 277:15-278:7 (also, App., at 310, 638:15-639:7). Tameler asserted that in a notice pleading state like West Virginia, he believed the *pro se* complaint contained allegations of a negligence claim. *Id.*, App., at 278:8-12 (also, App., at 310, 639:8-12). He further stated that he believed all three complaints all sounded in negligence. *Id.*, at 278:16-20 (also, App., at 310, 639:16-20). A review of the original *pro se* Complaint filed in this civil action reveals that Plaintiff Smith asserted that Pamela Tabor Lindsay had illegally, and wrongfully caused a check to be issued in her name on August 9, 1996 in the amount of $290,000.00. *See, Pro Se Complaint*, ¶ 8, App., p. 2 (also, App., p. 63).

While West Virginia has long held that, "[c]omplaints are to be read liberally as required by the notice pleading theory underlying the West Virginia Rules of Civil Procedure." *Means v. Kanawha Pizza, LLC*, 2011 W. Va. LEXIS 185, *5 (2011); *State ex rel McGraw v. Scott Runyan Pontiac Buick, Inc.*, 194 W. Va. 770, 776, 461 S.E.2d 516, 522 (1995). Tameler's attempt impose a negligence theory of recovery in Plaintiff Smith's *pro se* Complaint, where there is explicitly none stated, expands the concept of "notice pleading" to the benefit of an insurance company attempting to deny coverage to its insured. The concept of notice pleading was created to expand the rights of plaintiffs seeking recovery for injuries. The notice pleading requirement was not created to assist insurance companies in their efforts to deny insurance coverage to insureds, especially in consideration of the much later assertion of an explicit negligence claim by Plaintiff Smith in this litigation.

Tameler's attempted reliance on notice pleading requirements to impute a negligence claim in Plaintiff Smith's *pro se* Complaint forms the basis for ALPS to disavow the later explicit amendment of Plaintiff's Complaint to assert a negligence claim against TL&A. ALPS should not be permitted to utilize the concept of notice pleading as a "sword" in disavowing the significance of the later amendment of the Plaintiff Smith's complaint, which specifically asserted a negligence claim.[30]

Due to the manner by which ALPS viewed the notice provided to them, and the improper application of "notice pleading" as applied to insurance coverage, there are material issues of fact, which warrant this Court to reverse the award of summary judgment in favor of ALPS. In the June 23, 2010 correspondence sent from ALPS to TL&A, ALPS relied on the allegations contained in the Amended Complaint to deny coverage to TL&A. ("While ALPS is obviously not in a position to determine the veracity of Mr. Smith's claims, it is his allegations in the amended complaint that determine whether coverage exists." (Fn. 14 (citations omitted), App., p. 178 (also, App., p. 262).) Tameler's testimony contradicts the statements contained in the June 23, 2010 correspondence from

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[30] TL&A concedes that the analysis made by ALPS in this instance is unique based on the fact that a claims-made-claims-reported policy insured TL&A. The analysis may be different if different types of insurance policies were applicable.

ALPS' counsel. Mr. Tameler testified that ALPS examined the "Complaint" to determine whether allegations of negligence existed. ("We looked at the Complaint, the Complaint speaks for itself. It contains allegations of duty and in our practice if that was a negligence claim that we're going to defend unless there are other grounds not to defend it and in this case there were no grounds to defend." App., p. 646.) Additionally, if the allegations in the Amended Complaint controlled for purposes of the denial of coverage, why would ALPS not consider the allegations of the Second Amended Complaint? Why would ALPS rely on the allegations in the original complaint for a determination of whether "negligence" was asserted, but rely on the Amended Complaint for purposes of applying the "claims-made-claims-reported" provisions of the policy? These issues all remain unresolved and present ambiguities in the ALPS policy of insurance, which therefore constitute issues of fact for later resolution.

It should be remembered that "the controlling rule of law is that an insurer which gives one reason for its conduct and decision as to a matter in controversy cannot, after litigation has begun, defend on another and different ground." *Potesta v. United States Fid. & Guar. Co.*, 202 W. Va. 308, 318, 504 S.E.2d 135, 145 (1998), *citing Armstrong v. Hanover Ins. Co.*, 130 Vt. 182, 188, 289 A.2d 669, 672 (1972). Tameler's deposition testimony when juxtaposed with the initial denial letters sent from ALPS to TL&A strongly indicate a shifting basis for denial of coverage premised on which version of the complaints filed in this case were better suited for ALPS to assert specific reasons for said denials.

An "ambiguity" for purposes of the interpretation of an insurance policy is present 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)). Through its subjective selection of pleadings to determine whether insurance coverage existed, there is inherent ambiguity in the manner in which ALPS applies its "claims-made-claims-reported" provisions of its insurance

policies. While TL&A asserts that this ambiguity creates issues which warrant a finding of coverage under the policy, these issues, at the very least, create issues of fact which should be further developed and tried before a jury pursuant to West Virginia Code § 55-13-9.

In West Virginia, if the language in an insurance policy is ambiguous, this Court must be guided by the compass of the doctrine of reasonable expectations. *See*, *Soliva*, at 433.[31] The assertion of the negligence claim by Plaintiff Smith in 2010 created what could be viewed as an entirely new claim for purposes of insurance coverage. A policy holder's reasonable expectations would be frustrated by the denial of coverage in this matter following the completion of discovery.

2.) ALPS Failed to Conduct a Thorough Investigation Into the Differing Sets of Claims That May Be Applicable to Pamela Tabor Lindsay and Richard D. Lindsay

Tameler was questioned concerning the investigation that ALPS undertook to determine whether coverage existed for TL&A. He was specifically asked the following:

Q: All right. Was the search for coverage for Pam Tabor-Lindsay identical for that of Richard Lindsay?

A: Probably, yes. I couldn't tell you.

See, *Tameler Transcript*, App., at 645:2-5. A review of the Complaint and Amended Complaint reveals that Plaintiff Smith's allegations assert intentional conduct on the part of Pamela Tabor Lindsay. *See*, *Complaint*, App., pp. 1-3 (also, App., pp. 61-69), and *Amended Complaint*, App., pp. 4-7 (also, App., pp. 244-247). Pamela Tabor Lindsay is the only individual that is listed in the original complaint as undertaking any action which could lead to recovery by Plaintiff Smith.[32] *See*, *Complaint,* at ¶¶ 6-10, App., p. 2 (also, App., p. 62). Tameler noted in his deposition that if ALPS

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[31] TL&A further concedes the analysis concerning its reasonable expectations may be different had TL&A sought out new insurance coverage from another provider in the 2008 through 2010 time period and later came back to ALPS in 2010 and requested insurance coverage through a claims-made-claims reported policy in 2010 for a suit filed in 2008.

[32] Plaintiff Smith's *pro se* complaint does assert that Richard Lindsay approved of Pamela Tabor Lindsay's alleged actions and acted as a fiduciary to Plaintiff Smith, however any liability attributable to him would be derivative of the liability against Pamela Tabor Lindsay. *See*, *Complaint*, at ¶¶ 4-5, App., p. 1 (also, App., p. 62).

found out something that would be contrary to an allegation that would provide coverage, ALPS would cover it. *See*, App., at 658:21-659:4

ALPS did not amend or alter its coverage position following these acknowledgments, which contradicts Tameler's deposition testimony concerning the reevaluation of claims based upon evidence presented during discovery. Tameler also testified that he believed that there was an independent investigation addressing coverage for both Pamela Tabor Lindsay and Richard Lindsay. App., at 554:7-16. However, no one at ALPS ever contacted Pamela Lindsay to discuss the underlying case or any coverage related issues. *Id.*, App., at 553 and 554:1-2.

The circuit court's order granting summary judgment did not address the differences in the claims that were asserted against Richard Lindsay and Pamela Lindsay. ALPS has not indicated whether it has reviewed the motion for summary judgment on Plaintiff's claims filed on behalf of Richard Lindsay, individually, which clarifies the lack of foundation for any claim of misappropriation on his behalf due to his lack of involvement in the handling of money from the settlements which form the basis of the Plaintiff's claims in this litigation.

Because the circuit court's order (and ALPS' denial of coverage) failed to address the difference in the claims against Richard Lindsay and Pamela Tabor Lindsay, this Court should reverse the circuit court's award of summary judgment as to potential coverage for Richard Lindsay.

D.) The Circuit Court Erred By Not Finding That ALPS had Waived Its Right to Rely on Reporting Requirements of the Policy By Sending Communications to Its Insureds Which Informed Insureds Were "Encouraged" to Report "Potential Claims" Under the Facts of this Case.

The circuit court's order addressed the issues of waiver and estoppel, finding that they were not applicable to the instant set of facts. Addressing the issue of waiver in the context of insurance coverage, the West Virginia Supreme Court of Appeals in *Potesta v. USF&G*, 202 W. Va. 308, 504 S.E.2d 135 (1998), reiterated that "to effect waiver, there must be evidence which demonstrates that a party has intentionally relinquished a known right." *Id.*, *citing Ara v. Erie Ins. Co.*, 182 W.Va. 266, 387 S.E.2d 320 (1989). Additionally, this Court has previously held that to assert waiver to prevent

the insurer from asserting other, previously unarticulated reasons for denying coverage in subsequent litigation,

> the insured must show, by clear and convincing evidence where waiver is implied, that the insurer intentionally and knowingly waived the previously unarticulated reason(s) for denying coverage.

Potesta, supra, at 317, 504 S.E.2d at 144. Moreover, this Court has recognized:

> [i]nsurers will be encouraged to conduct reasonable investigations of claims and to notify their insureds of reasons for declination, as a failure to do so may result in a finding that the insurer has waived any unasserted grounds of forfeiture, or a finding that the insurer has acted in bad faith and is thus estopped from asserting previously unidentified defenses, even if they are based on noncoverage. This opinion also recognizes that an insurer may not assert a new ground for declination where the insured has reasonably relied to his/her detriment on previously asserted grounds for declination and would be prejudiced by the assertion of new grounds. Finally, nothing in this opinion changes the *McMahon* rule that an insurer "seeking to avoid liability through the operation of an exclusion has the burden of proving the facts necessary to the operation of that exclusion."

Id. at 314, 504 S.E.2d at 141. It is not disputed that ALPS forwarded correspondence to TL&A, which states that insureds are "encouraged" to report "potential claims." *See*, *Correspondence from Jim Mickelson*, App., p. 255. The applicable policies of insurance do not define what constitutes a "potential claim." The language indicating that insureds are "encouraged" to report these undefined claims, is critical when contrasted with its position that TL&A was required to report the Complaint sounding in intentional conduct. As the affidavit of Richard Lindsay makes clear, he believed that the allegations contained in Plaintiff Smith's Complaint and Amended Complaint would not be covered because they alleged intentional conduct. *See, Affidavit*, at ¶ 12, App., p. 274.

A reasonable individual could interpret, due to a lack of information to the contrary, that a "potential claim" may not be covered and could reference claims sounding in intentional conduct. Because ALPS forwarded literature to TL&A stating that TL&A was encouraged, but not required, to report "potential claims" ALPS should have been estopped from asserting that the strict application of the claims-made-claims reported policy provisions should control. Consequently, the circuit court erred by not applying the doctrine of waiver and estoppel to preclude ALPS from relying the claims-made-claims-reported policy provisions. This Court, in addition to the information already discussed

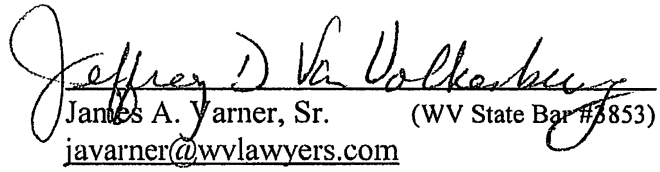
herein, should reverse the circuit court's order because ALPS waived the right to rely on the strict interpretation of its policy.

CONCLUSION

Based on the foregoing, ALPS, at the very least, must defend the interests of its insureds in this action. Furthermore the evidence contained herein demonstrates that there are continued issues of fact, which must be resolved by prior to decision on coverage. TL&A requests that this Court reverse the entry of summary judgment and find that there are still, at least issues of material fact that need to resolved. TL&A further requests such other relief as the Court deems appropriate.

Respectfully submitted this 27th day of February, 2012.

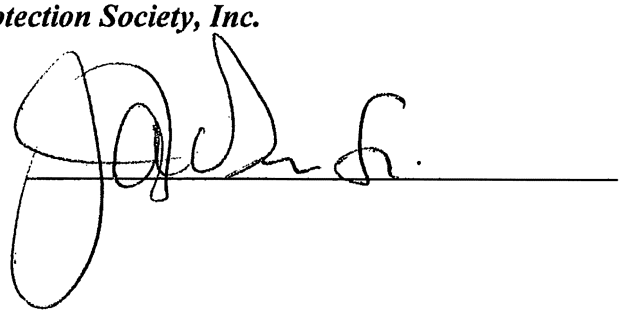
DEFENDANTS/THIRD-PARTY PLAINTIFFS, RICHARD D. LINDSAY and PAMELA LINDSAY, d/b/a TABOR LINDSAY & ASSOCIATES, Petitioners, By Counsel:



James A. Varner, Sr. (WV State Bar #3853)
javarner@wvlawyers.com
James N. Riley (WV State Bar #3111)
jnriley@wvlawyers.com
Jeffrey D. Van Volkenburg (WV State Bar #10227)
(Counsel of Record)
jdvanvolkenburg@wvlawyers.com
Empire Building - 400 West Main Street
P. O. Drawer 2040
Clarksburg, WV 26302-2040
Telephone: (304) 626-1100
Facsimile: (304) 623-3035

McNeer, Highland, McMunn and Varner, L.C.
Of Counsel

CERTIFICATE OF SERVICE

This is to certify that on the 27th day of February, 2012, the undersigned counsel served the foregoing ***"BRIEF ON BEHALF OF PETITIONERS, RICHARD D. LINDSAY and PAMELA LINDSAY d/b/a TABOR LINDSAY & ASSOCIATES, IN SUPPORT OF THEIR PETITION FOR APPEAL (re: Petitioners' Notice of Appeal from an Order of the Circuit Court of Kanawha County Entered on October 26, 2011)"*** upon counsel of record by depositing true copies in the United States Mail, postage prepaid, in envelopes addressed as follows:

Marc E. Williams, Esquire
Randy L. Saunders, Esquire
Nelson, Mullins, Riley & Scarborough, LLP
949 Third Avenue, Suite 200
Huntington, WV 25701
Counsel for Third-Party Defendant,
Attorneys Liability Protection Society, Inc.