Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | June 2012

Criminal Acts Exclusion Triggered by Insured's Admission of Elements of Crime

The United States Court of Appeals for the Sixth Circuit, applying Kentucky law, has held that a criminal acts exclusion applied to bar indemnity coverage for a judgment against a doctor in a medical malpractice action because the doctor admitted the necessary elements of a crime, precluding the necessity of a criminal adjudication of guilt to trigger the exclusion. *Med. Protective Co. v. Duma*, 2012 WL 1522663 (6th Cir. May 1, 2012).

The insured, a doctor, consumed a large amount of vodka before he delivered a baby without anyone noticing he was intoxicated. The mother and child suffered labor-related injuries during the delivery. When the smell of alcohol was detected after the delivery, a blood alcohol test was administered on the doctor, which indicated a highly elevated blood alcohol level. The mother sued for labor related injuries and obtained a judgment against the doctor.

The doctor's insurer filed a declaratory judgment action seeking a determination that it had no obligation to indemnify the doctor for the judgment because the policy's criminal acts

continued on page 9

ALSO IN THIS ISSUE

Complaint and Amended Complaint in Same Litigation Are a Single Claim

Applying Pennsylvania law, the Superior Court of Pennsylvania has held that a complaint asserting certain causes of action and an amended complaint in the same litigation asserting different causes of action constitute a single claim because they were both filed in one civil proceeding. *Superior Beverage Grp., Ltd. v. Cincinnati Ins. Co.*, 2012 Pa. Super. LEXIS 527 (Pa. Super. Ct. Apr. 13, 2012).

A company obtained a claims-made employment practices liability policy for the policy period from January 28, 2005 to January 28, 2008. The policy originally had a limit of liability of $500,000 per claim, but, in 2007, the limit was increased to $1 million per claim. On March 13, 2006, several employees filed an age discrimination lawsuit against the company. On October 18, 2007, the employees filed an amended complaint that asserted causes of action for race discrimination. The company's insurer undertook the company's defense throughout the litigation. After the action concluded with the entry of a judgment against the company, the company argued that the policy provided $1.5 million in coverage for the action because the age discrimination complaint was

continued on page 7

Court Orders Insurer To Disclose Communications Between the Insurer and Its Outside Counsel in Discovery Concerning Insured's Bad Faith Claim

The United States District Court for the Southern District of Ohio has granted in part and denied in part an insured's motion seeking discovery from its insurer concerning a bad faith claim. The court allowed potential discovery of communications between the insurer and its outside counsel, subject to an in camera review, but rejected any discovery seeking deposition testimony of the insurer's outside counsel. *Chubb Custom Ins. Co. v. Grange Mut. Cas. Co.*, 2012 WL 1340369 (S.D. Ohio Apr. 17, 2012).

In an underlying class action lawsuit, the insured was one of many insurance company defendants that allegedly engaged in certain improper adjustments of first-party claims for bodily injury. The underlying lawsuit ultimately settled with the insured agreeing to pay eligible class members an amount of money representing "specific elements of bodily damages."

The insurer then filed a declaratory judgment action seeking a determination that coverage for the settlement was barred by the "Benefits Due Exclusion" in an insurance company errors and omissions policy. The insured counterclaimed for indemnification, breach of contract and bad faith. In a previous holding in this case, which was reported in the April 2009 *Executive Summary*, the court denied in part the insurer's motion for summary judgment and granted the insured's motion for partial summary judgment. Thereafter, the insurer filed a renewed motion for summary judgment concerning the insured's bad faith claim, in response to which the insured filed a motion to conduct additional discovery concerning facts in opposition to the insurer's renewed motion for summary judgment.

continued on page 9

Insurer Provided Timely Notice of Non-Renewal

Applying Florida law, a federal district court has held that an architect was not entitled to an extended reporting period under a claims-made policy because the insurer provided timely notice of non-renewal, and therefore a claim alleging that the architect was negligent in providing architectural services for a condominium project was made after the policy expired. *James River Ins. Co. v. Oscar I. Garcia, Architect, P.A.*, 2012 WL 1252507 (S.D. Fla. Apr. 13, 2012). The court also held that, because the insurer had provided proper notice of non-renewal indicating that a residential condominium/town home exclusion would be added to the architect's renewal policy, the exclusion was enforceable to bar coverage for the condominium project's claim under the renewal policy.

The architect purchased a claims-made policy with a policy period from May 29, 2009 to May 29, 2010. More than 45 days prior to the expiration of the policy period, the insurer sent the architect a notice of non-renewal indicating that it would add a residential condominium/town home exclusion to the renewal policy. The architect accepted the terms of the renewal policy, which had a policy period from May 29, 2010 to May 29, 2011. Prior to the expiration of the earlier policy, a condominium project sent the architect notice of a claim alleging that the architect was negligent in providing services for the project. The architect did not tender the claim to the insurer until Jun 25, 2010. The insurer denied coverage under both policies because the claim (i) first was made, but not reported, during the earlier policy period, and (ii) was excluded from coverage by the exclusion added to the renewal policy.

The court granted the insurer's motion for summary judgment, holding that neither the 2009-2010 policy nor the 2010-2011 policy

continued on page 7

District Court: Lodestar-Multiplied Attorney Fee Award Not "Multiplied Damages" Because Exception Clause Ambiguous

The United States District Court for the Northern District of Illinois has held that the portion of an attorney fee award calculated by multiplying a base lodestar amount is not precluded from coverage by a carve out for "multiplied damages" in the definition of "loss" because the provision is ambiguous as applied. *Carolina Cas. Ins. Co. v. Merge Healthcare Inc.*, 2012 WL 1532266 (N.D. Ill. Apr. 30, 2012).

The insurer filed a declaratory judgment action seeking a determination as to the availability of coverage for the named insured with respect to an award of enhanced attorneys' fees in an underlying shareholders action. The court in the underlying shareholders action calculated the fee award by determining a lodestar amount based on hours worked times a reasonable rate. The court then multiplied that amount by five to account for the circumstances of the case, increasing the fee award from $630,000 to $3.15 million.

In the coverage litigation, the insurer sought to limit its obligation to the base $630,000 fee award, arguing that the multiplied portion of the attorney fee calculation was not covered loss. The policy defined loss as "damages, judgments, settlements and Costs of Defense; however, Loss shall not include . . . the multiplied portion of multiplied damages."

According to the court, the carve out was ambiguous because it "could refer simply to the double, treble, or other multiplied damages certain statutes apply to actual damages determined by the fact finder." The court then examined extrinsic evidence introduced by the policyholder, including expert testimony and a letter by the insurer in which it acknowledged coverage for fees "regardless of whether or not the fees are calculated as a percentage of the

continued on page 6

Underlying Policies Must Be Read As a Whole When Incorporated Equally Into Excess Policy

The United States Court of Appeals for the Sixth Circuit, applying Tennessee law, has held that a second-layer excess policy, incorporating the terms of its underlying policies, did not provide coverage for punitive damages because the first-layer excess policy expressly precluded coverage for such damages, even though the underlying primary policy was ambiguous as to whether such amounts were covered. *Chad Youth Enhancement Center, Inc. v. Colony Nat'l Ins. Co.*, 2012 WL 1059404 (6th Cir. March 30, 2012).

After a resident of a youth behavioral center died as a result of actions by the youth center's staff, the estate of the deceased brought a wrongful death action against the insured youth center. The parties ultimately settled, stipulating to payments "attributable to punitive damages." The insured sought a declaratory judgment that its second-layer excess liability insurance policy covered punitive damages. The second-layer excess policy incorporated the terms and conditions of both the underlying primary insurance policy and the underlying first-layer excess policy, except as otherwise specifically set forth in the second-layer excess policy. The primary policy excluded "[s]anctions, fines, or penalties" from the definition of "claims." An endorsement to the first-layer excess policy provided that "[t]his insurance does not apply to fines, penalties, [or] punitive damages."

The insured argued that the primary policy's exclusion was ambiguous and that it should be read separately from the first-level excess policy. The insured asserted that because all ambiguities must be construed in favor of the insured, the court must conclude that punitive damages were

continued on page 6

D&O Policy Affords No Coverage for Officer's Personal Contractual Obligation

A Washington appellate court has held that a D&O policy did not provide coverage for losses incurred by an officer in his or her personal capacity and that a guaranty executed by a corporate officer that secured the corporation's debt was not executed in the officer's official capacity. *Sauter v. Houston Cas. Co.*, 2012 WL 1699447 (Wash. Ct. App. May 14, 2012). The appellate court also concluded that amounts paid in satisfaction of that contractual obligation did not constitute "Loss" as defined by the D&O policy.

An insurer issued a D&O liability policy to a corporation. The corporation received a loan from a bank, and the corporation's CEO signed the loan agreement in his official capacity on behalf of the corporation. Pursuant to a requirement in the loan agreement, the CEO also executed a guaranty of the loan, which was secured by seven deeds of trust on real property that the CEO owned jointly with his spouse. The corporation failed to repay the loan, and the bank demanded payment in full on the CEO's guaranty. The CEO in turn demanded indemnification from the corporation. Although the corporation's members agreed that the corporation should indemnify the CEO, the corporation was insolvent. The corporation then tendered the bank's demand on the guaranty to the insurer.

The D&O policy afforded coverage for Loss resulting from a Claim against Insured Persons for a Wrongful Act. The policy defined "Wrongful Act," in relevant part, as "any actual or alleged act, misstatement, error, omission, misleading statement, neglect, breach of duty or act by . . . any of the Insured Persons, while acting in their capacity as . . . such on behalf of the Insured Organization." The definition of "Loss" carved out "matters deemed uninsurable under the law pursuant to which this Policy shall be construed." The insurer denied coverage and argued that that no act by the CEO constituted a "Wrongful Act" and that the CEO suffered no "Loss." In the ensuing coverage litigation, the trial court granted summary judgment in favor of the insurer.

continued on page 8

Nature of Consumer Class Action, Not Percentage of Meritorious Claims, Determines Coverage and Allocation

The Appeals Court of Massachusetts, the state's intermediate court of appeals, has held that an excess liability policy may afford coverage for indemnity costs associated with a consumer class action settlement without regard to the percentage of individual claims that were ultimately determined to be meritorious. *Allmerica Financial Corp. v. Certain Underwriters at Lloyd's, London*, 81 Mass. App. Ct. 674 (Mass. App. Ct. Apr. 30, 2012). The court held that the settlement was comprised of "both covered and uncovered" claims and therefore required allocation under the policy to determine what portion of the claims, if any, were covered.

The underlying class action litigation that gave rise to the coverage dispute involved alleged fraud, misrepresentation, negligent supervision, negligent misrepresentation, and other conduct in connection with so-called "vanishing premium" misrepresentations in the sale of life insurance. The insured settled the lawsuit by establishing a process of adjudicatory review that provided differing levels of compensation to members of the claimant class depending on a numerical category assigned to reflect the severity and level of resulting damages, if any. That process determined that only 27 percent of the underlying claimants had meritorious claims.

In light of this finding, the trial court in a subsequently-filed coverage action determined that the number of "wrongful acts" involved in the 27 percent of meritorious claims could never

continued on page 8

Malpractice Claim Deemed Made at Time of Insured's Legal Error

The United States District Court for the District of Maryland, applying Maryland law, has granted summary judgment in favor of an insurer, holding that a malpractice claim against an insured law firm was deemed first made during a prior policy period—at the time the law firm filed an opposition to a motion for summary judgment that failed to comply with state law in an underlying case, or alternatively, when the underlying trial judge noted an unexecuted affidavit as a basis for a ruling against the insured's client—and thus not covered under a subsequent policy. *Minn. Lawyers Mut. Ins. Co. v. Baylor & Jackson, PLLC*, 2012 WL 1109731 (D. Md. Apr. 3, 2012). The court also held that providing timely notice under a claims-made policy is a condition precedent to coverage such that an insurer is not required to prove prejudice to disclaim coverage for late notice.

In the underlying case, the insured law firm represented a defendant who was sued for breach of contract and breach of fiduciary duty in Maryland state court. In response to the underlying plaintiff's motion for summary judgment, the insured law firm filed an opposition brief in which the defendant contended that the contract at issue was not valid. The insured failed, however, to submit either an affidavit or sworn statement to support its client's contentions. Based on this failure and other arguments, the judge in the underlying action granted summary judgment to the underlying plaintiff. On appeal, the Maryland intermediate appellate court affirmed the trial court's ruling, commenting that the opposition to summary judgment "was not supported by affidavits, deposition testimony, interrogatory answers, or any sworn evidence as required by Maryland Rule 2–501" and that the insured's "failure to comply with Maryland Rule 2–501 severely undermined their opposition to summary judgment on all the counts." The insured provided notice of a potential malpractice claim shortly after the appellate court's decision. The insurer denied coverage on the grounds that notice of the potential malpractice claim should have been provided during a prior policy period, *i.e.*, at the time of the filing of the opposition to summary judgment or at the time of the trial court's ruling. The insurer also denied coverage under the prior policy in place at the time of the summary judgment filing on the basis of late notice.

Both the prior and subsequent policies provided that the "act, error or omission giving rise to the CLAIM must have occurred during the POLICY PERIOD or prior to the POLICY PERIOD . . . , if the INSURED had no knowledge of facts which could reasonably support a claim at the effective date of this policy." The policies further provided that a "CLAIM is deemed made when . . . an act, error or omission by any INSURED occurs which has not resulted in a demand for DAMAGES but which an INSURED knows or reasonably should know, would support such a demand."

> The court held that the insurer was not required to prove prejudice in order to disclaim coverage for lack of timely notice under Maryland law.

In the ensuing coverage action, the court held that, "[g]iven the policy's definition of coverage, the act, error, or omission giving rise to the . . . malpractice claim occurred . . . when [the insured] filed the opposition to summary judgment without supporting evidence." In applying an objective standard for evaluating the reasonableness of an insured's providing notice of a potential claim, the court held that "any reasonable lawyer faced with a motion for summary judgment could simply have read Maryland Rule 2–501 and known that an unexecuted affidavit does not satisfy the Maryland standard for summary-judgment practice." The court further stated that "[a]ny reasonable lawyer would have read [the trial judge's] opinion with alarm as to what it meant to him or her personally" and that "[a]ny reasonable lawyer would have been worried it could lead to a malpractice claim." In so holding, the court rejected the insured's argument that the trial court's decision only partly relied upon the filing of an unexecuted affidavit, noting that the insurer's

continued on page 6

Malpractice Claim Deemed Made at Time of Insured's Legal Error *continued from page 5*

"concern is liability for malpractice, not whether [the insured] would have lost the case on the merits anyway." The court held that, based upon the policy's language, the malpractice claim was deemed first made during the prior policy period, during which the insured failed to provide notice of a potential claim, and that the subsequent policy does not respond because the claim was made during the prior policy period.

In addition, the court rejected the insured's argument that the insurer must prove prejudice in order to deny coverage based upon the insured's untimely notice under the policy in effect when the summary judgment opposition was filed. After a discussion of Maryland's notice law, the court recognized that the prior policy's insuring agreement provided coverage only for claims that were made and reported within the policy period and that the time for reporting a claim "was incorporated into the definition of coverage and, therefore, became a condition precedent to coverage." Accordingly, the court held that the insurer was not required to prove prejudice in order to disclaim coverage for lack of timely notice under Maryland law. ■

District Court: Lodestar-Multiplied Attorney Fee Award Not "Multiplied Damages" Because Exception Clause Ambiguous *continued from page 3*

bump-up amount." The court noted that the insurer presented no applicable legal authority or any evidence supporting its interpretation of the provision. The court thus granted summary judgment to the policyholder on its request for a declaration as to coverage. However, the court rejected the policyholder's claim for bad faith damages, holding that the insurer's position was not so unreasonable as to amount to bad faith. ■

Underlying Policies Must Be Read As a Whole When Incorporated Equally Into Excess Policy *continued from page 3*

covered by the primary policy. The insured then argued that there was a conflict between the primary policy's coverage for punitive damages and the first-level excess policy's exclusion of punitive damages, and contended that this conflict should also be resolved in the insured's favor.

In rejecting the insured's position, the court stated that Tennessee law prohibited courts from applying this type of multi-step method of construction. Rather, the court was required to read the entire policy as a whole, from the perspective of the second-layer excess policy's contracting parties, taking into account all of the provisions of the two underlying policies. The court found that there was no conflict between the first-layer excess policy's express exclusion of punitive damages and the primary policy's silence regarding punitive damages, and held that the second-level excess insurer excluded punitive damages irrespective of any ambiguities in the primary policy. ■

Complaint and Amended Complaint in Same Litigation Are a Single Claim *continued from page 1*

a claim subject to a $500,000 limit and the race discrimination amended complaint was a separate claim subject to a $1 million limit. The insurer disagreed, and the company filed a declaratory judgment action on the issue of how much coverage was available under the policy.

On cross motions for summary judgment, the trial court ruled for the insurer. The appeals court affirmed, finding that the complaint and the amended complaint were a single claim subject to a single $500,000 limit of liability. The policy defined "claim" as a "civil . . . proceeding commenced by the service of a complaint," and provided that a "claim" maintained by multiple plaintiffs shall be subject to a single limit of liability. Here, the court concluded, the amended complaint did not constitute a new claim because it was not a new civil proceeding. Instead, it was part of the same civil proceeding as the original complaint, and thus the two constituted a single claim subject to a single limit of liability.

The company argued that the insurer was estopped from denying that the claim was subject to $1.5 million in coverage because the insurer had continued to defend the litigation after the claimants had filed the amended complaint. The court rejected this argument, finding that, in continuing to defend, the insurer acknowledged only that the action was a covered claim, not that it was two claims subject to two limits of liability. Indeed, the court held, because both complaints were a single claim, the insurer was obligated to continue to provide a defense throughout the litigation.

The company also argued that the definition of "claim" must be interpreted in connection with the policy's allocation provision, which provided for allocating between covered and uncovered loss in a single proceeding. The company argued that this provision contemplated that one proceeding could constitute multiple "claims." The court disagreed, holding that the allocation provision merely acknowledged that a single proceeding could have covered and uncovered causes of action, but that the proceeding was still only one claim. ■

The court held that the allocation provision merely acknowledged that a single proceeding could have covered and uncovered causes of action, but that the proceeding was still only one claim.

Insurer Provided Timely Notice of Non-Renewal *continued from page 2*

covered the condominium project's claim. With respect to the 2009-2010 policy, the court concluded that the insurer had provided the 45 days notice of non-renewal required by Florida statute, and, therefore, the architect could not rely on the statute to extend the policy period. The court also rejected the architect's argument that the 2009-2010 policy's 60-day automatic Extended Reporting Period applied, noting that the policy's plain language provided that "a change in Policy terms and conditions and/or premium shall not be considered non renewal for purposes of triggering" the automatic Extended Reporting Period. With respect to the 2010-2011 policy, the court considered the architect's argument that the condominium project's claim should be covered by that policy because, under Florida statutory authority, the residential condominium/town home exclusion constituted an unenforceable material change from the prior policy. The court disagreed, concluding that the exclusion in the 2010-2011 policy was enforceable because the insurer had provided the architect with the 45 days notice of non-renewal required by the statute. ■

D&O Policy Affords No Coverage for Officer's Personal Contractual Obligation *continued from page 4*

On appeal, the court examined the definitions of "Wrongful Act" and "Insured Person" and concluded that no coverage would be available unless the CEO's purported loss resulted from a claim made against him for an act that he committed "while acting in [his] capacity as [CEO] on behalf of" the corporation. The court then determined that the CEO was acting in his personal capacity when he executed (and later defaulted on) the guaranty, citing the facts that his signature on the guaranty did not note his position at the corporation, in contrast to his signature on the loan agreement, and that the guaranty was secured by the CEO's personal real estate. The court also reasoned that "the very nature of the guaranty indicates that [the CEO] was acting in his personal capacity in executing the guaranty" because, as a matter of law, "an entity cannot be a guarantor of its own obligations." Accordingly, the appellate court concluded that the Claim did not allege a "Wrongful Act" by the CEO, and the policy afforded no coverage.

The insurer also argued on appeal that "the repayment of a loan does not constitute a 'Loss' and that . . . liability insurance is not intended to insure against such an obligation." The court observed that Washington courts had not previously addressed whether satisfaction of a voluntary contractual obligation constituted insurable "Loss." The court concluded that it need not look beyond the policy language, however, to decide whether the amounts sought by the CEO were covered "Loss." The court focused on the insuring agreement requirement that the Loss *result from* a Claim for a Wrongful Act. The court explained that, in this case, the CEO incurred the obligation to pay the corporation's debt by executing the guaranty and that his obligation was not the result of a Claim, or the bank's demand on the guaranty.

The court therefore affirmed summary judgment in favor of the insurer. ■

Nature of Consumer Class Action, Not Percentage of Meritorious Claims, Determines Coverage and Allocation *continued from page 4*

reach a level of loss sufficient to reach the excess insurer's layer, which provided coverage for loss in excess of $20 million. The insured appealed this ruling. The intermediate appellate court reversed the lower court's decision, holding that the number of individual claims found to be meritorious was not relevant to coverage under the excess policy. The court noted that the policy afforded coverage for "wrongful acts," defined as "actual or alleged" misstatements or misleading statements. The court reasoned that the policy affords coverage for alleged, but not necessarily actual wrongdoing, and that a "loss" was incurred in establishing a process to respond to the underlying claim.

In addition, the court held that the underlying class action included some factual allegations and counts that would be covered under the policy because they alleged negligence, inaction, negligent supervision, failure to supervise, and reckless conduct. The underlying action also included numerous allegations and counts that would be excluded under the policy with respect to alleged fraud and other improper conduct. The court concluded that "[h]aving determined that damages resulting from allegations of wrongdoing as well as actual wrongdoing are within the policy's coverage, and having determined that the costs incurred by [the insured] in defending, then settling, the class action are potentially attributable in some proportion to claims that are covered by the policy, we must address allocation." The court remanded the case for proceedings to determine what portion, if any, of the insured's damages were attributable to covered allegations as opposed to uncovered allegations. In doing so, the court emphasized that "the percentage of claims ultimately resulting in adjudicated awards is not relevant to such a determination; neither the denial nor the payment of an award signifies the basis of the claim, it merely signifies whether the adjudicators considered the misstatement to be 'actual' or 'alleged,' a distinction, as we have seen, that is irrelevant for purposes of determining coverage." ■

Criminal Acts Exclusion Triggered by Insured's Admission of Elements of Crime *continued from page 1*

exclusion barred coverage. The criminal acts exclusion precluded coverage for "payment of damages . . . in any claim for damages if said damages are in consequence of the performance of a criminal act . . . ." The insurer contended that the exclusion applied because the doctor's actions constituted the misdemeanor of wanton endangerment under Kentucky law, which was defined as "when [a person] wantonly engages in conduct which creates a substantial danger of physical injury to another person."

The Sixth Circuit held that the criminal acts exclusion barred indemnity coverage for the medical malpractice action. The court reasoned that, although a criminal adjudication was normally required under Kentucky law before a criminal acts exclusion applied, a criminal adjudication was not necessary when the insured admitted all elements of the relevant criminal statute. The court found that the doctor's testimony in the underlying action constituted an effective admission of the elements of wanton endangerment because he admitted "knowing self-intoxication and the objective fact that his conduct created a substantial risk of harm to another." The court also held that the damages were "in consequence" of the criminal act because the jury's finding in the underlying action indicated that the doctor's criminal act was a substantial factor in causing the injuries. ■

Court Orders Insurer To Disclose Communications Between the Insurer and Its Outside Counsel in Discovery Concerning Insured's Bad Faith Claim *continued from page 2*

In granting the insured's motion to discover certain attorney-client communications between the insurer and its outside counsel, the court relied upon *Boone v. Vanliner*, 744 N.E.2d 154 (Ohio 2001). That case established a common law exception to Ohio's attorney-client privilege in cases involving bad faith claim handling allegations against an insurer, allowing discovery of certain attorney-client communications "related to the issue of coverage that were created prior to the denial of coverage." Citing *Boone*, the court held that "any document that [the insurer] identified on its privilege log as including communications with coverage litigation counsel [from the time the claim was tendered until the date of the filing of its declaratory judgment action], and which was previously withheld or redacted as protected by the attorney-client privilege, may be discoverable under *Boone*, and must be produced by the insurer for an *in camera* review." The court also ordered that the insurer produce documents potentially subject to the work product doctrine for an *in camera* review to determine whether each document was prepared in anticipation of litigation, as required by federal rules.

In addition, the court denied the insured's motion to the extent the insured sought deposition testimony from the insurer's outside counsel. The court held that Ohio Revised Code § 2317.02(A) requires that the insured make a prima facie showing of bad faith by the insurer before such testimony concerning attorney-client communications will be compelled. The court held, however, that the insured failed to make such a prima facie showing of bad faith based on the insured's admission that it "d[id] not know" if the privileged communications sought would reveal evidence of bad faith. In so holding, the court stated that "[a]lthough [the insured's] speculation regarding what it may find related to the claim of bad faith is enough to warrant this Court's review of the previously redacted documents, such speculation is insufficient to override the evidentiary privilege that ordinarily insulates the testimony of attorneys from the discovery process." ■

Professional Liability Attorneys

Kimberly A. Ashmore	202.719.7326	kashmore@wileyrein.com
Mary E. Borja	202.719.4252	mborja@wileyrein.com
Jason P. Cronic	202.719.7175	jcronic@wileyrein.com
M. Addison Dent Draper	202.719.7574	adraper@wileyrein.com
Cara Tseng Duffield	202.719.7407	cduffield@wileyrein.com
Benjamin C. Eggert	202.719.7336	beggert@wileyrein.com
Dale E. Hausman	202.719.7005	dhausman@wileyrein.com
Justin D. Heminger	202.719.7327	jheminger@wileyrein.com
John E. Howell	202.719.7047	jhowell@wileyrein.com
Peter J. Jenkins	202.719.7136	pjenkins@wileyrein.com
Leland H. Jones, IV	202.719.7178	lhjones@wileyrein.com
Parker J. Lavin	202.719.7367	plavin@wileyrein.com
Charles C. Lemley	202.719.7354	clemley@wileyrein.com
Mary Catherine Martin	202.719.7161	mmartin@wileyrein.com
Kimberly M. Melvin	202.719.7403	kmelvin@wileyrein.com
Jason O'Brien	202.719.7464	jobrien@wileyrein.com
Leslie A. Platt	202.719.3174	lplatt@wileyrein.com
Marc E. Rindner	202.719.7486	mrindner@wileyrein.com
Kenneth E. Ryan	202.719.7028	kryan@wileyrein.com
Gary P. Seligman	202.719.3587	gseligman@wileyrein.com
Richard A. Simpson	202.719.7314	rsimpson@wileyrein.com
William E. Smith	202.719.7350	wsmith@wileyrein.com
Daniel J. Standish	202.719.7130	dstandish@wileyrein.com
Karen L. Toto	202.719.7152	ktoto@wileyrein.com
Sandra Tvarian Stevens	202.719.3229	sstevens@wileyrein.com
David H. Topol	202.719.7214	dtopol@wileyrein.com

Wiley Rein LLP Offices:
1776 K Street NW
Washington, DC 20006
202.719.7000

7925 Jones Branch Drive
McLean, VA 22102
703.905.2800