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"Scope of coverage of Liability Insurance. What and when the coverage is triggered? Accrual of cause of action"

(Determinación del momento en que ha ocurrido el siniestro en el seguro de RC)

Selected readings (English).

1) Scope of coverage

Forms of liability insurance. Liability insurance provides cover against the risk of the assured incurring liability to third parties, rather than against the risk of damage the property as such, and is a contract of indemnity. It is nevertheless common for policies to provide both first-party property or personal-injury cover and third party liability cover: motor and householder's policies are generally in this combined form. Similarly, there may be some difficulty in ascertaining whether a policy procured by a bailee is an insurance on the goods or an insurance on the bailee's liability for the goods, as the bailee is entitled to insure in respect of both matters.

Liability policies may cover liability arising from the use of goods or the provision of services. Under a liability policy it is generally the case that the conduct which gives rise to liability will occur some time before the assured actually incurs liability for that conduct. It may also be the case that different policies are in force at the times of the former and latter events. It is important to determine, therefore, whether the policy covers liability flowing from the assured's conduct within the policy period, or whether it covers the establishment of the assured's liability within the policy period, as both are possibilities.

Liability policies may be written in a number of different ways. Professional indemnity covers, including directors' and officers' insurance, are these days written on a "claims made" basis. Under a claims made policy the insurers face liability for any claims made by a third party against the assured during the currency of the policy, even though those claims do not result in the assured's liability actually being established and quantified (the trigger for the insurers' liability under a liability policy) for some years to come and possibly at a time when the insurers in question are no longer providing cover for the assured. Claims made policies typically provide an extension, in the

form of the right or obligation on the assured to notify to the insurers any circumstances which have occurred during the currency of the policy and which "may" or "are likely" lo give rise to a claim at some point in the future: notification by the assured during the currency of the policy is then deemed to be treated as a claim made against the assured during the currency of the policy should a claim actually be made at some later date. A further typical form of extension is found in the form of an Extended Period of Discovery, which is triggered where the policy is not renewed: the policy will provide that in the event of non-renewal, any claims made against the assured within 12 months following expiry are to be treated as covered. This type of extension is normally by its terms removed if any other insurance covering the loss is in force. A claims-made policy will exclude claims made against the assured during some earlier policy, and in some cases the exclusion will extend to claims arising out of circumstances which could have been notified under an earlier policy.

Policies covering liability for personal injury or damage to property may written on a claims made basis, but are more commonly written on a losses occurring or events basis. There are two separate concepts here. A "losses occurring" policy is one that responds to injuries inflicted upon the third pare y during the currency of the policy even though the assured's liability for (hose injuries is not established until a later date. An "events" policy provide indemnity for events that occur during the currency of the policy, even those events do not give rise to injury until a later date and so to liability al an even later date. The distinction between losses occurring and events policies will often be unimportant, because the assured's act of negligence and the loss to third party which flows from that act will be simultaneous, as in the case of a road accident. However, the distinction becomes significant in exposure cases, where the third party is exposed to a harmful substance by the assured during the currency of the policy but the substance does not cause physical injury to the third party for some time afterwards. The provision of an indemnity "in respect of all sums which [the assured] shall become legally liable to pay as compensation arising out of ... accidental bodily injury or illness…to any person which occurs during the currency of the policy" has been held to provide losses occurring cover and not exposure cover, on the basis that exposure is no of itself an injury and that the phrase "accidental bodily injury" did not require the accident giving rise to the injury to be in the same policy year as the injury, as the word accidental referred to the initial exposure.

Robert Merkin, “Colinvaux’s Law of Insurance”, Eight Edition, Sweet and Maxwell, London, 2006, pages 685, 686.

2) Accrual of cause of action.

1982. Right to indemnity. It may be necessary to determine for limitation purposes when the right to an indemnity arises. An insurance against liability, like an insurance on property, is a contract of indemnity,[1] and no obligation arises on the part of the insurer to pay a claim until the insured has suffered a loss. The common law doctrine was that nothing less than payment would suffice as proof of loss.[3] Equity, however, accepted that a loss was suffered once the fact and extent of the liability of the party seeking to enforce the indemnity had been ascertained in proceedings or otherwise. Since the passing of the Judicature Acts the equitable rule has prevailed.

Consistent with these principles a majority[6] of the Court of Appeal has held in *Post Office* v. *Norwich Union Fire Insurance Society Ltd.* that the insured's right to be indemnified under a liability insurance policy arises only once the insured's liability to the third party claimant is ascertained, and determined by agreement, award or judgment, and not upon the occurrence of the event which gives rise to a liability on the part of the insured to the third party.

1983. Reservations have been expressed about this decision. It might be thought to be inconsistent with the decision of *Megaw J. in Chandris v. Argo Insurance Co. Ltd.*, a case not cited to the Court of Appeal, in which he held that a cause of action for an indemnity under a marine hull policy against liability to contribute in general average arose at the time of the general average loss, and not after the extent of the liability was ascertained by adjustment or otherwise. It is also inconsistent with expressed in *Hood's Trustees* v. *Southern Union General Insurance Co, Ltd.* that an insured's right to indemnity under a motor policy arose immediately after the accident creating the insured's liability to the third party. It is submitted, however, that the decision of the majority in Post *Office* v. *Norwich Union Fire Insurance Society Ltd.* correctly states the law. The decision in *Chandris* v. *Argo Insurance Co. Ltd.* can be explained by the provisions of the Marine Insurance Act 1906 which were held to grant a right of recovery against the insurer as from the time of the loss. The opinion expressed in *Hood's Trustees* was based on the assumption common to counsel and the court, and was not the subject of argument.

Right to indemnity. See also *Royal & Sun Alliance Ins. plc v. Dornock* [2005] Lloyd's Rep. I.R. 544 at [11] and the decision in *Lumbermen Mutual Casualty Co. v. Bovis Lend Lease Ltd* [2005] Lloyd's Rep. I.R. 74, where it was held that a settlement agreement had a different effect from a judgment or arbitration award. Whereas the latter would normally be conclusive as to liability and quantum, the settlement of a claim by a third party was not conclusive as to either. An assured who relied on a settlement as ascertaining the loss had to prove by extrinsic evidence that he was in truth under a liability insured by the policy and that what he paid was reasonable, having regard to the amount of damages that he would have had to pay had the matter

gone to trial. A settlement that failed to identify the loss suffered specifically by reference to the insured liability could not amount to a valid ascertainment. No cause of action for an indemnity would arise and no amount of extrinsic evidence would cause it to do so.

Michael Parkington et al. – Nicholas Legh-Jones et al. , ***"MacGillivray on Insurance Law"***, Thomson, Sweet & Maxwell, Eight and tenth Editions, 1988 and 2005.

3) Special Coverage Problems in Liability Insurance

[a] The Meaning of Occurrence

Liability insurance provides coverage for legal liability imposed upon the insured as a result of unintentional and unexpected personal injury or property damage. Until 1966, the coverage was keyed to the word "accident," which was defined as "a sudden and unforeseeable event." One of the difficulties with this definition was that the insured had no coverage if the event was not "sudden." For example, if toxic chemicals leaked from a storage site over a long period of time, the insured's liability would not be covered.

In 1966, the standard comprehensive liability form was revised to key the coverage to the word "occurrence." In 1973, revisions were made in the definition of occurrence. Today, liability policies define "occurrence" as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured." The word "accident" is retained in the definition, but it is clarified to embrace events that are not sudden. Thus, the word "occurrence" denotes wider coverage than the word "accident." Yet under the plain language of the clause, a repeated exposure to conditions is *one* accident, meaning that the policy limits apply once, regardless of the number of losses.

[b] Problems with the Word "Accident"

The term accident has always been difficult for courts. In common parlance, an accident is something that is sudden, usually accompanied by some kind of violent force. Courts have defined accident in different ways, but the common theme in these definitions, whether it arises in property, personal, or liability insurance, is that an accident is an unforeseen, unexpected, and unintended event that results from some cause, either known or unknown.

Definitions that stress the absence of foreseeability as an element of an accident raise the question of whether negligent activity on the party of the insured is excluded from coverage. In tort law, "accidents" are often distinguished from "negligent acts," and foreseeability is an element of establishing negligence. However, excluding negligent acts from a liability policy's coverage vitiates much of the coverage.[2] For this reason some courts have rejected tort law's foreseeability test in determining whether

an accident has occurred.[3] Some courts have gone to the other extreme and have required the insurer to show that the insured intended to cause the specific kind of harm that resulted before denying coverage.

Prior to 1966, a split in authority existed as to whether an accident must be determined from the standpoint of the insured or the victim. Viewing the incident from the viewpoint of the victim would almost always lead to a conclusion that the loss in question was an accident and therefore covered, since victims rarely foresee, intend, or expect the loss caused by the insured. However, the 1966 revision specifically required that whether an accident occurred be determined from the insured's viewpoint. This revision constricted coverage and mooted the conflict in the older cases. Under the new language, an insured who is vicariously liable for the intentional act of an another will be covered so long as the loss was not intended or expected from the insured's viewpoint.[6] Although no dramatic shift resulted from the 1966 revisions in the policy forms, it does appear that a higher degree of certainty that damage will result from a particular act is required to bar coverage under the definition of occurrence. It is not necessary that the insured literally intend the results from his acts, but a high degree of certainty that damages will must exist to bar coverage.

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[d] Problems of What Triggers Coverage

Under the revised comprehensive general liability ("CGL") policy, the insurer is obligated to pay on behalf of the insured sums which the insured "shall be obligated to pay as damages *because of bodily injury or property damage* to which this [policy] applies." The bodily injury or property damage must be "caused by an *occurrence*." Obviously, the meaning of occurrence is crucial. In the revised CGL policy, "occurrence" is defined as "an accident, including continuous or repeated exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured." Under this definition, "occurrence" includes accidents in the normal sense — an unforeseen, sudden event, usually involving some kind of force or violence, that causes an unanticipated loss. "Occurrence" also includes events that last over a longer period of time. For example, if a company repeatedly but unintentionally discharges small portions of a toxic substance into a community's water supply, and if the cumulative effect of many months of discharges renders the water unsafe, the pattern of discharges, although not sudden in the usual sense of an accident, is an "occurrence" under the CGL policy.

Under the plain language of the CGL policy, the "occurrence" must result during the policy period in "bodily injury or property damage." The event need not happen during the policy period, but the *result* of the event must happen during the policy period. Thus, long-term exposures to a toxic substance need not happen during the policy's term, but the result of the

exposures — the bodily injury or property damage — must occur during the policy's term. This is buttressed by the CGL policy's definition of "bodily injury" as "bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting there from."

Thus, the drafters of the revised CGL policy intended to make clear that coverage under the policy would be triggered by bodily injury resulting during the policy period. The drafters, however, did not explicitly consider how to determine when the injury occurs in illnesses involving long exposures. If they contemplated anything, it was probably that more than one policy might provide coverage in cases involving progressive diseases. Whatever their intent, they provided no guidance on when bodily injury is deemed to occur. Three different times could be used to determine when the injury occurs: the date of the injurious contact (the exposure theory), the date of manifestation of symptoms (the manifestation theory), and the date of measurable injury (the diagnosis theory). This ambiguity has left courts with two questions in progressive injury cases: (1) what constitutes bodily injury? (2) when does bodily injury occur in such cases?

As for the first question, it is clear that a disease — such as asbestosis or silicosis — constitutes a bodily injury and is therefore covered under the CGL policy. However, that is where the clarity ends. The CGL policy casts "bodily injury" and "disease" in the alternative, indicating that a bodily injury can be something distinct from a disease. At one level, this seems obvious: a bodily injury occurs when some force or violence strikes a person, whereas a disease occurs when someone becomes ill. Yet diseases are often preceded by bodily injuries, and in one sense all diseases are preceded by bodily injuries, that is, a "localized abnormal condition of the living body." Under this definition, a bodily injury might exist before a disease exists, because the effect of the occurrence might exist in the body — an abnormal condition might have been created — before anyone is aware of it. For example, a virus invades the body and attacks an organ or body system, resulting in a "bodily injury," and only some time after the injury occurs will the abnormality be noticed by the individual and understood as a disease.

Since a bodily injury is not necessarily simultaneous with a disease, this suggests the second, more difficult question: when does bodily injury occur? Thus far, courts have provided four different answers to it: the manifestation rule; the exposure rule; the actual injury rule; and the multiple-trigger rule.

The "manifestation rule" limits coverage solely to liability for injuries that manifest themselves during the policy period. This approach was followed by the First Circuit in *Eagle-Picher Industries, Inc. v. Liberty Mutual Insurance* Co. The insured manufactured and sold asbestos products until 1971 or 1972 but had no insurance until 1968 and no excess coverage until 1973. Numerous plaintiffs alleged personal injury or wrongful death resulting from the inhalation of asbestos from Eagle-Picher's products. The court reasoned that asbestosis, which is commonly understood as a disease, consists of two things: an accident, which includes exposure to conditions,

and a bodily injury resulting from the accident. The medical evidence before the district court was that "insults" to the lung tissue do not occur simultaneously with exposure to asbestos, and that not all exposures lead to the disease. Thus, the evidence showed that exposure is logically distinct from the resulting injury or disease. The policy required that the resulting injury, not the exposure, occur during the policy period. Since the inception of asbestosis, the inhalation of the fibers, is not an injury discernible by the claimant, the court decided that the appropriate time for concluding that the injury occurred is when the claimant first experienced symptoms of the disease that impaired the claimant's "sense of well-being," or the time when a doctor could detect sufficient scarring of lung tissue "to make a prognosis that the onset of manifested disease was inevitable." Other courts have followed the manifestation approach in a variety of settings.

Because *Eagle-Picher* can be read as equating manifestation with the time at which the disease is *capable* of being diagnosed, the decision has been criticized as a departure from the pure manifestation approach. The District Court's opinion in *Insurance Co. of North America v. Forty-Eight Insulations,* which was later affirmed by the Sixth Circuit, has been offered as an example of a "pure" manifestation theory. There, the court stated that the date of manifestation is "the date on which the condition became known or should have be-come known to plaintiff or the date on which plaintiff's condition was medically diagnosed, whichever comes first." The distinction between the two formulations is hard to detect, if it even exists. The date on which the presence of a disease "should have been known" by the claimant is likely to be near the date that symptoms impairing a sense of well being were first experienced, even if the claimant did not understand the message of the symptoms on that date, and this date is likely to be near the date on which the disease is capable of being diagnosed. The manifestation approach is difficult to articulate, but it appears to require some sort of overt signal that a disease is present, even if the claimant does not understand the signal's significance.

So understood, the manifestation rule provides relatively narrow coverage. Liability tends to fall on the small group of insurers that provided coverage when the existence of a disease becomes obvious, which is likely to be the same time the disease is diagnosed on a widespread basis. This tends to allocate losses to the more recent policy years. Furthermore, once diagnosis of a disease becomes widespread, policy cancellations are likely. This leaves policyholders unprotected against future claims for injury, which often means that the liability falls upon the insured. If this scenario develops, insured’s reasonable expectations of coverage are likely to be completely destroyed.

Under the "exposure rule," exposure to the injury-causing substance triggers coverage. All insurers who provided coverage while exposure occurred, whether it be the first exposure or a continuing exposure, must contribute to reimbursing the insured's tort liability. This approach was adopted by the Sixth Circuit in *Insurance Co. of North America v. Forty-Eight Insulations, Inc.*, the first federal appellate court decision to address insurance coverage issues in

the asbestos context. INA sought a declaratory judgment that coverage for injury under its CGL policies should be determined according to the manifestation rule. The policyholders urged the exposure rule instead, and the court approved this test. At one point, the court seemed to understand the time of inhalation as the time of exposure, but at a later point in the opinion the court referred to the period of inhalation combining with continuing injury thereafter. Despite this ambiguity in *Forty-Eight Insulations,* the exposure rule has been approved by other courts, most notably by the Fifth Circuit in *Porter v. American Optical Corp.*

The differences between the manifestation rule and the exposure rule are apparent. Unlike the manifestation rule, the exposure rule does not enable insurers to escape their obligations once a disease is diagnosed on a widespread basis. If the claimant was exposed to the injury-producing substance while the policy was in force, the claimant is entitled to coverage. Moreover, if exposure continued over a long period of time while several different policies were in effect, each policy provides coverage.

The exposure rule takes a broader approach to coverage, but it does not necessarily follow that the rule coincides with the reasonable expectations of insureds. Many insureds no doubt believe that when they purchase coverage, protection has been secured from all liability caused by their products, including unknown injuries resulting from exposure to products during the period prior to coverage. Until the statute of limitations runs, insureds are potentially liable in tort for injuries resulting from pre-coverage exposures; insureds who expect that their liability coverage is coextensive with their zone of liability for unintentional torts Buffer from a misapprehension under the exposure rule, which does not provide this coverage.

The "injury-in-fact" approach is not a simple one to understand. Under one formulation, an injury-in-fact occurs and coverage is triggered when the body's defenses are "overwhelmed" and disability or premature death becomes inevitable. Under this formulation, the injury-in-fact definitely comes later than the exposure, and often comes later than the manifestation. Yet if the injury-in-fact is treated as an abnormality which need not be understood by the claimant or diagnosed, the injury-in-fact may even precede the manifestation. Whenever the injury-in-fact occurs, insurers on the risk after the date of actual injury are bound to provide coverage. Thus, if the insured has switched insurers from time to time, this approach tends to diffuse the coverage among various insurers. The Second Circuit, according to its decision in *American Home Products Corp. v. Liberty Mutual Insurance Co.,* purports to adhere to the injury-in-fact rule. *American Home* arose out of claims based on the use of six different pharmaceutical products, including DES, oral contraceptives, and Anacin. The district court rejected both the exposure and manifestation theories of coverage and ruled that an occurrence of "personal injury, sickness or disease" is read to mean any point in time at which a finder of fact determines that the effects of exposure to a drug actually resulted in a diagnosable and compensable injury. Depending upon the facts of each case, the drug involved, the period and intensity of

exposure, and the person affected, an injury may occur in this sense upon exposure, at some point in time after exposure but before manifestation of the injury, and at manifestation.

On appeal, the Second Circuit disapproved of the district court's use of the terms "diagnosable" and "compensable," and deleted those terms from the judgment, but it otherwise affirmed the district court's decision:

> First, no clause in the policy uses either of those terms or any equivalents. Second, compensability is a legal concept that is not material to the determination of whether an injury has in fact occurred;. . .Diagnosability need not coincide with the actual occurrence of injury; to add the requirement that an injury be diagnosable limits the scope of the "injury-in-fact" trigger-of-coverage clause in a way that is not justified by the policies' language. . . . To paraphrase the district court's analysis rejecting the manifestation theory, "a real but undiscovered injury, proved in retrospect to have existed at the relevant time, would establish coverage, irrespective of the time the injury became [diagnosable]."

The injury-in-fact approach has been approved by other courts as wel1. The disadvantage of this approach is that determining when the body's defenses were overwhelmed or when a "real injury" first arose requires expert testimony. With respect to many diseases, including asbestosis, it is difficult for a doctor to state accurately when the disease developed to a point that it became an "injury-in-fact." In practice, however, the rule probably serves merely to provide the opportunity to the insured (or claimant) to establish that the bodily injury occurred prior to the manifestation. When a disease is diagnosed or becomes manifest, it may be possible to infer that the harm must have begun sometime before. If the insured can show that the prior exposure caused a medical injury (not necessarily a diagnosable injury), the insured would be entitled to coverage under policies in force before the date of manifestation.

The fourth approach is the "multiple-trigger approach," which combines the coverage of the various individual approaches. This approach views progressive diseases as cases of continuous injury; any insurer that was on the risk during the progression is liable. This is the broadest of the various approaches; it makes all insurers that ever provided coverage potentially liable for indemnification.

The leading case espousing this approach is *Keene Corporation v. Insurance Co. of North America,* in which the United States Court of Appeals for the District of Columbia circuit considered when an injury due to asbestos exposure and inhalation occurred. The court said the policy did not clearly point to either manifestation or exposure as the triggers of coverage. Therefore, the court interpreted bodily injury to mean "any part of the single injurious process that asbestos-related diseases entail," including inhalation, development of the disease after inhalation, and manifestation of the disease.[43] Further, the court held that once an insurer's policy is triggered, the insurer is required to defend and indemnify a policyholder to the extent of the entire policy limits, without proration, even though part of the injury occurred when the policyholder was self-insured.[44] However, only one

policy's limits apply to each injury, and the policyholder may select the policy under which it desires to be indemnified. If more than one policy applies to the loss, the "other insurance" clauses of the policies provide the method for apportioning the insurers' liability among the various insurers." A number of courts have followed the *Keene* approach. Cases such as *Keene* reveal that the relief-granting powers of the courts are limited. The question actually confronted in *Keene* was a basic one: in circumstances where the assets of an industry are inadequate to remedy all of the injuries it has caused, to what extent should the risk be transferred to insurers? The court decided to transfer the maximum amount of risk to insurers by applying a multiple-trigger approach, thus making available to victims the deepest-possible pocket of financial relief, subject only to the limitation that one policy's limits apply to each injury, which prevents the insured from obtaining more coverage than that purchased. Despite the far-reaching potential of such a remedy, the available funds, consisting of both manufacturer and insurer assets, are, according to some analysts, insufficient to provide compensation for all present and future asbestosis claims.

The American legal system presumes that persons injured by defective products should be compensated for their injury, and that the producers of such products should provide the compensation. The assumption is that liability will deter manufacturers from producing harmful products and distributing them in the marketplace. The American system also contemplates that manufacturers can transfer their liability for damages, whether based on a finding of negligence or imposed under a strict liability doctrine, to an insurer. If the insurance is priced according to the underlying risk, manufacturers who tend to send dangerous products into the marketplace end up paying more for insurance. For most kinds of liabilities, this system, although far from ideal, is at least functional; injured parties are compensated for their losses to some extent. However, some kinds of injuries — asbestosis, for example — are so widespread and so expensive that the total potential liability is too great for either the insurers or the industry to manage. If the total cost of asbestosis claims exceeds the combined assets of both the manufacturers and their insurers, it is inevitable that some victims will never be compensated, unless the federal government is prepared to help pay some of the claims by in effect spreading the risk across the entire nation through the taxing power. In short, the problem of how to compensate victims of occupational illnesses, toxic torts, and other similar hazards is a profound one, and workable solutions are elusive.

Robert H. Jerry II, "*Understanding Insurance Law*"; Matthew Bender & Co., New York, 1987, Pages 333 and followings.