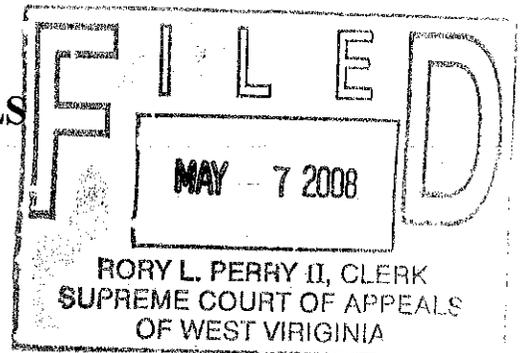


IN THE
SUPREME COURT OF APPEALS
OF THE
STATE OF WEST VIRGINIA



CAMDEN-CLARK MEMORIAL
HOSPITAL CORPORATION,

Plaintiff,

v.

Supreme Court Docket No. 080493

ST. PAUL FIRE AND MARINE
INSURANCE CO.,

Defendant.

CAMDEN-CLARK MEMORIAL HOSPITAL CORPORATION'S
BRIEF ON CERTIFIED QUESTIONS POSED BY
THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT WEST VIRGINIA
Civil Action No.: 6:06-CV-01013
Honorable Joseph Robert Goodwin, Presiding

Dino S. Colombo, Esq. (WVSB #5066)
Travis T. Mohler, Esq. (WVSB #10579)
Colombo & Stuhr, PLLC
1054 Maple Drive
Morgantown, West Virginia 26505

-and-

Donna S. Quesenberry, Esq. (WVSB # 4653)
MacCorkle, Lavender & Sweeney, PLLC
300 Summers Street, Suite 800
Charleston, West Virginia 25301

*Counsel for Camden-Clark Memorial
Hospital Corporation*

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Howard, Davis J., *Apportioning An Insurer's Liability Between Covered And
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I. NATURE OF PROCEEDINGS BELOW

~~This is a declaratory judgment action filed by Camden-Clark Memorial Hospital Corporation in the United States District Court for the Southern District of West Virginia after its insurer, St. Paul Fire and Marine Insurance Company, denied coverage in its entirety for a verdict rendered against Camden-Clark in an underlying medical malpractice action tried before a jury in the Circuit Court of Wood County, West Virginia. After considering Camden-Clark's motion for partial summary judgment, the district court certified questions to this Court as to which party, the insurer or the insured, bears the burden of proof when a verdict against an insured does not specify (1) whether covered or non-covered conduct gave rise to the insured's liability, and (2) whether the punitive damages awarded were based on a covered or non-covered claim.~~

II. STATEMENT OF FACTS

Camden-Clark Memorial Hospital Corporation ("Camden-Clark") was a named defendant in a complaint filed in the Circuit Court of Wood County, West Virginia styled *Bernard Boggs, as administrator of the Estate of Hilda Boggs, deceased, as personal representative of the statutory beneficiaries of the wrongful death claim herein asserted in his own right v. Camden-Clark Memorial Hospital Corp., United Anesthesia, Inc. and Manish I. Koyawala, M.D.*, Civil Action No. 03-C-296 ("underlying action").¹ That lawsuit alleged that while Hilda Boggs was admitted to Camden-Clark for an open reduction and internal fixation

¹ There actually were three cases filed as a result of the death of Hilda Boggs: Civil Action No. 02-C-202 (Boggs I) was dismissed for failure to achieve proper service of process; Civil Action No. 03-C-296 (*Boggs II*) and Civil Action No. 03-C-623 (*Boggs III*). *Boggs II* and *Boggs III* are substantively equivalent, the only difference being that *Boggs II* was filed under the original version of the West Virginia Medical Professional Liability Act ("MPLA"), W.Va. Code §55-7B-1, et seq, that was in effect prior to July 1, 2003, and *Boggs III* was governed by the amended version of the MPLA effective June 30, 2003.

surgery on her ankle, the defendants, Camden-Clark, United Anesthesia, CRNA Evelyn Melvin and Manish Koyawala, M.D., breached the applicable standard of care, resulting in her death. In addition to the above claim, plaintiff's allegations against Camden-Clark included negligent hiring, retention and privileging of co-defendant Manish I. Koyawala, M.D., spoliation of evidence, and that Camden-Clark was vicariously liable for all the actions of Dr. Koyawala and CRNA Evelyn Melvin. The plaintiff in the underlying action also alleged that the "acts and omissions of the Defendants . . . were so willful, wanton, intentional and outrageous that the Plaintiff is entitled to recover punitive damages."

At all relevant times herein, Camden-Clark was insured by St. Paul under a primary Health Care Medical Professional Commercial General Liability Protection policy of insurance. In fact, Camden-Clark purchased two insurance policies from St. Paul. In addition to the above-referenced primary policy, Camden-Clark had also purchased an umbrella policy that covered any liability not covered by the primary policy. Camden-Clark was insured with St. Paul from July 1, 1993 to July 1, 2002, when St. Paul decided to abandon the healthcare providers in West Virginia and ceased writing medical malpractice liability insurance. During these years, Camden-Clark paid more than \$1.7 million for the primary healthcare coverage alone (excluding surcharges). Moreover, prior to the instant claim, Camden-Clark had only submitted minor claims to St. Paul, none of which resulted in St. Paul providing indemnity.

Pursuant to the St. Paul policy, Camden-Clark tendered all three complaints filed in the underlying Boggs litigation to St. Paul with a request for coverage/indemnity. The initial claim was reported to St. Paul in October of 2001, shortly after Ms. Boggs' death. The Summons and Complaint from the initial suit were presented to St. Paul, with the request for coverage, in March 2002. Thereafter, the second and third suits were tendered to St. Paul for coverage.

As early as June 2002, St. Paul was put on notice, by Camden-Clark's outside litigation counsel, Richard A. Hayhurst, that the claim/suit could exceed Camden-Clark's self-insured retention and impact coverage under the St. Paul policy. It was not until December 27, 2005 – three months before trial – that Samuel R. McEwen, the Director of Major Case Liability at St. Paul, wrote a reservation of rights letter to Sherry Johnston, the Director of Risk Management at Camden-Clark. In that letter, Mr. McEwen set out St. Paul's coverage position and acknowledged that St. Paul would “continue to monitor this matter subject to the reservation of rights set forth below.”

St. Paul, through Mr. McEwen, correctly summarized that the underlying complaint “alleged causes of action for negligent medical care and spoliation of evidence” and that “the plaintiff seeks both compensatory and punitive damages.” Ultimately, however, St. Paul only reserved its right to deny indemnification “for any damages awarded to Plaintiffs based upon spoliation of Evidence” and “for any punitive damages which are awarded to the Plaintiff because of intentional acts by the named insured and/or which arise from non-covered damages such as spoliation of evidence.”² St. Paul did not identify which allegations it considered “intentional acts,” nor did it identify any allegations, other than Spoliation of Evidence, it considered to fall outside of coverage for professional services, bodily injury, property damage, personal injury or advertising injury. Finally, the letter summarily advised Camden-Clark without any further detail that St. Paul reserved its “rights to limit or deny coverage on the basis of any other grounds.”

St. Paul monitored the case throughout the course of litigation through extensive written and oral communications with the legal department of Camden-Clark and its outside retained

² The St. Paul policies issued to Camden-Clark do not contain an exclusion for punitive damages.

legal counsel. Interestingly, co-defendants Dr. Koyawala and United Anesthesia, Inc. (hereinafter, "UAI") were also insured by St. Paul. Before the underlying case went to trial, St. Paul settled on the behalf of Dr. Koyawala and UAI for a total of two million dollars (\$2,000,000). For some unknown reason, St. Paul made itself an actual party to the release. This release included a provision that prohibited Dr. Koyawala and UAI from sharing expert witness testimony with St. Paul insured Camden-Clark. Therefore, St. Paul was a party to a release that could potentially prejudice its own insured. In effect, St. Paul entered into a release that protected St. Paul; yet, left its insured, Camden-Clark, exposed.

Although the St. Paul policy did not impose a duty to defend on St. Paul, it did give St. Paul a right to associate in the defense of any claim or suit and even to force Camden-Clark to settle within its self-insured retention. Interestingly though, at no time did St. Paul suggest, recommend or demand that Camden-Clark settle the underlying case. Prior to trial, St. Paul had already interpreted coverage under the Camden-Clark policy and determined that some claims would be covered and some would not. Knowing this, it did nothing to protect its insured, nor did it do anything to assure that the verdict delineate covered versus non-covered damages. Consequently, the underlying case went to trial with Camden-Clark as the only viable defendant.

Prior to trial, Mr. Boggs abandoned his claim for spoliation of evidence – the only specific cause of action upon which St. Paul based its December 27, 2005 reservation of rights. Accordingly, Camden-Clark proceeded and continued through the lengthy trial of the underlying case under the auspices of St. Paul and the assured belief that coverage existed for all damages except punitive damages that arose from so-called "intentional acts." Throughout the trial, Camden-Clark's outside retained counsel, Richard Hayhurst, sent lengthy and detailed trial

reports via e-mail to Laura Toregas, St. Paul's new Director of Major Case Liability.³ To that end, St. Paul was made exceedingly aware of the testimony at trial; yet, St. Paul still never suggested or demanded a settlement and never submitted an additional reservation of rights. More importantly, St. Paul never even hinted to Camden-Clark that special interrogatories should be submitted to the jury to separate covered from non-covered damages.

On March 10, 2006, at the conclusion of the two week trial, the jury returned a verdict awarding total damages in the amount of six million five hundred forty-five thousand dollars (\$6,545, 000.00). The jury found that Camden-Clark and Dr. Koyawala or Evelyn Melvin were negligent toward Hilda Boggs and such negligence was a proximate cause of Hilda Boggs' death and awarded the statutory beneficiaries of Hilda Boggs' estate an aggregate, pre-interest sum of one million five hundred seventy thousand dollars (\$1,570,000.00).⁴ The jury also found that Dr. Koyawala, Evelyn Melvin and/or UAI were apparent agents of Camden-Clark.

In addition, the jury found that the negligence of Dr. Koyawala or Evelyn Melvin was so excessive, reckless or aggravated that punitive damages should be awarded and did, indeed, award punitive damages for their negligent conduct in the amount of one million five hundred thousand dollars (\$1,500,000.00). Likewise, the jury also found that the conduct of Camden-Clark, separate and apart from any conduct of Dr. Koyawala or Evelyn Melvin, was so outrageous, wrongful or intentional that punitive damages should be awarded and again levied punitive damages in the amount of three million dollars (\$3,000,000.00). Also, the jury found that 1) Camden-Clark fraudulently concealed information about Hilda Boggs' death from Ray

³ Ms. Toregas assumed Mr. McEwen's responsibilities of overseeing the underlying case at some point before trial. The exact date that Mr. McEwen's duties shifted to Ms. Toregas is not clear because Camden-Clark was not notified of the change at the time it occurred.

⁴ As mentioned above, Dr. Koyawala had already been dismissed from the case in exchange for a two million dollar check written by St. Paul, but was left off the verdict form.

Boggs and awarded Mr. Boggs one-hundred thousand dollars (\$100,000) for that count, and 2) Camden-Clark's conduct toward Ray Boggs was so outrageous that a reasonable person could not have been expected to endure it and awarded Mr. Boggs a total of three hundred and seventy-five thousand dollars (\$375,000) for that count.⁵

On April 28, 2006, the Circuit Court signed a Journal Order and Judgment Entry explaining how the Court would apply the two million dollar (\$2,000,000.00) set-off from the settlement between the Boggs Estate and Dr. Koyawala and Evelyn Melvin against the damages awarded by the jury. Specifically, the Order held that the total damages were equal to four million eight hundred thirty four thousand three hundred eighty dollars (\$4,834,380.00), which represented the total verdict, PLUS pre-judgment interest of two hundred eighty nine thousand three hundred eighty dollars (\$289,380.00) accrued on Mrs. Boggs' lost wages from the negligence counts, LESS the two million dollar (\$2,000,000.00) credit from the settlement proceeds that St. Paul paid on behalf of Dr. Koyawala and UAI. According to the Order, the \$2,000,000.00 set-off was first applied to negate the \$1,500,000.00 punitive damages award against Dr. Koyawala and Evelyn Melvin. The remaining \$500,000.00 of the set-off was applied to reduce the compensatory damages awarded against the statutory beneficiaries of Hilda Boggs' estate for the negligence of Camden-Clark and Dr. Koyawala – reducing that portion of the judgment to \$1,359,380.00.

⁵ This count refers to what is known as the "Tort of Outrage" in West Virginia. In syllabus point six of Harless v. First National Bank in Fairmont, 169 W.Va. 673, 289 S.E.2d 692 (1982), this Court held that "[o]ne who by extreme and outrageous conduct intentionally or recklessly causes severe emotional distress to another is subject to liability for such emotional distress . . ." (emphasis added) Therefore, the Tort of Outrage can be predicated upon either negligent or intentional conduct. The verdict form in the underlying case did not allow the jury to divulge whether Camden-Clark's conduct relative to the tort of outrage claim was based upon negligent or intentional conduct.

Following the return of the verdict, Camden-Clark once again tendered its request for coverage/indemnity to St. Paul. St. Paul responded to Camden-Clark's request for coverage by hiring attorney Michael Farrell to relay St. Paul's dubious coverage position via an "interim coverage analysis." Mr. Farrell sent his conclusions to Camden-Clark's counsel via a letter dated July 18, 2006 – over four months after the jury's verdict. In that letter, Mr. Farrell opined that the jury verdict included covered and non-covered elements. It was Mr. Farrell's opinion that "the death of Mrs. Boggs does qualify as a medical professional injury" as defined by the insurance policy and thus, coverage existed for those damages.

On the other hand, Mr. Farrell opined that "the Fraudulent Concealment verdict does not constitute a medical professional injury, personal injury or property damage," and accordingly, St. Paul did not have a duty to indemnify Camden-Clark regarding that action. Contrary to St. Paul's reservation of rights, Mr. Farrell concluded that the verdict for the "Tort of Outrage" cause of action was not covered by the insurance policy for the same reason – it did not fall within the scope of coverage. Finally, in continuing with St. Paul's implausible speculation on coverage, Mr. Farrell concluded that based on the "Jury Instructions, Jury Verdict, Journal Order and Judgment Entry and related memoranda submitted by the parties," the \$3,000,000.00 punitive damages award "was based on conduct by the Hospital that consisted of destroying records, misleading [Hilda Boggs'] family, and covering up Mrs. Boggs' death" St. Paul put forth this specious conclusion without any factual basis and knowing that the Spoliation of Evidence allegations – i.e. destruction of records – were dropped before trial and never prosecuted.⁶

⁶ St. Paul's coverage position also ignores the fact that the jury's award on the fraudulent concealment count was only \$100,000. Accordingly, if the jury based its \$3 million punitive damages award exclusively on the ground of fraudulent concealment, as St. Paul claims, an award of such ratios would be grossly unconstitutional.

In response to the Farrell letter, coverage counsel for Camden-Clark, Anita Casey, sent a letter to Laura Toregas. In that letter, Ms. Casey aptly asserts that even absent coverage for fraudulent concealment and the tort of outrage, St. Paul's obligation under the policy at issue is still \$2,559,380.00 plus defense costs. Naturally, Ms. Casey agreed with St. Paul's conclusion that the insurance policy provides coverage for the damages awarded for wrongful death in the amount of \$1,359,380.00.⁷ More importantly, Ms. Casey also succinctly explains why the St. Paul policy covers the \$3 million punitive damages award assessed against Camden-Clark. She states as follows:

Also covered under the policy is the award for punitive damages assessed to Camden-Clark in the amount of \$3,000,000.00, as there is no exclusion in the policy for the payment of such damages. "Where the liability policy of an insurance company provides that it will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury and the policy only excludes damages caused intentionally by or at the direction of the insured, such policy will be deemed to cover punitive damages arising from bodily injury occasioned by gross, reckless or wanton negligence on the part of the insured." Syl. Pt. 2, *Hensley v. Erie Ins. Co.*, 168 W. Va. 172, 283 S.E.2d 227 (1981).

In her letter, Ms. Casey requested that St. Paul advise Camden-Clark of its final position on coverage no later than November 10, 2006. No response was forthcoming and, as a result, on December 1, 2006 Camden-Clark filed this declaratory judgment action in the United States District Court for the Southern District of West Virginia. After the declaratory judgment action was filed, and in response to, yet, another demand for coverage, St. Paul put forward one last, and increasingly speculative, position on coverage.

⁷ This number was calculated by Ms. Casey in accordance with the judgment order as follows: \$1,570,000.00 (compensatory damages awarded on verdict form for wrongful death) + \$289,330.00 (pre-judgment interest on the award for Mrs. Boggs' loss of income as calculated in the Judgment Order) – \$500,000 (the remaining amount of the set-off after extinguishing the \$1.5 million punitive damage award attributable to Dr. Koyawala and Nurse Melvin.)

In this letter, Perry W. Oxley, counsel for St. Paul, agrees that the death of Mrs. Boggs is a covered injury and that Dr. Koyawala and Nurse Melvin are protected persons under the policy. Expectedly, St. Paul, through Mr. Oxley, steadfastly maintains with little or no factual reasoning that both the Fraudulent Concealment and Tort of Outrage causes of action are based on intentional conduct and not negligent, reckless or wanton conduct. More importantly, with regard to punitive damages Mr. Oxley points out the issue that gives rise to the current exercise before this Court – “The first part of the punitive damages analysis is whether the punitive damages awarded against Camden-Clark for ‘outrageous, wrongful or intentional’ conduct was for negligent conduct or intentional conduct.”

Not surprisingly, St. Paul – continuing its course of putting forth mere conjecture in order to avoid providing its insured the coverage which it paid over a million dollars to obtain – concluded that the punitive damages awarded against Camden-Clark either “*clearly* . . . arose out of fraudulent concealment and the tort of outrage” or is “*clearly* the result of expected or intended acts, which also excludes coverage” One may balk at the use of the word “clearly” when referring to possible alternatives for the same result; however, such misplaced conviction is not surprising in light of St. Paul’s incongruous positions maintained thus far. St. Paul goes on to say, through Mr. Oxley, that “there is no coverage for the \$1,500,000 punitive damages award against Dr. Koyawala and CRNA Melvin because that award was based on actions that were not medical professional services and which were expected or intended acts” This position ignores, of course, the fact that Dr. Koyawala and CRNA Melvin were found liable exclusively for the negligent practice of medicine – a covered act under the St. Paul policy.

In view of Mr. Oxley’s letter, it appears that St. Paul’s post-verdict coverage position is that it is “off the hook” for any damages assessed to Camden-Clark because the verdict form did

not elucidate the jury's reasoning for awarding certain damages. Had St. Paul bothered to participate in the underlying action, it could have presented the jury with special interrogatories which would have allowed it to make findings of fact relative to the coverage issue at hand. Of course, St. Paul's reservation of rights never mentioned the necessity of special interrogatories to allocate the verdict between covered and non-covered damages, nor was such a request ever made to Camden-Clark or its retained counsel.

St. Paul took absolutely no action during the litigation or trial of the underlying case to protect or pursue its denial of coverage for punitive damages based upon the intentional acts exclusion in its policy. That is, until after an unfavorable verdict was rendered when St. Paul filed a self-serving motion to intervene because it felt that the two million dollar set-off was applied in a manner that was in favor of coverage for the verdict. Ultimately, St. Paul was continuously and painstakingly updated during the litigation and trial of this matter; yet, chose to remain silent throughout – a silence which it now relies upon for its own benefit.

Undeniably, the verdict form in the underlying case did not indicate the jury's reasoning for awarding the damages assessed to Camden-Clark. Accordingly, the district court has certified questions to this Court as to the parties' burden of proof regarding an ambiguous verdict.

III. CERTIFIED QUESTIONS

1. Under West Virginia law, when an insured is found liable for a tort, and the complaint indicates that the tort could be based on conduct that the insurance policy covers, on conduct that the insurance policy does not cover, or both, and when the jury verdict does not specify which conduct gave rise to the insured's liability, does the insured bear the burden of

proving that the liability was based on covered conduct, or does the insurer bear the burden of proving that the liability was based on non-covered conduct?

2. Under West Virginia law, when a jury awards punitive damages against an insured, and the punitive damages could be based on a claim covered by the insurance policy, on a claim not covered by the insurance policy, or both, does the insured bear the burden of proving that the punitive damages were based on a covered claim, or does the insurer bear the burden of proving that the punitive damages were based on a non-covered claim?

IV. DISCUSSION OF LAW

A. Standard of Review

As this Court most recently opined in *Osborne v. United States*, 211 W.Va. 667, 670, 567 S.E.2d 677 (2002), “[w]hen this Court is called upon to resolve a certified question, we employ a plenary review.” “A de novo standard is applied by this [C]ourt in addressing the legal issues presented by a certified question from a federal district or appellate court.” *Id.* citing Syl. Pt. 1, *Light v. Allstate Ins. Co.*, 203 W.Va. 27, 506 S.E.2d 64 (1998). Moreover, it is undisputed that the questions posed by the United States District Court for the Southern District of West Virginia are exclusively questions of law. Accordingly, this Court should undertake its review and determination of the certified question posed by the district court by applying a *de novo* standard of review. *See Id.*, *Feliciano v. 7-Eleven, Inc.*, 210 W.Va. 740, 744, 559 S.E.2d 713, 717 (2001) (holding that certified questions of law are to be considered using a *de novo* standard of review).

B. Discussion of law regarding burden of proof when a jury verdict does not specify whether covered or non-covered conduct gave rise to the insured’s liability.

When asked to determine basic coverage disputes under an insurance policy, this Court frequently recites the principle that the insured bears the burden to establish a prima facie case of

coverage⁸, and that an insurer seeking to avoid liability through an exclusion has the burden of proving facts necessary to the operation of that exclusion.⁹ For the majority of insurance coverage disputes, these black letter principles require little or no detailed analysis. However, in certain instances where the basis for a jury's award of damages is unknown and the judgment intermingles between covered and non-covered claims, the traditional burden of proof rule often offends equity.

Not surprisingly, the esoteric questions certified by the district court in this matter have not been addressed often in other jurisdictions. In those jurisdictions and treatises where authority on very similar issues could be found, it is apparent that the weight of authority provides that the burden of proof should shift to the insurer when a jury's verdict represents both covered and non-covered items, and there is a dispute as to how to allocate the judgment between the two. As a preliminary matter, it should be noted that the task of determining whether the grounds for a judgment are outside the coverage of the policy can, in most instances, be simplified or eliminated through the use of jury interrogatories or a special verdict form. See 1 Allan D. Windt, *Insurance Claims & Disputes* § 6:26, n.1 (5th ed. 2007).

The only treatise that seems to take on this particular issue states that although the burden to prove that a judgment is covered by a policy is usually on the insured, an exception should exist "in those cases in which the circumstances surrounding the defense of the underlying action were such that the insurer was obligated to seek an allocated verdict or advise the insured of the need for one, but failed to fulfill that obligation." 1 Allan D. Windt, *Insurance Claims &*

⁸ See i.e., *Payne v. Weston*, 466 S.E.2d 161, 165 (W.Va. 1995); *Jarvis v. Penn. Cas. Co.*, 40 S.E.2d 308, 312 (W.Va. 1946) (noting that before any burden is placed upon an insurer, the insured must make out "a prima facie case of loss within the coverage provided by the policy").

⁹ See i.e., *Nat'l Mut. Ins. Co. v. McMahon & Sons, Inc.*, 356 S.E.2d 346, 495, n.5 (W.Va. 1987); *Jenkins v. State Farm Mut. Auto. Ins. Co.*, 632 S.E.2d 346, 350 (W.Va. 2006) ("[W]here the policy language involved is exclusionary, it will be strictly construed against the insurer in order that the purpose of providing indemnity not be defeated.").

Disputes § 6:27 (5th ed. 2007).¹⁰ In other words, “the insured’s burden may be reduced or shifted if the [insurance] carrier failed to adequately apprise the insured of the importance of apportionment. *Premier Parks, Inc. v. TIG Ins. Co.*, No. 02C-04-126-PLA, 2006 WL 2709235 (Del. Super. Sept. 21, 2006) (unreported), citing Howard, Davis J., *Apportioning An Insurer’s Liability Between Covered And Noncovered Parties and Claims*, 369 PLI/Lit 597 (1989).

Various jurisdictions have held, almost uniformly, that the insurer should have the burden of proving the allocation between covered and non-covered damages in circumstances where 1) the insurer breaches its duty to defend and/or, 2) the insurer defends under a reservation of rights but fails to inform the insured of the necessity of an allocated verdict for coverage purposes. For instance, in *Duke v. Hoch*, 468 F.2d 973, 979-80 (5th Cir. 1972) the Fifth Circuit shifted the burden to the insurer because it failed to advise its insured that an allocated verdict would be required to avoid the loss of coverage.

In *Duke*, the Plaintiff, Duke, sued his accounting firm for negligence and intentional misconduct. *See Id.* at 975. The insurer had issued the accounting firm an “accountants’ professional liability policy” that insured the firm for negligent performance of professional services but not intentional misconduct. *See Id.* At the conclusion of the trial of the underlying matter, the judge allowed the jury to consider liability for the negligence claims only, but also

¹⁰ *see, e.g., Magnum Foods, Inc. v. Continental Cas. Co.*, 36 F.3d 1491, 1498-99, 9 I.E.R. Cas. (BNA) 1601 (10th Cir. 1994) (when an insurer controls the defense, the burden of proof in allocating a judgment between covered and non-covered damages is on the insurer because the insurer could “request a special verdict on special interrogatories,” and the insurer being “in the best position to see to it that damages are allocated . . . should be given an incentive to do so”); *American Home Assur. Co. v. Evans*, 589 F. Supp. 1276, 1288-89 (E.D. Mich. 1984), order vacated on other grounds, 791 F.2d 61 (6th Cir. 1986) (holding that the insurer’s duty of good faith owed to its insured makes it “appropriate to shift the burden of proof . . . based upon the failure to provide independent counsel and the failure to adequately warn the insured of the various aspects of the divergent interests involved”) and *see generally Herrera v. C.A. Seguros Catatumbo*, 844 So. 2d 664, 668 (Fla. Dist. Ct. App. 3d Dist. 2003) (The insurer, “aware of the terms of its own policy, made no effort to have the final disposition result in a verdict that would provide a basis for consideration of the exclusionary clause. The [insureds] are, therefore, entitled to recover the unsegregated damage awards on all claims”).

instructed it to determine damages for the intentional misconduct claim which the judge had already directed a verdict. *See Id.* The jury returned a general verdict in favor of the plaintiff and awarded monetary damages in a lump sum – including compensation for the covered negligence claim and the non-covered intentional claim. *See Id.* After Duke obtained the judgment against his accounting firm, he brought a garnishment action against the firm’s insurer to obtain the proceeds of the liability policy. *See Id.* at 974.

The district court below, applying general principles of Florida law, held that the burden of proving the proper allocation of the verdict between covered and non-covered items was on the insured. *See Id.* at 977. Because there was no evidence or proof of any kind as to how the jury’s verdict should be divided, the decision to place the burden on the insured necessarily led to a finding of no coverage. *See Id.* at 977-78. The Fifth Circuit Court of Appeals reversed, holding that because “the insurer failed to fully advise its insureds of the divergence of interest between it and them with respect to [allocation of] the verdict, the insureds must . . . be freed of the impossible burden of proof placed on them.” *See Id.* at 979-80.

In so holding, the court recognized that “[the insurer] has . . . an interest in the verdict’s not being allocated which is in conflict with the insured’s interest that covered damages be segregated.” *See Id.* at 980. Accordingly, the insurer by not recommending that the verdict be allocated had “protected its interest and secured for itself an escape from responsibility at the expense of the insureds, who remain personally liable for the full judgment, unprotected even to the extent they have paid for protection.” *Id.* at 979. The appeals court opined that the insurer’s “notification of defense under a reservation of rights was not a sufficient notification to the insureds that they should protect their interest by requesting an appropriate verdict.” *Id.* at 979. Therefore, *Duke* stands for the proposition that an insurer, even if it complies with its duty to

defend, is required “to make known to the insured the availability of a special verdict and the divergence of interest between them and the insurer” and if the insurer fails to do so, it bears the burden of proving the allocation of non-covered damages.¹¹ See also *Doe v. Ill. State Med. Inter-Ins. Exch.*, 599 N.E.2d 983, 989 (Ill. App. 1992) (reflecting the insurer’s obligation to allocate because it is the insurer that is aware of the issue.)

This is not St. Paul’s first rodeo on this issue. In *Gay & Taylor, Inc v. St. Paul Fire & Marine Ins. Co.*, 550 F.Supp. 710 (W.D. Okla. 1981), the Oklahoma District Court shifted the burden to St. Paul to allocate damages between covered and non-covered items in a non-allocated settlement.¹² The court diminished the insured’s burden on the ground that St. Paul concealed the importance of allocation. See *Id.* at 716-17. The court recognized the plaintiff’s argument that the burden of proof shifted to St. Paul because St. Paul “knew of the settlement negotiations, had a representative present, failed to inform Plaintiff of the necessity of apportioning damages, and failed to object to the settlement.” *Id.* at 716. The court reasoned that if the insurer had adequately and timely apprised its insured “that it was critical that any settlement . . . reflect an apportionment between covered and noncovered . . . claims[,] . . . the insured would have insisted upon apportionment as part of a settlement[,] . . . and thus avoided the insurmountable problems encountered in post hoc prorating.” See *Premier Parks*, 2006 WL

¹¹ The court in *Duke* also points out other policy concerns that support shifting the burden of proof upon an insurer that fails to advise its insured of the propriety of an allocated verdict and the perils of not doing so. For instance, the court notes that “[t]he consequence to the insureds of a nonallocated verdict is the catastrophic total loss of coverage [whereas,] [t]he risks to the insurer in requesting an allocated verdict are of no such magnitude, if of any consequence at all.” *Id.* Also, the court quoted from Section 4(b) of the Statement of Principles of the ABA and the Conference Committee on Adjusters: “If any diversity of interest shall appear between the policyholder and the company, the policyholder shall be fully advised of the situation”

¹² “Although the instant case deals with the failure to apportion a settlement paid rather than a failure to require apportionment of a general verdict, the Court conclude[ed] that the general principles set forth in the *Duke* case should be applied [in the case of an unallocated settlement.]” *Gay & Taylor*, 550 F. Supp. at 716.

2709235, at *11 (discussing *Gay & Taylor*) citing Howard, *supra*. In other words, the insured's detrimental reliance upon the insurer's silence warranted the shifting of the burden from the insured to the insurer." *See Id.*

A similar case, *Premier Parks, Inc. v. TIG Ins. Co.*, No. 02C-04-126-PLA, 2006 WL 2709235 (Del. Super. Ct., Sept. 21, 2006), applies the same principles recited in *Duke* and *Gay & Taylor* to an unallocated settlement. In the underlying case, Premier Parks, otherwise known as Six Flags, was sued in a class action lawsuit for allegedly employing racial profiling. *See Id.* at *1. In all, the complaint alleged twelve causes of action – some covered under the TIG insurance policy, some not. *See Id.* at *3. Six Flags immediately tendered defense to TIG, which in response, sent Six Flags reservation of rights letters reserving its right under the insurance contract to “obtain an allocation of damages between covered and uncovered claims in any future judgment, settlement, arbitration, mediation or similar disposition.” *See Id.* at *4. The court noted that Six Flags kept TIG informed and updated them early and often regarding the ongoing progress of the suit and of the need to settle. *See Id.* at *7-8. Despite Six Flags' efforts to engage its insurer in the defense and settlement of this matter, TIG remained indifferent and apathetic regarding the litigation. *See Id.* at *2, 8. Eventually, Six Flags reached a settlement with the plaintiffs; however, that settlement did not allocate the damages amongst the various alleged covered and non-covered causes of action. *See Id.* at *10.

TIG, in turn, filed a declaratory judgment action against Six Flags requesting that the court either allocate the settlement or, if that isn't possible, excuse TIG from indemnification even from the covered claims. *See Id.* at *1. The court rebuffed TIG's request holding that “TIG should bear the burden to allocate.” *See Id.* at *11. The court reasoned that “[i]f TIG had wanted an allocation of the settlement by claim, it should have timely informed Six Flags that

any settlement *must* reflect an apportionment between covered and non-covered claims.” *See Id.* at *11. Moreover, TIG “failed to adequately apprise Six Flags of the need for apportionment” and “[i]ts issuance of reservation of rights letters, without more, did not fulfill its duties owed to Six Flags.” *Id.* The court also aptly acknowledged that, like here, “[the insurer]’s indifference and apathetic attitude regarding the litigation against [the insured] are responsible for the inability of the Court to apportion the settlement amount” *Id.* at *2.

Analogous to the present case, in *TIG Ins. Co. v. Premier Parks, Inc.*, No. 02C-04-126-JRS, 2004 WL 728858 (Del. Super. Ct. Mar. 10, 2004) (unreported)¹³, visitors to Six Flags amusement park were involved in an altercation with park attendants which resulted in an action alleging assault, battery, false imprisonment, negligent supervision and “injury with ill will, intent to injure or malice.” *Id.* at *2. TIG assumed the defense of the park and reserved its rights to require an allocation between those claims covered under the policy insuring the park and those that were not. *Id.* At the conclusion of the evidence, TIG’s trial counsel proposed special interrogatories that were ultimately submitted to the jury to guide it through deliberations. Those interrogatories; however, only separated the claims by plaintiff and did not require the jury to allocate damages as between covered and non-covered claims. *Id.* Consequently, the jury awarded compensatory and punitive damages to each plaintiff in unallocated lump sums. *Id.*

Subsequently, TIG argued that the Court must either conclude that no coverage is available for any of the claims or, alternatively, must allocate the damages in a manner consistent with the evidence presented at trial. *Id.* at *3. Conversely, Six Flags argued that TIG’s coverage position comes to late – if TIG wanted an allocation of damages as between covered and non-

¹³ To avoid any confusion, there are two cases involving the same parties, but with different facts. One case deals with an unallocated settlement (*Premier Parks, Inc. v. TIG Ins. Co.* (2006)) and the other deals with an unallocated verdict (*TIG Ins. Co. v. Premier Parks, Inc.* (2004)).

covered claims, it should have directed the attorneys it engaged on behalf of its insured to draft appropriate jury interrogatories to accomplish this goal. *Id.* at *2. In response, the court noted that it cannot reasonably be expected to perform a post-verdict allocation of damages between covered and non-covered claims when the records provides little, if any, evidence of the jury's methodology in reaching its damages award. *Id.* at *1. In staying in line with the above-cited case law, the Court held that because the jury found in favor of the plaintiffs on both covered and non-covered claims, and given that the jury's awards could have been prompted by covered claims alone, the court held that the insurer, TIG, could not deny coverage for those damages.

Id.

- C. This Court Should hold that an insurer has a duty to, at least, inform its insured of the importance of an allocated verdict when a claim is tendered that encompasses both covered and non-covered claims and, if the insurer fails to so inform its insured, then the burden of proof shifts to the insurer.**

When an insured makes a claim that encompasses both covered and non-covered items, the insurance company has an obligation to inform its insured that an allocated verdict will be necessary to determine the scope of coverage. *See* Discussion in Sec. B, *supra*. If the insurer fails to so inform its insured, then the insurer should bear the burden of proving regarding which damages are not covered. *See Id.* An illustration of the appropriateness of this rule may be helpful.

Assume that, like here, an insured faces a lawsuit that alleges causes of action that include covered and non-covered claims under an insurance policy. The insured tenders the claim to its insurer pursuant to its policy and requests indemnity. The "duty to pay" carrier receives notice of the claim and monitors the underlying litigation through claims personnel or outside counsel under a reservation of rights allowing it to later deny coverage on certain grounds. Barring an early declaratory judgment action, such reservations become operative only

when the underlying action is over and a dispute as to coverage begins. If the insured bears the burden of proof regarding what portion of the jury's verdict is covered, it gives the insurer an incentive not to recommend special interrogatories.¹⁴ On the other hand, if the burden is on the insurer, it has an incentive to recommend or even demand that special interrogatories be submitted to the jury to determine what was in the juror's minds when damages were awarded.

Moreover, this rule comports with other areas of West Virginia law. In West Virginia, an insurance company owes its policyholders a duty of good faith and fair dealing.¹⁵ See *Honaker v. Mahon*, 210 W.Va. 53, 62, 552 S.E.2d 788, 797, n.8 (2001) citing *Shamblin v. Nationwide Mut. Ins. Co.*, 183 W.Va. 585, 396 S.E.2d 766 (1990). A "duty to pay" insurer who monitors a claim that includes both covered and non-covered components should not be permitted to sit in silence under a general reservation of rights and allow its insured to proffer a general verdict form, all the while cognizant that there will be no coverage without special interrogatories. In accordance with its duty of good faith and fair dealing, in circumstances like the instant facts, a "duty to pay" insurance carrier should be required to advise its insured of the importance of special interrogatories and of the fact that the insured will bear all losses without proffering such interrogatories. See *American Home Assur. Co. v. Evans*, 589 F. Supp. 1276, 1288 (E.D. Mich. 1984) (applying Florida law) (holding that failing to inform the insured of the conflict of interest

¹⁴ If special interrogatories are not submitted to the jury in these circumstances, any attempt to allocate "between covered and non-covered claims would be speculative and arbitrary." See *Liquor Liability Joint Underwriting Ass'n of Mass. v. Heritage Ins. Co.*, 644 N.E.2d 964, 419 Mass. 316 (Mass. 1995). In other words, without special interrogatories, the burden of proving which damages are covered and which damages are not is tantamount to the impossible task of reading the minds of the jurors. Accordingly, if the insured is charged with the impossible burden of proving which damages are covered, it will certainly lose without the assistance of special jury interrogatories. Therefore, a rule that puts the burden of proof on the insured in such circumstances creates a conflict of interest between the insurer and its insured.

¹⁵ Likewise, Section 4(b) of the Statement of Principles of the ABA and the Conference Committee on Adjusters states that "[i]f any diversity of interest shall appear between the policyholder and the [insurer], the policyholder shall be fully advised of the situation" See *Duke*, 468 F.2d 973.

and availability of special interrogatories is a breach of the duty of good faith and fair dealing and, thus putting the burden of proof on the insurer). If the insurer fails to inform its insured, then it will bear the burden of proof and ultimately, there will be coverage. On the other hand, if after being informed, the insured does nothing to protect its interest, it will bear the burden of proof on coverage and likely lose coverage all together.

Some courts have equated placing the burden of proof on the insurer to the defense of equitable estoppel. *See, i.e. Premier Parks v. TIG*, 2006 WL 2709235 at *12. Likewise, West Virginia recognizes the defense of equitable estoppel. *See, e.g. Folio v. City of Clarksburg*, 221 W.Va. 397, 655 S.E.2d 143 (2007). “Equitable estoppel precludes a party from asserting rights that might have existed where that party assumes a position or engages in conduct that causes another party to change its position to its detriment.” *Premier Parks v. TIG*, 2006 WL 2709235 at *12. In West Virginia, “to raise an equitable estoppel there must be conduct, acts, language or *silence* amounting to a representation or concealment of material fact.” *Folio*, 221 W.Va. at 148 (emphasis added). West Virginia’s recognition of the defense of equitable estoppel comports with a rule placing the burden of proof on the insurer. To be sure when an insurance company monitors litigation under a general reservation of rights and remains silent as to the importance of special interrogatories, that insurer should be estopped from denying coverage post-verdict because the judgment was unallocated.

Furthermore, placing the burden on the insurer and thereby encouraging the use of special interrogatories promotes judicial economy. First, it is the insurance companies’ business and trade to deal in insurance litigation. To that end, they are the ones that are aware of the benefits of allocation and are in the best position to recommend or demand that they be used to ameliorate the allocation problems in the underlying case. Thus, if this Court recognizes that the

insurance companies have the burden of proving allocation, the insurers will no doubt fervently demand that its insureds utilize special interrogatories in the underlying case, lest they be responsible for the entire judgment. Accordingly, expensive and time-consuming coverage litigation will be avoided because the allocation issue will be decided by the jury in the underlying case.

On the other hand, if the policyholders bear the burden of allocation, then it will be in the insurance companies' best interest not to recommend special interrogatories. As a result, the insurer is not likely to recommend allocation and the insured, not dealing with insurance matters regularly, is not likely to allocate the verdict on its own accord. Without submitting special interrogatories to the jury, the only other method of determining what was in the juror's minds is to file a declaratory judgment action asking the court to do what could have been done by the insurer in the underlying case. Thus, placing the burden of allocation on the insured not only creates a conflict of interest between the insurer and its insured, it also makes expensive and time-consuming coverage litigation more likely. Therefore, as a matter of law, public policy and judicial economy, the burden of proving allocation of a jury's verdict between covered and non-covered claims should be on the insurance companies.

D. Under West Virginia law, when an insurance policy does not have a punitive damages exclusion, it is equally appropriate to put the burden of proof on the insurer when a jury awards punitive damages against an insured, and the punitive damages could be based on a claim covered by the insurance policy and a claim not covered by the insurance policy.

This court has held that “[t]he public policy of this State does not preclude insurance coverage for punitive damage arising from gross, reckless or wanton negligence.” Syl. pt. 3, *Hensley v. Erie Ins. Co.*, 168 W.Va. 172, 283 S.E.2d 227 (1981). This Court has also “recognize[d] that an insurance company may decline to insure against punitive damages by an

express exclusion in its policy to that effect and to the extent that the insurance company exercises this option it is protected against payment of punitive damages.” *See Id.* at 183-84.

“However, if the insurer fails to expressly exclude punitive damages . . . , the policy will be deemed to cover such damages.” *See* Syl. pt. 5, *State ex rel. State Auto Ins. Co. v. Risovich*, 204 W.Va. 87, 511 S.E.2d 498 (1998) (referring to underinsured motorist insurance). Further, in *Hensley*, this Court held in syllabus point two that:

[w]here the liability policy of an insurance company provides that it will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury and the policy only excludes damages caused intentionally by or at the direction of the insured, such policy will be deemed to cover punitive damages arising from bodily injury occasioned by gross, reckless or wanton negligence on the part of the insured.

Hensley, 168 W.Va. at 172, Syl. Pt. 2:

Accordingly, if an insurance policy does not have a punitive damages exclusion, then the only avenue for denying coverage of a punitive damages claim is through an intentional acts exclusion. Therefore, under West Virginia law, when there is no punitive damages exclusion, the analysis for a punitive damages claim that may be covered and may not be covered should be the same as the allocation analysis for any other type of damages. Likewise, for all the reasons addressed above, the insurer should bear the burden of, at least, advising its insured that special interrogatories are necessary to determine whether punitive damages are being awarded for “gross, reckless or wanton negligence” or for an intentional act. If the insurer fails to advise its insured of the importance of an allocated verdict, then the burden of proving non-coverage should shift to the insurer, likely resulting in coverage.

E. Any Ambiguity in the Underlying Verdict Should be Construed Against the Insurer and In Favor of Coverage.

In West Virginia, it is well-settled law that any ambiguities in an insurance contract are construed against the insurer and in favor of coverage. Syl. pt. 4, *Nationwide Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 356 S.E.2d 488 (1987). Presumably, this rule is in place because the insurance company either created the ambiguity or was in the best position to cure it. It would stand to reason then that this same principle would apply to ambiguities in a verdict form. The best and only way to cure ambiguities in a verdict form is by proposing special interrogatories that elucidate a jury's reasoning for awarding damages. See *Windt, supra* at § 6:26, n.1. Insurance companies write the policies, interpret and apply the policy provisions to the claims submitted by their insureds and, ultimately, inform the insureds as to which claims are covered and which are not. Accordingly, Insurance companies are in a far better position to be aware of the importance of special interrogatories in order to cure ambiguities in a verdict form. See *Doe*, 599 N.E.2d at 989. Not to mention, Insurance companies by their very nature, deal in coverage litigation on a daily basis. Therefore, if an insurance company fails to at least advise its insured that special interrogatories will be necessary to protect that insureds interest in coverage, any ambiguities in that verdict form should be construed against the insurance company and in favor of coverage.

For example, in *St. Paul Fire and Marine Ins. Co. v. Shernow*, 22 Conn. App. 377, 577 A.2d 1093 (1990), a dentist insured by St. Paul was sued in an underlying action for assault and battery and for medical malpractice. The insurer defended its insured under a reservation of rights on the question of indemnity. The jury found for the underlying plaintiff on both counts and awarded \$400,000 in damages. St. Paul then instituted a declaratory judgment action against its insured seeking a declaration that the insured dentist was not entitled to indemnification under

its policy for any part of the damages because the judgment was not allocated. The court dismissed the declaratory judgment action because, *inter alia*, "it was impossible to determine from the jury verdict whether the defendant intended to cause the injury that resulted to" his patient. The appellate court reversed and remanded the case to the trial court with direction to decide the issue of indemnity. While the appellate court noted that the trial court had sufficient facts from which it could determine whether the dentist's actions were covered by his insurance policy, it further noted that "*if the court finds any ambiguity relating to the indemnity question, such ambiguity should be construed against the insurer.*" *Id.* (emphasis added)

Similarly, in *Herrera v. American Standard Ins. Co.*, 203 Neb. 477, 279 N.W.2d 140 (1979), the insured brought a declaratory judgment action against his insurer after obtaining a verdict awarding him uninsured motorist coverage. Subsequent to the verdict, the insured denied coverage claiming that the verdict included property damage which was not recoverable under the uninsured motorist coverage of the insured's policy. The Nebraska court held the insurer was not entitled to re-litigate, in a subsequent declaratory judgment action filed against it by its insured, whether the general verdict for damages returned by the jury contained any amounts for uncovered damages where the insurer, which intervened in the action and then withdrew, did not request a special verdict itemizing the type of damages included in the verdict.

V. ARGUMENT

The decision that this court makes in this case could potentially affect every insured in the state of West Virginia who finds themselves named as a defendant in a civil action. Today, Camden-Clark is denied insurance coverage by St. Paul, but tomorrow it could easily be an individual or family who is summarily denied insurance coverage after it is too late to do anything about it.

Insurance companies, such as St. Paul, are billion dollar companies who employ a multitude of attorneys and claims specialists who routinely evaluate insurance policies to determine when coverage does and does not apply. Insureds not only purchase coverage from these insurance companies, but they, in effect, purchase their expertise and advice. From a practical point of view, insureds routinely have no choice but to rely upon the expertise and advice of these insurance companies. A typical family or individual does not have the knowledge or resources to go out and hire coverage counsel when an insurance company refuses to provide them with coverage. In effect, the insureds are at the mercy of the insurer.

In this particular situation, Camden-Clark paid \$1.7 million in premium to St. Paul insurance company – for what? In Camden-Clark's time of need they received no advice, no input and, ultimately, no insurance coverage. St. Paul knew of the significance of this claim and knew of the potential for there to be damages awarded to the underlying plaintiff some of which, based on St. Paul's own analysis, were covered and some that were not. So, St. Paul decided to say nothing to its insured, decided to give no advice and decided to remain silent until after an unfavorable verdict was rendered. Once, the unfavorable verdict was reached, St. Paul then threw up its hands and denied coverage based upon an ambiguous verdict.

As has been previously cited, West Virginia law has consistently construed ambiguities against the insurance company and in favor of providing insurance coverage. If St. Paul, or any other insurance company, is allowed to remain silent and after the fact take advantage of an ambiguous verdict, this would be the only instance that West Virginia law would allow an insurer to benefit from an ambiguity. An ambiguity that is foreseeable and avoidable by the insurance company in the underlying action.

The burden should rightfully fall to the insurance company who has far greater expertise and resources to assure that a verdict is appropriately allocated. This can be done through direct recommendations to the insured or its counsel or by intervening in the underlying action for the purposes of obtaining an allocated verdict. **What is unacceptable is to allow the insurance company to lie silently in the weeds, allow an ambiguous verdict to be reached and then deny coverage based on the ambiguous verdict.** How could this possibly be fair?

St. Paul wishes to take advantage of its insured through uncertainties and ambiguities in a verdict. An ambiguous verdict which St. Paul knew or should have known would occur. Camden-Clark advocates a position that requires the insurer to take reasonable steps to make sure that an allocated verdict is reached which delineates covered versus non-covered damages. That way, the insured knows up front what will be covered by insurance and what will not. Further, protracted post-verdict litigation will be avoided.

The insurance company is in the business and trade to deal in insurance litigation. They are far better suited to recommend that the verdict be allocated and/or intervene in the underlying action to assure that an allocated verdict is reached. Placing this burden on the insured, who at the same time is defending their conduct in the underlying action, can create disastrous consequences. For example, Camden-Clark was in the fight of its life in the underlying medical malpractice action. Its attention and resources were devoted to the defense of that case. Camden-Clark understandably relied upon St. Paul to give them advice on insurance related matters. In reality, Camden-Clark did not consider an allocated verdict and never fathomed that the mere design of a verdict form would result in the loss of millions of dollars of coverage. St. Paul, who was monitoring the medical malpractice action, stood silently by, all the while knowing of the potential for an ambiguous verdict. Moreover, the whole time St. Paul had an

interest in the verdict not being allocated. That interest is in conflict with its insured's best interests, existing insurance law and public policy.

In accordance with the above-cited case law and public policy, the particular facts of the case before this Court justify placing the burden on St. Paul to prove whether and in what proportion the compensatory and punitive damages awarded in the underlying matter were based upon non-covered claims. Pursuant to the policy insuring Camden-Clark, St. Paul had "the right to investigate and associate in the defense of any claim or suit for covered injury or damages made or brought against any protected person." Though the gravamen of the Complaint filed in this matter sought damages as a result of a covered medical malpractice claim, St. Paul did not associate in the defense of the underlying matter. Camden-Clark, however, met all duties required under the policy by promptly and timely notifying St. Paul of the claim and keeping the insurer advised throughout the pendency of the litigation and post-trial motions.

In addition to associating in the defense, St. Paul also had the option of intervening in the underlying matter for the purpose of posing special interrogatories to the jury which likely would have rendered the instant litigation unnecessary. Not only did St. Paul not intervene in the underlying action prior to trial, it never once even hinted to Camden-Clark that it should request special interrogatories for coverage purposes. Throughout the trial, Camden-Clark's outside retained counsel, Richard A. Hayhurst, sent St. Paul lengthy and detailed trial reports via e-mail. To be sure, St. Paul was made exceedingly aware of the testimony given at trial for both sides. Despite Camden-Clark's efforts to engage St. Paul in the defense and/or settlement of this matter, St. Paul remained indifferent. Now, only after an unfavorable verdict was rendered, St. Paul seeks to put the near impossible burden of proving allocation of the jury's verdict on its insured.

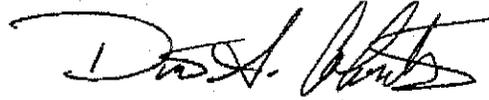
St. Paul had a duty to advise Camden-Clark that special interrogatories would be needed to protect coverage. If St. Paul would have advised Camden-Clark that special interrogatories were needed, they no doubt would have been proposed. Nevertheless, St. Paul – apparently under the impression that its insured would bear the burden of proof if it remained silent – had an interest in the verdict's not being allocated. It is obvious now, that St. Paul's interest in an unallocated verdict was directly in conflict with its insured's interest that covered damages be segregated on the verdict form. This is the very reason that this Court should adopt a rule that shifts the burden of proving non-coverage to the insurance company when claims include both covered and non-covered damages and they fail to properly advise their insureds of the conflict.

If this Court recognizes that the insurance companies have the burden of proving allocation, the insurers will no doubt fervently demand that its insureds utilize special interrogatories in the underlying case, lest they be responsible for the entire judgment. On the other hand, if the policyholders bear the burden of allocation, then it will be in the insurance companies' best interest not to recommend special interrogatories. What is more, placing the burden of allocation on the insured not only creates a conflict of interest between the insurer and its insured, it gives the insurance companies a sly and "technical" defense to avoid providing coverage. Therefore, in instances such as this, the burden of proving allocation of a verdict between covered and non-covered damages should rightfully be on the insurance company. To hold otherwise, would give insurers an interest in creating confusion.

VI. CONCLUSION

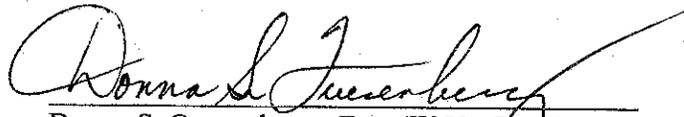
For all of the foregoing reasons, Camden-Clark respectfully requests this Court to hold that the insurer has the burden of proving non-coverage in response to the questions certified by the district court.

Respectfully submitted,



Dino S. Colombo, Esq. (W.Va. Bar # 5066)
Travis T. Mohler, Esq. (W.Va. Bar # 10579)
Colombo & Stuhr, PLLC
1054 Maple Drive
Morgantown, West Virginia 26505

-and-



Donna S. Quesenberry, Esq. (W.Va. Bar # 4653)
MacCorkle, Lavender & Sweeney, PLLC
300 Summers Street, Suite 800
Charleston, West Virginia 25301
*Counsel for Camden-Clark Memorial
Hospital Corporation*

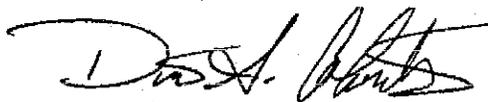
CERTIFICATE OF SERVICE

I, Dino S. Colombo, counsel for Camden-Clark Memorial Hospital Corporation, do hereby certify that service of the attached "Camden-Clark Memorial Hospital Corporation's Brief on Certified Questions Posed by the United States District Court for the Southern District of West Virginia" was had upon the persons listed below by filing true copies thereof in the United States mail, postage prepaid, addressed as follows:

D.C. Offutt, Jr., Esquire
Perry W. Oxley, Esquire
David E. Rich, Esquire

OFFUTT & NORD
949 Third Avenue, Suite 300
Post Office Box 2868
Huntington, West Virginia 25728-2868

Counsel for Defendant, St. Paul Fire and Marine Insurance Co.



Dino S. Colombo, Esq.