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CONSTRUCTION LEGAL EDGE

FALL 2013

ARTICLES CONTAINED IN THIS ISSUE OF THE CLE:

Choosing A Construction Insurance Broker

Relationships are critically important to the success and the well-being of all individuals and organizations. Without strong relationships, organizations, businesses, and individuals face an uphill battle in a rapidly changing world. The success of construction companies and contractors rests upon not only their work product, but also the critical need to build strong relationships with customers, vendors, regulators, politicians, and employees. One of those vendors with which that strong relationship must exist is the construction company's insurance broker.

In the past two decades the landscape of the insurance brokerage world has changed. At one time brokers such as Johnson & Higgins, Alexander & Alexander, Fred S. James, Sedgwick, Marsh & McLennan, and others competed in the marketplace. Today, according to Business Insurance Magazine and Bests, that landscape is led by the top three brokers, Marsh, AON and Willis, as well as others such as Arthur J. Gallagher, Wells Fargo, Brown and Brown, Lockton, Hub and USI, Inc. Numerous capable regional brokers also provide brokerage services. There is no shortage of potential partner choices for an organization and most certainly for a construction company. So, the questions become: (1) how important is a relationship with a key individual at that insurance brokerage regarding the decision to retain that broker to place insurance coverage such as property/casualty, executive products, surety and healthcare coverage; and (2) how does a construction company or any organization best choose an insurance broker to examine risk, place appropriate insurance programs to address that risk and support the firm with its risk management needs? Clearly, a key relationship with an insurance broker is an important component of that decision making process.

However, an even more important component of that decision making process revolves around the evaluation of a prospective insurance broker's experience, staffing, geographic footprint and how the broker matches up with the profile and the needs of the construction company. This is not always an easy evaluation to make. However, once a well thought out evaluation is completed, the construction company can comfortably move forward to build a solid, long-term relationship with an insurance broker that is focused on a clear understanding of client service and appropriate and fair compensation for those services provided by that broker.

In order to make the evaluation of the competency of an insurance broker and how that insurance broker fits with a construction company's business model, there are five key areas of discovery that a company should explore. Those five areas are:

1. Does the insurance broker in question maintain a construction practice to serve its construction clients?

It is critically important that a construction company's insurance broker understands the company's business and be able to respond deftly to new issues and concerns in that business. The maintenance by the brokerage of an in-house construction practice staffed with insurance brokerage employees immersed in day in and day out construction issues is critically important. The construction company can find comfort in knowing that its insurance broker will bring answers to issues and concerns before those issues and concerns become problems. In addition, it is critically important that the insurance brokerage have expertise in providing review and commentary on contracts and insurance requirements from customers, subcontractors and vendors.

2. Does the insurance broker in question maintain strong relationships with insurance carriers that understand and provide competent services to the construction space?

Not every insurance carrier understands or provides appropriate insurance products and services for the construction marketplace. Many say they can. Many cannot. Some do not wish to be in that space. An insurance broker needs to know the construction insurance markets intimately, must maintain cordial and professional relations with those insurance markets and must ensure that those insurance markets. products and services are provided to the construction company in the form of the most appropriate and comprehensive coverage and service, all at the best price.

3. Does the insurance broker in question maintain a staff of capable professionals who have the expertise and knowledge to negotiate the best terms and conditions on the construction company's behalf in the construction insurance marketplace?

A construction company needs to ask specific questions about the insurance broker's staffing. Who within the brokerage structure will negotiate on the construction customer's behalf? What is the level of construction and brokering experience? How many other construction customers do they serve? The insurance broker must know the benchmark construction industry terms and conditions available in the marketplace, must negotiate those terms and conditions into the construction company's insurance contracts, while at

the same time removing exclusions from those contracts to achieve the broadest coverage and best possible pricing.

4. Does the broker in question maintain a local claims staff well versed in construction law and issues?

When a claim occurs, to coin a phrase, "the rubber hits the road." The construction company's bottom line and its good reputation are both at risk. Construction companies require the advice and guidance of experienced claims professionals to protect the construction company's best interests when claims are filed by employees, customers and third parties. Decisions on liability and damage need to be made efficiently, ethically and quickly. The insurance broker should provide the construction company with access to experienced construction claims professionals who are prepared to assist on a 24/7 basis.

5. Does the broker in question maintain a local engineering and safety capability?

The best way to manage claims is not to have them. To help prevent claims from occurring, an insurance broker should make available to the construction company experienced property and casualty safety/engineering professionals who will help protect the construction company's property, assets, people and those third parties who come in contact with the company's operations. These safety professionals should be well versed in all aspects of property preservation and human safety. Their role is to assist and guide the construction company in putting into place risk prevention techniques specific to the company's construction activities.

If a construction company, or for that matter, any organization, uses the answers to these five basic questions to choose an insurance brokerage partner, the company will find itself well on the road to building a profitable partnership with an insurance broker that can last for many years. A solid, honest and frank relationship between the construction company and an insurance broker who provides strong core insurance broker competencies, consistent service, experienced personnel and an ongoing and thorough understanding of the construction marketplace will be profitable for both the broker and the construction company.

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WHAT YOU THINK IS COVERED BY COMMERCIAL GENERAL LIABILITY PROPERTY DAMAGE INSURANCE MAY NOT BE "PROPERTY DAMAGE" UNDER MOST POLICIES

When a claim is presented to a commercial general liability insurer, the adjuster must first determine if there is coverage for the loss. An essential step in the process is to determine if the claim satisfies the insuring agreement of the policy. Sometimes, the answer to that inquiry is simple. However, in some others, it is not. At times, the results may seem inconsistent to policyholders who are not well versed in the subject of insurance. Often, the

results can be reconciled on the basis of subtle distinctions.

The insuring agreement contained in a typical commercial general liability policy states "we [meaning the insurer] will pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which this insurance applies." The term "property damage" is defined in such policies, and the term typically includes "**physical** injury to **tangible** property, including all resulting loss of use of that property." Accordingly, the adjuster must investigate the claim to determine if there is indeed physical injury to tangible property.

The term "tangible" is not defined in the commercial general liability policy. Accordingly, most courts would refer to the dictionary definition of the term. According to Black's Law Dictionary, the definition of that term includes "having or possessing a physical form. Capable of being touched and seen." Therefore, the adjuster must investigate the loss to determine if there exists damage to tangible property.

For example, consider a claim brought against a plumber for faulty installation of water lines when the lines leak and the water causes damage to drywall and other structural components of the building. In this situation, it is easy to identify property damage to tangible property because the damage to the drywall and framing would be readily apparent. But, suppose that the same plumber installed a gas line that leaked, and the faulty workmanship was detected from the smell of the leaking gas. If the gas did not harm the drywall or other structural components, the loss would not be due to any visible or physical injury to any tangible property. So, in the second hypothetical, the coverage trigger would be missing.

In the case of the water damage, some, but not all of the repair costs would be considered as covered damages. The cost to rip out the damaged drywall and other components in order to locate and repair the leak would be treated as consequential damages. The same work undertaken to locate and repair the gas leak would not be covered, however, because it did not arise from any covered damage to tangible property. In neither case, would the cost of repairing or replacing the piping be covered. Most commercial general liability policies exclude damages for repair or replacement of the insured's own work or product.

Some forms of economic loss may be covered damages. For example, if the owner must vacate the building and cannot use it while the repairs are being made, the owner's cost of obtaining a temporary replacement would be recoverable if the loss of use was associated with physical injury to tangible property. So, in the water leak, the rental of a temporary office or storefront may be recoverable, but, in the gas leak scenario, it would not be recoverable.

Suppose that the value of the building declined because of the leaky pipes. Generally, the decline in value alone is not considered to be an element of recoverable damage.

Another claim example was when a contractor installed a pump that allowed air to enter a utility company gas line. A claim was presented because the gas lines of many customers had to be serviced in order to remove the air, all at a significant cost. Insurance was not found to be applicable because there was no damage to any tangible property.

An additional claim example would be when an excavation contractor struck an electrical

line that caused a power outage resulting in a computer shutdown and the loss of a significant amount of computer data to a company that had not yet backed up its data. Unfortunately, under most policy forms, computer or electronic data is not considered to be tangible property that can be physically damaged. So the cost of recovering the lost data was not covered by the contractor's insurance.

Several of these potential coverage gaps can be covered and insured under special coverage forms, such as pollution liability, design build, contractor's professional liability or computer data liability insurance. The point here is that "property damage" insurance is too often taken for granted and, depending on the nature of the construction operations, broader coverage forms must be considered. An insurance professional with particular expertise in the construction arena can help a contractor to identify the risks commonly associated with the contractor's business and that insurance professional can locate the proper insurance products to manage that risk.

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PA Superior Court Limits Insured's Ability To Settle Cases Defended Under Reservations of Rights

A recent decision by the Superior Court of Pennsylvania limits the ability of an insured to settle a case that the insurer is defending under a reservation of rights. In *Babcock & Wilcox Co. v. American Nuclear Insurers*, 2013 WL 3456969 (Pa. Super. July 10, 2013), the court held that, in a case defended by the insurer subject to a reservation of rights, the insured could not recover the settlement payment from the insurer absent a showing that the claim was, in fact, covered by the policy **and** that the insurer acted in bad faith when it refused to consent to a fair, reasonable, and non-collusive settlement that the insured deemed to be in its best interests. Before this decision, the prevailing thought was that an insured could enter into such a settlement in order to protect itself from a potentially uninsured loss and then recoup the settlement payment from the insurer merely upon proof of coverage under the policy. After this decision, an insured wishing to retain that ability to settle must either reject the insurer's offer of a defense and fund its own defense, as well as the settlement; or, it must be prepared to prove bad faith on the part of the insurer. As one can appreciate, few insureds have the wherewithal to undertake the defense and settlement of a suit (after all, that is why they purchase insurance in the first place), and even those that can afford to do so may not be willing to stake their right of recovery on the ability to prove a bad faith case at the end of the day. If this decision withstands review by the Pennsylvania Supreme Court, it puts an added burden upon the insured to get timely and effective advice regarding its rights vis-à-vis the insurer as soon as a reservation of rights is received. Any delay or inaction on the part of the insured could limit the insured's ability to protect its interests later in the case.

In order to understand the impact of the *Babcock & Wilcox* case, it is important to understand some of the basic rights and duties allocated to one party or the other by a typical liability

insurance policy, such as a commercial general liability policy, a business auto policy, or a professional liability policy. While the following generalizations are accurate in most instances, please keep in mind that the particular terms and conditions of the policies are controlling and the policies should be reviewed by legal counsel or an insurance professional before any action is undertaken.

Generally speaking, an insurance policy imposes upon the insurer two distinct duties when a lawsuit against the insured is submitted to the insurance company. First, an insurer has a duty to pay covered claims brought against the policyholder. Second, the insurer has the duty to defend any suit brought against the policyholder on a covered claim. To facilitate its performance of those duties, the typical policy cedes to the insurer the right and duty to control the investigation and defense of the suit. Additionally, the insurer also has the prerogative to settle any suit.

Moreover, to prevent the insured from prejudicing the insurer's rights to investigate, defend and settle claims, policies typically forbid an insured from entering into settlements of suits without the insurer's consent. If the insured were to settle without obtaining the insurer's consent, the insured would forfeit any coverage, and the insurer would have no obligation to pay the unauthorized settlement.

Whenever a suit against a policyholder is submitted to an insurance company, the insurer basically has three options. First, it can accept the claim and provide the insured with a complete and unqualified defense. Whenever this occurs, the insurer will also have an unqualified obligation to pay the claim on behalf of the insured. At the opposite end of the spectrum, the insurer might deny coverage for the claim, thereby leaving the insured to its own devices to defend against the claim and to pay any damages that may be imposed upon the insured. In between those two extremes is a wide middle ground, a grey area of sorts, and that is where the *Babcock & Wilcox* case fell. In those situations, an insurer may be willing or perhaps even be required to provide the insured with a defense against the suit, but the insurer may wish to reserve its right to disclaim coverage, that is, to refuse to pay some or all of the damages, at a later date. In order to pursue that course of action, an insurer is required to issue a so-called reservation of rights letter to the insured.

The purpose of a reservation of rights letter is to notify the insured of potential defenses that the insurance company may have under the policy or under applicable law, which defenses would enable the insurance company to decline the payment of a claim. Once the insured is put on notice of those potential defenses, the insured can then decide what, if anything, it should do to protect its rights under the policy or under the law to ensure the continuity of the defense or to guaranty the eventual payment of any verdict or settlement that may be forthcoming.

As one can appreciate, the defense of a case under a reservation of rights can often lead to a divergence of interests between the insurer and the insured.

In some jurisdictions, California for example, courts have held that the issuance of a reservation of rights letter creates an immediate conflict of interest between the insurer and the insured, thereby affording the insured the right to have independent counsel of the insured's choice to defend the suit at the insurer's expense. This independent counsel would have undivided loyalty to the insured and counsel would be free to act in the insured's best interests in order to achieve the delicate balance between defense of the case and coverage for the claim.

In other jurisdictions, courts are reluctant to hold that there is an immediate conflict of interest that triggers a right on the part of the insured to have independent counsel of its choice to conduct and control the defense at the insurer's expense. In those jurisdictions, insurers still enjoy the rights to select counsel and to control the defense and the insurers must pay for that defense. Pennsylvania falls into this category. So, in Pennsylvania, defense counsel is put into a precarious position of defending the case as instructed by the insurer, and sometimes tensions will arise when the defense of the case is juxtaposed against coverage for the claim.

With that backdrop, let us turn to the facts of the *Babcock & Wilcox* case.

In that case, Babcock & Wilcox operated two facilities that processed radioactive material. For years, Babcock & Wilcox maintained insurance for its nuclear hazards. Over the years, it substantially increased its policy limits, reaching $160,000,000 per facility by 1979. In 1994, several suits, including several class actions, were filed in federal court seeking damages for bodily injuries and property damages allegedly caused by exposure to radioactive emissions from the facilities. More than 300 plaintiffs were identified in these suits. Babcock & Wilcox denied liability for all such claims. Babcock & Wilcox tendered these lawsuits to its insurer and it requested defense and indemnity from the insurer. The insurer agreed to provide Babcock & Wilcox with a defense, albeit subject to a reservation of rights. In other words, the insurer made no promise or representation that it would ever pay a claim against Babcock & Wilcox. The insurer did conduct the defense, which included the trial of eight test cases. The test case verdicts were in favor of the plaintiffs, and over $36,000,000 in damages were awarded. However, a new trial was granted. After the grant of a new trial, and before the new trial occurred, a dispute arose between Babcock & Wilcox and the insurance company concerning the coverage, if any, provided by the policy.

The coverage dispute led to a declaratory judgment action filed in state court. In that declaratory judgment action, the court was called upon to decide several issues, one of which was whether the insurer had a duty to provide separate counsel for Babcock & Wilcox. The court ruled in favor of Babcock & Wilcox on that issue, and that ruling stood up on appeal. Thereafter, Babcock & Wilcox selected its own defense counsel and, through the efforts of that counsel, it negotiated a settlement of the claims for the aggregate amount of $80,000,000. Based upon the test case verdicts, Babcock & Wilcox reasonably believed that its exposure to the numerous plaintiffs could have exceeded $320,000,000. Despite this potential exposure to Babcock & Wilcox, the insurer refused to engage in the settlement talks and it did not consent to the settlement that Babcock & Wilcox reached.

After the settlement occurred, Babcock & Wilcox sought to recover the settlement payment of $80,000,000 from the insurer. In a jury trial, it was determined that the settlement payment was fair, reasonable and non-collusive. Eventually, the court issued an order holding the insurer liable for the settlement payment, as well as interest on the payment.

On appeal, the insurer contended that Babcock & Wilcox could not recover the settlement payment because the settlement was reached without the insurer's consent and because the insurer did not act in bad faith when it refused to consent to the settlement. The insurer argued that it retained the right under the policy to control the course of settlement and that

it was fully performing its policy obligations by defending Babcock & Wilcox to the tune of more than $40,000,000.

The appellate court ruled that, whenever the insurance company tenders defense of a claim subject to a reservation of rights, the insured has two options. **First**, it may accept the defense, in which case the insured remains unqualifiedly bound by the consent to settle provision. If the insured were to choose that option, the insurer would retain control over the litigation, and the insured's sole protection against any injuries arising from the insurer's conduct of that defense would lie in the bad faith standards. In other words, the insured could step in and usurp the insurer's prerogative and settle the claim unless the insurer acted in bad faith by refusing to settle a claim. **Second**, the insured could reject the defense, in which case it would retain control over the defense and it would have the ability to settle on whatever terms it deemed to be in its best interests. If the insured were to take that path, then the insurer would be obliged to pay the settlement and the defense costs in the event that coverage were found. The settlement would, of course, have to be fair, reasonable, and non-collusive.

After fashioning those rules, the appellate court applied them to the facts of the case. In doing so, it concluded that the case had to be remanded because two key questions still remained unanswered. First, it was not clear whether Babcock & Wilcox rejected the defense that was offered to it by the insurer. Also, it was not determined whether the insurer acted in bad faith.

The lesson to be learned from this case is that any insured receiving a reservation of rights letter from an insurer needs to get prompt advice from counsel or an insurance professional concerning the risks of accepting or rejecting the defense. If the insured accepts the defense (or if it simply acquiesces to the defense), it may lose its ability to negotiate a favorable settlement or it may be required to prove a bad faith case in order to recover a settlement that it may reach over the insurer's objections. On the other hand, in order to protect its right to self-determination of the settlement issue, the insured may have to forego the benefit of a defense funded by the insurer. These are difficult choices, especially for insureds that do not have the financial ability to undertake the costs of defense and settlement of claims. Also, these are choices that can best be made with the guidance of counsel and/or an insurance professional, as they may be better informed about the terms and conditions of the policy, of the reservation of rights, and the risks presented by the litigation itself.

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Pursuing Misallocated Contract Funds Against The General Contractor's President In Bankruptcy: Recent Developments Regarding Non-Dischargeability and Fraudulent Misrepresentations

The United States Court of Appeals for the Fourth Circuit issued an interesting opinion this past summer titled *SG Homes Associates, LP v. Marinucci*, 718 F.3d 327 (4th Cir. 2013). The opinion examines the pursuit of a general contractor's president/shareholder by a project owner through the bankruptcy court for misallocated project funds, and whether the bankruptcy debt of the general contractor's president/shareholder can be deemed non-dischargeable based on fraud pursuant to section 523(a)(2)(A) of the Bankruptcy Code.

In *SG Homes*, the project owner sued the general contractor and its president/shareholder in Maryland state court for breach of contract, fraud, and a violation of the Maryland Construction Trust Fund Statute. While the case was pending, the president/shareholder individually filed for Chapter 7 bankruptcy protection. Thereafter, the project owner filed an adversary proceeding against the president/shareholder in the bankruptcy court, seeking a declaration that the underlying debt was non-dischargeable based on fraud. Particularly interesting was the project owner's argument that the president/shareholder falsely certified in the monthly payment applications that the general contractor was paying its subcontractors and suppliers on the project. The bankruptcy court found from the "totality of the evidence" that the certifications at the bottom of each monthly payment application constituted false representations that monies received from the project owner were used to pay subcontractors and suppliers connected with the project. As such, the bankruptcy court determined that the underlying debt of the president/shareholder was non-dischargeable under 11 U.S.C. § 523(a)(2)(A), which disallows the discharge of a bankruptcy debt obtained by fraud. The decision of the bankruptcy court was appealed.

On appeal, court held that 11 U.S.C. § 523(a)(2)(A) requires a showing of fraud as an underlying basis for non-dischargeability. To succeed on the fraud claim, the project owner had to prove that one or more false representations had been made, the president/shareholder had to know that the representation was false, the president/shareholder had to intend to deceive, the project owner had to justifiably rely on the representation, and the fraud had to be the proximate cause of damages.

The payment application certifications became a central focus of the trial and appeal because the president/shareholder expressly indicated the project funds would be used to pay the project's subcontractors and suppliers. The court noted that the president/shareholder knew these representations were false and intended to deceive the project owner to obtain payments. The court further agreed that the owner had relied on the representations and incurred damages when it was discovered that the general contractor had not paid subcontractors and suppliers. As such, the court held that the project owner satisfied all of the elements of fraud and the debt was deemed non-dischargeable with respect to the president/shareholder's personal bankruptcy.

This appellate decision provides guidance when chasing companies or individuals into a bankruptcy court based on improperly allocated contract funds. In such a situation, fraud is a basis for non-dischargeability. To satisfy the justifiable reliance element to prove fraud, a

plaintiff must show that it actually relied on the debtor's misrepresentations and was justified in doing so because of "the circumstances of the particular case." Further, a plaintiff "is justified in relying on a representation although he might have ascertained the falsity of the representation had he made an investigation." In *SG Homes*, the Fourth Circuit held that the bankruptcy court was entitled to find, and did find, that the project owner justifiably relied on the president/shareholder's false certifications in the monthly payment applications that the general contractor was paying its subcontractors and suppliers. Otherwise, the project owner would not have continued to pay the general contractor had it known the general contractor was making false certifications, and instead the owner would have paid the subcontractors directly. As a result, the finding of fraud on the basis of justifiable reliance was allowed.

It bears noting that, in *SG Homes*, the pursuit of bankruptcy non-dischargeability against the general contractor's president/shareholder came "from above", i.e., via the project owner. This is not to say that unpaid subcontractors and suppliers cannot likewise pursue non-dischargeability claims "from below" based on fraud. The benefit of *SG Homes* is the guidance offered by the appellate court to define the elements of proof, specifically: (1) a false representation, (2) knowledge that the representation was false, (3) intent to deceive, (4) justifiable reliance on the representation, and (5) proximate cause of damages. The facts of each specific case will dictate whether the pursuit will ultimately be successful.

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No Extra-Territorial Application of PA Human Relations Act

The United States District Court for the Eastern District of Pennsylvania recently held in *Blackman v. Lincoln National,* 2012 WL 6151732 (E.D. Pa. December 10, 2012), that the Pennsylvania Human Relations Act ("PHRA") does not cover employees who neither reside nor work in Pennsylvania. While that conclusion may seem obvious and logical, the decision may have a broader impact on employers, such as Pennsylvania-based construction companies and developers whose workforce may include non-Pennsylvania residents.

Plaintiff, Kathy Blackman, was an Illinois resident working in the Illinois office of Lincoln National Corporation and Lincoln Financial Group, companies headquartered in Pennsylvania. She alleged sex and age discrimination following a demotion, lodging a complaint with the Equal Employment Opportunity Commission. When she was subsequently fired and had exhausted her administrative remedies, she filed a discrimination and retaliation lawsuit under Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act (ADEA), and the PHRA against her former employers in the Eastern District of Pennsylvania.

Because the pertinent section of the PHRA was silent as to whether it applied to non-residents employed outside the Commonwealth, the court examined other sections for the legislature's intent. The court premised its decision on the statutory language that the act's intent was to

protect the "inhabitants" and "the people of the commonwealth." The court opined that to overcome the presumption that a state statute applies only within the state, there must be explicit statutory language providing for application beyond the state's borders.

The court rejected the plaintiff's argument that the PHRA should apply to her because her employer, Lincoln National, was headquartered in Pennsylvania. Rather, it is the place of employment, not the location of the corporate headquarters, that dictates the application of state anti-discrimination laws. Further, the court ruled that the plaintiff's attendance at quarterly meetings in the state and daily interactions with people in Pennsylvania were not enough to justify extending the PHRA to residents who work outside of Pennsylvania.

The decision, however, leaves an unresolved issue – whether the PHRA protects those who live outside Pennsylvania, but who work in Pennsylvania. How does the act treat a West Virginia resident who commutes across the border to his job in downtown Pittsburgh, or the New Jersey resident who works in Philadelphia? Do these commuters have a cause of action under the PHRA if they do not live in Pennsylvania?

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Has The West Virginia Supreme Court of Appeals Determined That Defective Workmanship Causing Bodily Injury or Property Damage Is An "Occurrence" Under A CGL Insurance Policy?

On June 18, 2013, the West Virginia Supreme Court of Appeals issued a decision in the case of *Cherrington v. The Pinnacle Group, Inc.,* 231 W.Va. 470, 745 S.E.2d 508 (2013), that purports to extend coverage under a commercial general liability (CGL) policy of insurance for defective workmanship that causes bodily injury or property damage. In this case, Ms. Cherrington entered into a "cost plus" contract with Pinnacle for the construction of a home, landscaping and interior furnishing. After the home was completed, Ms. Cherrington observed defects in the home including uneven concrete floor on the ground level, water infiltration through the roof and chimney joint, a sagging support beam, and numerous cracks in the drywall. Ms. Cherrington filed suit alleging that Pinnacle was negligent in the construction of the home and breached its fiduciary duty.

Pinnacle had a CGL policy issued by Erie Insurance Property & Casualty Company and it requested coverage and defense under the policy. Erie denied coverage and a duty to defend. Pinnacle filed a declaratory judgment action against Erie. Erie filed a motion for summary judgment and prevailed, as the circuit court ruled that Ms. Cherrington failed to establish covered property damage. Rather her damages alleged were for diminution in the value of her home and for excess charges she was required to pay. The circuit court also determined that Ms. Cherrington had not established that an "occurrence" had caused the damages she allegedly sustained because faulty workmanship, absent a separate event, was not sufficient to give rise to an "occurrence." Further, the circuit court held that even if there were coverage

for the claims, the coverage would be barred by the policy's exclusions. Specifically, exclusion M ("Damage to Impaired Property or Property Not Physically Injured") precluded coverage because it applied irrespective of the existence of subcontractors. Erie also successfully argued that exclusion L ("Damage to your Work") and N ("Recall of Products, Work or Impaired Property") applied to preclude coverage.

The West Virginia Supreme Court of Appeals noted that, in a trilogy of seminal cases on the issue, it previously concluded that a claim for faulty workmanship is not covered by such a policy. The court then noted that since it addressed the issue in 2001, a majority of states have reached the opposite conclusion either by court decisions or by legislation.

The subject policy defined "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." The West Virginia Supreme Court of Appeals noted that the Erie policy did not define the term "accident." In a previous decision, it determined that in order to be an accident, the damages or injuries must not have been "deliberate, intentional, expected, desired, or foreseen." In the subject case, the damages incurred by Ms. Cherrington during the construction of her home were not within the contemplation of Pinnacle when it hired the subcontractors alleged to have performed most of the defective work. Therefore, the alleged damages were not "deliberate, intentional, expected, desired, or foreseen" by Pinnacle and were considered to be the result of an accident.

The court also noted that Exclusion L in the policy specifically provided coverage for work performed by subcontractors as it was excepted from the "your work" exclusion by the following policy language: "this exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor." Because the court previously held that an insurance policy should never be interpreted so as to create an absurd result, it concluded that defective work performed by a subcontractor on behalf of an insured does give rise to an "occurrence" under this CGL policy. Specifically, the subject policy expressly provided coverage for "damaged work performed by a subcontractor."

Notably, the court then specifically overruled prior decisions that were inconsistent with this opinion.

Other exclusions in the policy were also addressed by the West Virginia Supreme Court. Exclusion M, "Damage to Impaired Property or Property Not Physically Injured," appeared to preclude coverage for: (1) a shortcoming in "your product" or "your work"; and (2) an issue arising from the insured's or the insured's agent's failure to perform his/her contractual obligations. Most of the work in this case was done by subcontractors and on its face, Exclusion M seemed to preclude coverage. However, because the parties did not contend that the damage resulted from a breach of contract, Exclusion M did not apply to bar coverage. Exclusion N, "Recall of Products, Work or Impaired Property" (a/k/a "sistership" exclusion), is typically used for losses from a product that has been recalled or withdrawn from the market. There were no allegations of recalled products and, therefore, the West Virginia Supreme Court determined that this exclusion did not apply to bar coverage in this case.

This case is being discussed by some as a case that extends coverage under a CGL policy to defective workmanship. However, this case covers a very specific set of circumstances involving defective work by subcontractors under a CGL policy of the general contractor.

Further, the policy contained some unique language, particularly the verbiage of Exclusion L. Thus, the court did not go so far as to extend coverage for defective workmanship in all circumstances. This case clearly enlarges the coverage potentially available to contractors in a defective workmanship claim, but still leaves unanswered questions when subcontractors are not involved with the alleged defective work and when the term "accident" is defined in the policy as something that is not "deliberate, intentional, expected, desired, or foreseen."

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The Construction Legal Edge is a quarterly publication
of the Construction Practice Consortium.

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