Appellate Notes

PULLMAN & COMLEY

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Week of October 13

Welcome to our Supreme and Appellate Court summaries webpage. On this page, I provide abbreviated summaries of decisions from the Connecticut appellate courts which highlight important issues and developments in Connecticut law, and provide practical practice pointers to litigants. I have been summarizing these court decisions internally for our firm for more than 10 years, and providing relevant highlights to my municipal and insurance practice clients for almost as long. It was suggested that a wider audience might appreciate brief summaries of recent rulings that condense often long and confusing decisions down to their basic elements. These summaries are limited to the civil litigation decisions based on my own particular field of practice, so you will not find distillations of the many criminal and matrimonial law decisions on this page. I may from time to time add commentary, and may even criticize a decision's reasoning. Such commentary is solely my opinion . . . and when mistakes of trial counsel are highlighted because they triggered a particular outcome, I will try to be mindful of the adage . . . "There but for the grace of God . . .." I hope the reader finds these summaries helpful. – Edward P. McCreery

Posted October 15, 2014

- SC18975 - Connecticut Ins. Guaranty Assn. v. Drown
- SC18975 Concurrence - Connecticut Ins. Guaranty Assn. v. Drown
- SC18975 Dissent - Connecticut Ins. Guaranty Assn. v. Drown

This started as a medical malpractice action against an obstetrician and his practice group. No direct claims of negligence were made against the practice group. Rather it was asserted it was vicariously liable for the actions of the doctor. The defendant doctor had not been scheduled on the policy addendum. The policy excluded coverage for any claim arising out of:

...injury arising solely out of acts or omissions in the rendering or failure to render professional services by individual physicians or nurse anesthetists, or by any paramedical for whom a premium charge is shown on the declarations page.....

The practice group's medical malpractice insurer provided a defense to the group without any reservation of rights for six years. As a trial date approached, the defense attorney recommended the insurer pursue settlement options, but it declined. When a mediation session was scheduled, the insurer ignored a court order to send a representative. Only then did the insurer, for the first time, write to the practice group stating there was no coverage for the claim as the policy did not cover vicarious liability alleged for the acts of

individual physicians. The insurer then skipped a second mandatory mediation session, causing the judge to enter a default judgment against the group. Accordingly, the practice group and the doctor were forced to enter into a settlement agreement on their own for $2 million and assigned their claims against the insurer in satisfaction of the judgment. Shortly thereafter, the insurer was declared insolvent in New Jersey, and the Connecticut Guaranty Association assumed its obligations. The Association then sought declaratory relief that it had no obligations under the policy. The malpractice plaintiff retorted that the Association was estopped to deny coverage due to the pre-insolvency bad conduct of the original insurer. The Trial Court granted summary judgment in favor of the malpractice plaintiff (now defendant in the declaratory judgment action) on the grounds that the insurer had breached its duty to defend and the Association must be liable to the same extent as the pre-insolvency insurer.

The Appellate Court reversed, holding that the exclusion in the policy clearly precluded coverage for a claim again, and even if the malpractice insurer had breached its duty to defend, the Association was not estopped from excluding coverage. The Supreme Court agreed with the Appellate Court that the malpractice insurer's pre-insolvency misconduct during the litigation does not estop the Association from challenging the existence of coverage for the claim. This is consistent with most sister states and a prior CT decision holding that the Association is not liable for pre-insolvency awards of sanctions unless covered under the policy. Holding the Association vicariously liable for the misconduct of an insolvent insurer would be inconsistent with the limited purpose of the statute to pay only covered claims that cannot be paid due to insolvency. The Association is not bound by all the prior insurer's baggage, only its obligations under the policy.

Now that it was clear the Association was not estopped to reconsider the coverage issue, the Court then turned to the policy to see if coverage had been properly denied under the vicarious liability exclusion. Here, the practice group was being sued for vicarious liability for the acts of an individual physician who was a member of the group. The defendant argued that to read the exclusion in the manner urged by the Association would mean there would be no coverage for vicarious liability for any act of any doctor and most nurses and paraprofessionals. Why would a medical group buy a policy with no coverage for all of its individual doctors and nurses they asked. They argued that the Association's interpretation of the policy rendered coverage illusory. Finally they argued that the last part of the exclusion after "OR" meant the defendant doctor would only be covered by the exclusion if he had been scheduled on the dec page. The Association countered that the policy language clearly precluded coverage for claims arising "solely" due to the malpractice of individual physicians who were supposed to get their own coverage....and coverage was not illusory as there might be undetermined types of claims alleging vicarious liability other than from doctors and nurses. The majority of the Supreme Court agreed with the Association and the Appellate Court that there was no coverage for the claim.

Once again, the Court reviewed the method by which insurance contracts are to be interpreted, and how to address claims that policy language is ambiguous. The decision held that the exclusion clearly covered claims against individual doctors. Further, the "OR" segregated the modification from the rest of the sentence. It

applied the "**last antecedent rule**" of contract construction, which provides that qualifying phrases, absent a contrary intent, refer solely to the last antecedent in a sentence. When a contract separates phrases with the use of a comma, "OR" and "BY", the separation results in the phrase modifying only the section before it. Thus, whenever possible, a modifier should be placed next to the word or phrase it modifies. The majority disagreed with the Dissent, who argued that the application of the last antecedent rule was an improper hyper-technical approach to contractual interpretation. The Dissent felt that it was counterintuitive for a medical practice group, or any medical group for that matter, to purchase a corporate liability policy that would, in turn, exclude coverage for the most obvious source of potential liability, the negligence of its physician members. The Dissent would have concluded that when the provisions of the policy were read together, it rendered coverage for vicarious liability illusory. The majority disagreed, stating that there could be vicarious corporate liability for actions from other types of para-medicals not listed. In a Footnote, the majority said it did not have to speculate as to what situations might arise where there could be vicarious liability to the corporation caused by one other than physicians nurses & paraprofessionals, and was content with the fact that there could be such scenarios. [Comment: It seems like pretty narrow and limiting coverage, however....and if it is not illusory, ...it is awfully close.]

In Footnote 14, the majority criticized the Dissent's reliance upon the title of the policy, which was called, "**Physicians and Surgeons Professional Liability Claims Made Insurance**." The majority stated that the title of an insurance policy cannot be used to create an ambiguity within the terms of the contract itself. Only the body of a contract can be read to decipher its intent.

Finally, in a parallel concurrence by Justice Rogers and Zarella, they wrote to emphasize that they believed that when an insurance policy term is deemed ambiguous, the parties are entitled to present extrinsic evidence as to the intended scope of coverage, and that the Court must consider such evidence before applying the rule of *contra proferentem* to resolve any ambiguity in favor of the insured. In other words, the concurrence argued that the rule of interpretation should only be applied as a "tie-breaker." In this case, however, the matter was decided on cross-motions for summary judgment, and thus, there was no resort to extrinsic evidence.

• SC19163 - Mills v. Commissioner of Transportation

The Supreme Court agreed with the Appellate Court that a highway defect claim should be dismissed as against the State DOT when the Highway Defect Notice only indicated an intent to sue the City of Milford, and did not name the State of Connecticut as a potential defendant.

• SC18914 - State v. Kendrick

• SC18914 Dissent - State v. Kendrick

• SC18914 Dissent - State v. Kendrick

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The facts and holdings of any case may be redacted, paraphrased or condensed for ease of reading. No summary can be an exact rendering of any decision, however, so interested readers are referred to the full decisions. The docket number of each case is a hyperlink to the Connecticut Judicial Department online slip opinion.

The factual summary, or even the legal conclusions, of any case may be summarized, redacted, paraphrased or altered at the author's discretion for ease of reading. Accuracy of the summary cannot be guaranteed and the viewer is referred to the actual case for an exact reading. The Docket number should be a link to the full decision.