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Torts, Insurance & Compensation Law Section Journal

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of the New York State Bar Association

In this issue...

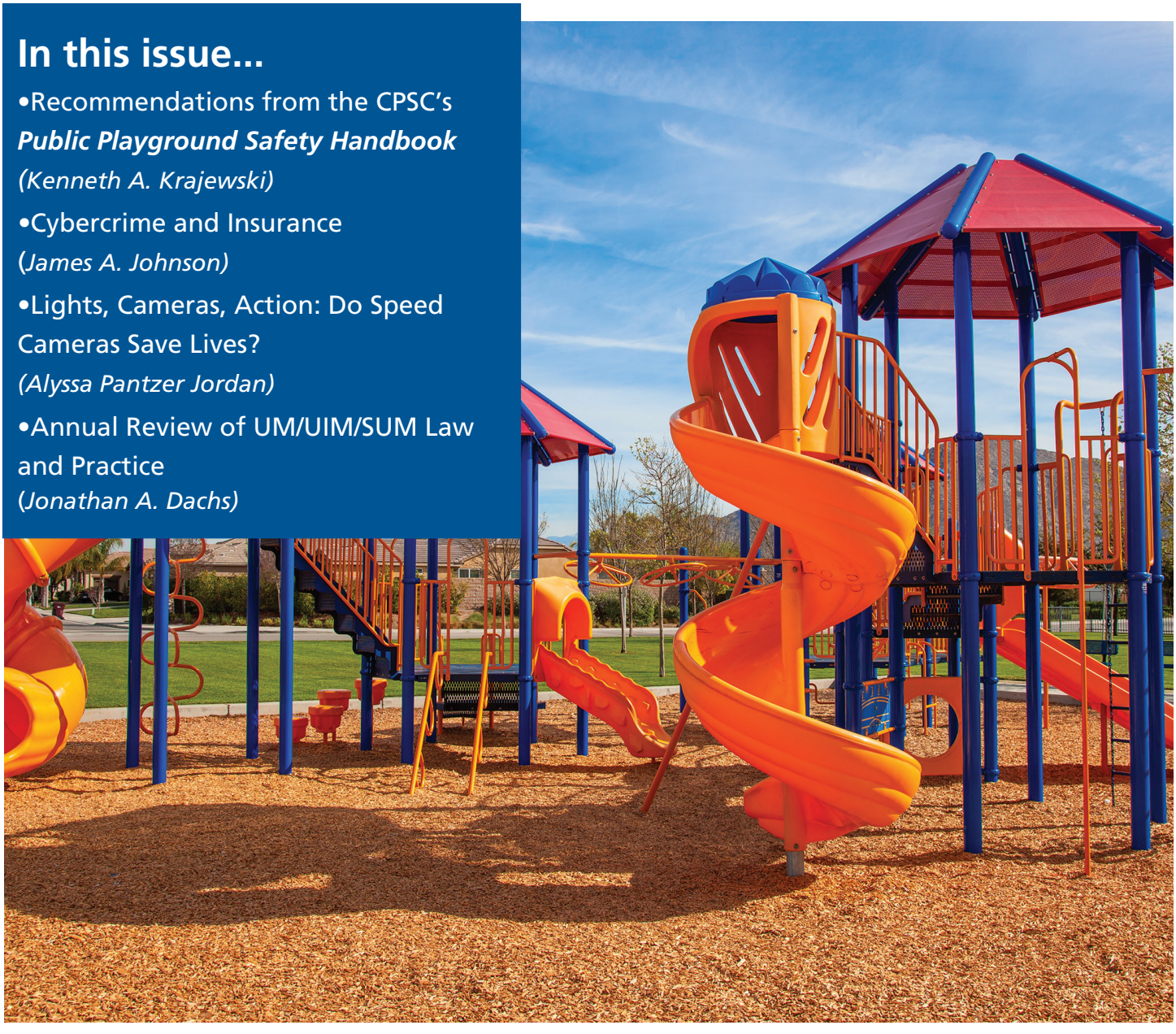

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Table of Contents

Vol. 48, No. 1

Page

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Message from the Chair

As is the tradition of our Section, I took over as Chair of the Section after the events concluded at the New York State Bar Association Annual Meeting in New York City in January.

Please allow me the courtesy of offering the Section's gratitude to immediate Past Chair Tim Fennell. For many years, Tim has been active in our Section and the Executive Committee for our Section. So, he was a natural to serve this past year as Chair. His institutional knowledge of the Section's history was invaluable. His year as Chair included a terrific trip to the Powerscourt Resort in Enniskerry, Ireland in late July. The program included fantastic CLE including several panels moderated by Professor Patrick Connors of Albany Law. The seminar guests, including NYSBA's then-President, Michael Miller, and his wife, Cindy, enjoyed our trip to Dublin, which included an authentic Dublin pub tour, a tour of Trinity College, and a meeting with Ireland's Chief Justice, Frank Clarke, at the Four Courts. After our meeting with Chief Judge Clarke, we adjourned to "The Sheds Bar" at the Distillery Building for a reception with Irish barristers and solicitors. It was a great meeting for our Section!

In April, our Section sponsored the New York State Bar Association's Young Lawyers Section Trial Academy at Cornell Law School in Ithaca, New York. This program has been successfully run for many years. The Section's sponsorship allows one Section member to attend as a "scholarship winner." This year, an attorney from the Capital District (Albany) attended as TICL's scholarship award winner. Hopefully, an article will follow about his experiences in a future issue of the *TICL Journal*.

In early May, the New York State Bar Association's Executive Staff and Officers, including President Hank Greenberg, hosted the Section Leadership Conference at the State Bar Center. On behalf of the Section, I attended with Section Secretary Mike O'Brien and Section Past Chair Tom Maroney. It was exciting to hear of the future changes coming to the NYSBA. Takeaways from the meeting included how other Sections are more effectively using social media platforms to promote their Section activities, and membership efforts to identify and recruit active NYSBA members whose practice areas align with our Section, but who are not yet Section members.

More recently, I attended the NYSBA Commercial and Federal Litigation Section's "Smooth Moves" Diversity Program at Lincoln Center. Our Section was one of eight sponsoring Sections from the NYSBA. The program included a 90-minute CLE entitled "The Color of Neutrality: Increasing Diversity in Alternative Dispute Resolution." Following the CLE program, the Honorable George Bundy Smith Award was presented to Honorable Preet Bharara and Honorable Joon Kim, former U.S. Attorneys of the Southern District of New York.

James P. O'Connor

Speaking of CLE, many thanks to Lisa Smith for co-chairing our full-day CLE held in conjunction with the Trial Lawyers Section at the January Annual Meeting of the NYSBA. Also, many thanks to TICL Executive Committee members Joanna Roberto and Elizabeth Fitzpatrick for continuing to co-chair TICL's CLE efforts. Many programs are being offered in the summer and fall.

Thanks are also in order to *TICL Journal* Editor David Glazer, for his many years of service to the Section. I hope you enjoy this issue. The subject matter of the articles includes: indemnification in labor law construction cases; a review of the law relating to school traffic cameras; cybercrime; litigation from playground accidents, and workers' compensation. Great work by the authors.

James P. O'Connor

Message from the President

Diversifying the Legal Profession: A Moral Imperative

By Hank Greenberg

No state in the nation is more diverse than New York. From our inception, we have welcomed immigrants from across the world. Hundreds of languages are spoken here, and over 30 percent of New York residents speak a second language.

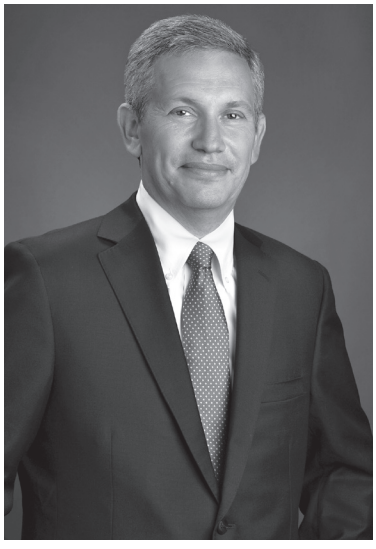
Our clients reflect the gorgeous mosaic of diversity that is New York. They are women and men, straight and gay, of every race, color, ethnicity, national origin, and religion. Yet, the law is one of the least diverse professions in the nation.

Indeed, a diversity imbalance plagues law firms, the judiciary, and other spheres where lawyers work. As members of NYSBA's Torts, Insurance and Compensation Law Section, you have surely seen this disparity over the course of your law practices.

Consider these facts:

- According to a recent survey, only 5 percent of active attorneys self-identified as black or African American and 5 percent identified as Hispanic or Latino, notwithstanding that 13.3 percent of the total U.S. population is black or African American and 17.8 percent Hispanic or Latino.
- Minority attorneys made up just 16 percent of law firms in 2017, with only 9 percent of the partners being people of color.
- Men comprise 47 percent of all law firm associates, yet only 20 percent of partners in law firms are women.
- Women make up only 25 percent of firm governance roles, 22 percent of firm-wide managing partners, 20 percent of office-level managing partners, and 22 percent of practice group leaders.
- Less than one-third of state judges in the country are women and only about 20 percent are people of color.

This state of affairs is unacceptable. It is a moral imperative that our profession better reflects the diversity of our clients and communities, and we can no longer accept empty rhetoric or half-measures to realize that goal. As Stanford Law Professor Deborah Rhode has aptly observed, "Leaders must not simply acknowledge the importance of diversity, but also hold individuals accountable for the results." It's the right thing to do, it's the smart thing to do, and clients are increasingly demanding it.



Hank Greenberg

NYSBA Leads On Diversity

On diversity, the New York State Bar Association is now leading by example.

This year, through the presidential appointment process, all 59 NYSBA standing committees will have a chair, co-chair or vice-chair who is a woman, person of color, or otherwise represents diversity. To illustrate the magnitude of this initiative, we have celebrated it on the cover of the June-July *Journal*. [www.nysba.org/diversitychairs]

Among the faces on the cover are the new co-chairs of our Leadership Development Committee: Albany City Court Judge Helena Heath and Richmond County Public Administrator Edwina Frances Martin. They are highly accomplished lawyers and distinguished NYSBA leaders, who also happen to be women of color.

Another face on the cover is Hyun Suk Choi, who co-chaired NYSBA's International Section regional meeting in Seoul, Korea last year, the first time that annual event was held in Asia. He will now serve as co-chair of our Membership Committee, signaling NYSBA's commitment to reaching out to diverse communities around the world.

This coming year as well we will develop and implement an association-wide diversity and inclusion plan.

In short, NYSBA is walking the walk on diversity. For us, it is no mere aspiration, but rather, a living working reality. Let our example be one that the entire legal profession takes pride in and seeks to emulate.

Hank Greenberg can be reached at hgreenberg@nysba.org.

Cybercrime and Insurance

By James A. Johnson

The internet is a part of our daily lives. Almost anything you do on the internet can be observed by other people. Advancement in computer technology creates new kinds of insurance risks. Enter cybercrimes that create new and different insurance policy forms. When a new risk emerges so too do new coverage issues. For example, how do intentional act exclusions apply to computer crimes? Cybercrime is a new body of insurance law that is constantly evolving.

Cybercrime is an emerging risk evidenced by a bevy of news stories of hacking involving Equifax, Yahoo, J. P. Morgan, Target, American Express, Kmart and many other companies. A hacker is one who uses programing skills to gain illegal access to a computer network or file.[1] The purpose of this article is to highlight effective procedures to protect a company or law firm against the theft of its data. Law firms and companies should make a thorough review of their computer use policies, including training, to ensure that employees have no expectation of privacy in using company computer systems.

> "A lawyer must act competently to safeguard information relating to the representation of a client against inadvertent or unauthorized disclosure by the lawyer. "

Cyber liability coverage is an important part of an insurance package to protect against claims that client information has been disclosed. Even data stored in the cloud is hard to protect because it is difficult to detect a breach. Also, Dropbox, Evernote and Google have experienced data breaches. Dropbox was hacked in 2012, Evernote and Google were hacked in 2014. Cybercrime is so prolific it requires law firms to make hard choices as to insurance coverages and what kind of backup system to employ to protect data.

Commercial general liability (CGL) polices specifically exclude data. Cybercrime policies are specifically tailored policy provisions and claims involve intentional bad acts. But, by whom? The hacker or the policyholder? In *Lambrecht & Assoc's, Inc. v. State Farm Lloyds*, the court held that a hacker acted intentionally and not the policyholder. Thus, the injury was not intended by the policyholder and there was coverage.[2] A question of coverage arises when criminals give bad information that is legally entered into the policyholder's computer. In *Hudson United Bank v. Progressive Cas. Co.*, the court held hacking coverage did not apply because there was no actual breaking into the computer. Fraudulent data entry was not recoverable because data was not entered into the covered computer. This case demonstrates the difference between hacking a computer and using a computer.[3]

Coverage

Computer-specific policies provide specific grants of coverage. Coverage is limited to defined persons, acts and injuries. A common question in cybercrime claims is whether the policy applies to acts of the person who used the computer to cause the injury. Computer-specific polices often limit coverage to the bad acts of the person who are *not authorized* and *exclude acts by employees*.[4] In *Universal American Corp. v. National Union Fire Insurance Co. of Pittsburgh, PA*,[5] a computer systems fraud policy covered "loss resulting directly from a fraudulent entry of Electronic Data." The insured, a health insurer, lost $18 million from fraudulent claims submitted by providers who entered fraudulent information. The pivotal question was the meaning of *fraudulent entry*. The court held for the insurer based on the word *entry* which is the act of entering data.

Another question facing cybercrime insurance is the issue of whether the injury comes within the definition of property damage. Specifically, is data physical or tangible? Some insureds have established physical damage by tying data to hardware.

Claims under computer policies involve a causation issue. Coverage in most cases is limited to losses directly related to some type of bad act on a computer. In *Retail Ventures, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, criminals used computers to steal credit card information and then stole from the accounts. The losses resulted from a computer hacking scheme that compromised customer credit card and checking account information. The Sixth Circuit held that the losses resulted directly from computers used by the criminals, but the computers were not used to carry out the crimes.[6]

Law Firms

Law firms are prime targets for cybercrimes. It is your data that cybercriminals and hackers want. A lawyer must act competently to safeguard information relating to the representation of a client against inadvertent or unauthorized disclosure by the lawyer. Special circumstances may warrant special precautions depending on the sensitivity of the information. Law firms should use encryption to protect confidential information. Encryption is increasingly required in areas such as banking and health care by virtue of reported hacking in these industries.

Ransomware encrypts your data and follows with a demand for payment to get your data back. Training your employees not to click on suspicious email, attachments or links is your first defense. Have a strong password consisting of uppercase and lowercase letters, symbols and numbers. And change your passwords every five months. Hackers do research on law firms and may know about your existing cases and the names of principal attorneys. How many times have you seen in an email referencing a specific case and saying: "Please forward document....; the next hearing set for the 18th has been rescheduled or you do not have to appear at the summary judgment hearing set for the 10th because the court will decide on the pleadings before it." For those of you who have not received such emails, you certainly will in the future. Also have a backup system in place to avoid any significant data loss. Moreover, employees should be required to strictly adhere to company policies on personal use of company computers with severe consequences. Some studies suggest employees are rogue by nature and steal your data and often bring their own devices, which can infect your network.

Cybersecurity Training

Hire a third party consulting firm that does cybersecurity training. Large law firms can afford hiring a consulting firm. Smaller firms with investigation can find companies that do cybersecurity training within their budget. Make it mandatory for employees to attend training sessions. Trainers must explain to employees why security policies are needed and must be enforced. The importance of encryption on all devices and emails should be emphasized.

Also training is needed to avoid negligent handling of documents by attorneys or employees that can compromise a case in disclosing confidential information. For example, in *Harleysville Ins. Co. v. Holding Funeral Home, Inc*. the defendant uploaded privileged documents into a cloud file sharing account that was not protected by a password. Opposing counsel found the hyperlink, accessed the account and downloaded and read the documents.[7] Harleysville Ins. Co. filed a motion to disqualify opposing counsel that was denied. Harleysville failed to redact an email and opposing counsel discovered the hyperlink. The court held that Harleysville waived both the attorney-client privilege and the work product doctrine.

Although the court found that Harleysville's disclosure was inadvertent under Virginia law, intent is not determinative. Using the Supreme Court of Virginia's five-factor test, it concentrated on the reasonableness of the precautions to prevent inadvertent disclosure. The court opined that the investigator had taken no precautions to prevent the files disclosure.[8] In addition, the court noted, the investigator left the files accessible in the account for six months and therefore waived the attorney-client privilege.[9]

Harleysville's work product privilege claim is governed by Federal Rule of Evidence 502(b). This rule states that an inadvertent disclosure does not operate as a waiver if…

> The disclosure is inadvertent;
>
> The holder of the…… protection took reasonable steps to prevent disclosure; and
>
> The holder promptly took reasonable steps to rectify the error, including….. following Federal Rule of Civil Procedure 26(b)(5)(B).

Rule 502 requires that the proponent bears the burden of proving that each of the rule's elements are met. The court held that Harleysville's information release did not qualify as inadvertent under federal law. The court reasoned that Harleysville did not argue that its investigator acted unintentionally. Moreover, Harleysville took no measures to prevent and remedy the disclosure.

Company Policies

A company or law firm can easily spell out what is forbidden through a compliance code, employee handbook or employee agreements. Whether an employee has an expectation of privacy on the company computers can be a critical issue when it is suspected that an employee may have stolen company data. Clearly define the computer systems covered by the policy encompassing the technology used such as text messaging, removable flash drives and disks. Spell out precisely the scope of an employee's permissible authorization to the company computers. Make clear that all data created in furtherance of any personal use belongs to the company and will be monitored by the company and will not be confidential. Make certain by specific language that employees have no expectation of privacy in using the company computer systems and delineating the scope of the employee's permissible access to the company's computers.[10]

Cybercrimes

As technology continues to advance with mobile devices, so do efforts to better protect content from unauthorized access. In addition to its existing privacy features, WhatsApp also encrypts voice calls.[11] This accelerated development revolves around the Apple/FBI dispute and accessing encrypted data in the iPhone iOS. The Fifth Amendment of the U. S. Constitution guarantees that no person shall be compelled in any criminal case to be a witness against himself. So, compelling a defendant to divulge a passcode on a mobile device is protected. Such evidence is testimonial or communicative.[12] Therein lies the current problem in which the government cannot force an accused to reveal knowledge of facts or share his thoughts or beliefs relating him to the offense that may incriminate him.[13] But, what about using a fingerprint is that a physical characteristic not protected by the Fifth Amendment? The answer to this question is a topic for another day.

The Fifth Circuit Court of Appeals in *Apache Corp. v. Great American Ins. Co.*, held that losses from social engineering scams by business emails are not covered by computer fraud provisions of commercial crime insurance policies. Scammers pretended to be a vendor of Apache and called one of its employees with new bank wiring instructions and then followed up the call with an email on the purported vendor's letterhead. Apache sent $7 million to the scammers.

Apache made a claim under the "Computer Fraud" provision of its commercial crime insurance policy based on the position that the email caused the transfer of funds. However, this provision covered losses *resulting directly from the use of any computer to fraudulently cause a transfer of funds. The use of the email was incidental to the transfer.*[14]

Effective September 1, 2017, the Texas Cybercrime Act amended the criminal version of the Texas hacking law, the Breach of Computer Security[15] section of the Texas Penal Code, to make certain that the methods of cyberattacks criminals currently use are prohibited by statute. Thus, malware and ransomware attacks are specifically prohibited by Texas statute. Also these attacks are prohibited by the federal Computer Fraud and Abuse Act.[16]

Lawyers engaging in business in Texas have cybersecurity and data privacy duties to implement and maintain reasonable procedures to protect personal information they collect or maintain.[17] Also, they must follow data destruction procedures[18] and notify any individual whose electronic sensitive personal information was or is reasonably believed to have been acquired by an unauthorized person.[19]

Cybercrime liability is a new body of insurance coverage law that is constantly evolving in New York State and nationwide. For example, commencing January 1, 2019, insurers doing business in the state of South Carolina are required to have a comprehensive information security program that protects consumer data. They are required to investigate breaches and notify regulators within 72 hours of a cyber event that affects more than 250 state residents.[20]

American Bar Association

The American Bar Association on Oct. 17, 2018 issued Ethics Opinion 483 titled Lawyers' Obligations After an Electronic Data Breach or Cyberattack. Opinion 483 requires lawyers to address cybersecurity and data privacy issues.[21] Ethics Opinion 483 defines a data breach as a data event where material client confidential information is misappropriated, destroyed or otherwise compromised.[22]

Conclusion

Cybersecurity intersects substantially with national security, giving rise to complex questions of policy and law. Lawyers have an ethical duty to safeguard confidential information. A first line of defense in protecting company or law firm data is to create an effective computer policy that protects the company or firm against the theft of its data by its own employees.

Lawyers need to be aware of how little privacy there is on the internet if you are not using encryption. Some type of encryption should be used when sending confidential information over the internet. Encryption can also keep anyone from seeing where you browse on the web.

Advancement in computer technology creates new kinds of insurance risks. Cybercrimes create new and different insurance policy forms. When a new risk emerges so too does new coverage issues. Cybercrime liability is the new body of coverage law. Cybercrime claims implicate new policy forms and terms. An effective cybersecurity policy should be a primary policy. A primary policy responds first. A common coverage question in cybercrimes is whether the policy applies to the acts of the person who used the computer to cause the injury. Computer-specific policies often limit coverage to bad acts of persons who are not authorized and acts of employees are excluded.

Computer fraud occurs when someone hacks or obtains unauthorized access or entry to a computer in order to make an unauthorized transfer. In cybercrime insurance, it appears that computer fraud coverage requires more than a criminal using a computer. The criminal must use the computer to cause the fraud. A combination of computer-specific policies, encryption technology and employee training should be in place to prevent cybercrimes and data loss.

Equifax is experiencing a tidal wave of class action litigation for a data breach in exposing the sensitive per-

sonal information of 143 million customers in the United States and abroad. This should be notice enough as to the importance of cybersecurity.

James A. Johnson of James A. Johnson, Esq., is an accomplished trial lawyer in Southfield, Michigan. Mr. Johnson concentrates on insurance coverage under the commercial general liability policy, serious personal injury, sports and entertainment law and federal crimes. He is an active member of the Massachusetts, Michigan, Texas and Federal Court bars and can be reached at www.JamesAJohnsonEsq.com.

ENDNOTES

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Taher or Not *Taher*, That Is the Question: Whether the Workers' Compensation Board Is to Follow the Appellate Division or Attempt to Distinguish It Away

By Ronald Balter

It had been understood for years that if a claimant sustained an injury to a body part or system that was not included in Workers' Compensation Law § 13(3)(a) through § 15(3)(t) (schedulable sites) as well as one of the schedulable body parts, and there was any ongoing disability, whether temporary or permanent, the injured worker could not receive the award for any permanent disability for any of the schedulable body parts. There was one exception to this rule and involved a permanent disfigurement.[1] This was true even if the injured worker was found to have a permanent partial disability and was not entitled to an award for the permanent partial disability for any reason.

Forty-five years ago, the Appellate Division[2] ruled that a claimant who was found to have a mild permanent partial disability and was working without any reduced earnings was entitled to be awarded and paid benefits for a permanent facial disfigurement.[3] The court also indicated that if the claimant were to make a claim in the future for awards for lost time, that the workers' compensation carrier would be entitled to take credit for the value of the facial disfigurement that was awarded ($850).[4] There does not appear in *Gallman* any reason as to why the same principle should not apply if any of the other schedulable injuries were involved. It was just conventional wisdom that for some reason facial disfigurements were treated differently from all of the other schedulable sites.

As in politics, the conventional wisdom is not always correct. In 2018, the Appellate Division was faced with the issue as to whether or not the *Gallman* doctrine should apply to all of the other schedulable sites of injuries in Workers' Compensation Law § 15(3) and ruled that *Gallman* applied to all schedulable injuries in *Taher v. Yiota Taxi, Inc*.[5]

Mr. Taher sustained injuries to his neck, back, right knee and right shoulder. He later went back to work earning at least his pre-accident wages. Eventually both Mr. Taher and the workers' compensation carrier obtained reports indicating varying opinions on permanency to all of the sites of injury. After litigation, the law judge found that the claimant had a permanent partial disability but refused to award a scheduled loss of use for the permanent disability in the right leg and right arm. On appeal the Board Panel affirmed that the claimant could not receive the scheduled loss of use awards because he was found to have a permanent partial disability, as a result of the injuries to the neck and back.

Although schedulable injuries are technically an award for a permanent partial disability, they are treated differently from a non-schedulable injury that results in a permanent partial disability. They are different in that an award is payable for the schedulable injury regardless of whether there is lost time from work. A person who sustains a 10% scheduled loss of use of an arm is entitled to an award for 31.2 week of benefits with or without lost time. If there is lost time, the workers' compensation carrier is entitled to a credit for the weeks paid for the lost time. If the person missed 13 weeks from work, they would be entitled to only an additional 18.2 weeks when the scheduled loss of use award is made.

A schedulable award and a non-schedulable award are both paid to compensate an injured worker for loss of wage-earning capacity. Both awards are not paid simultaneously because that would amount to duplicative compensation. However, in determining the loss of wage earning capacity, all injuries are taken into account. The Appellate Division in *Taher* then indicated that after a finding of a permanent partial disability and a finding of loss of wage-earning capacity, a determination must be made as to whether the claimant is entitled to awards for the permanent partial disability under Workers' Compensation Law § 15(3)(w). If they are not entitled to such an award at that time, then they can be awarded the scheduled loss of use award(s). The Appellate Division was quite clear that if there was ever a claim in the future for the non-schedulable award, the workers' compensation carrier would be entitled to a credit for the monies paid for the scheduled loss of use award before having to pay any additional money to the claimant.[6]

As stated earlier, this changed the conventional wisdom as to what benefits can be awarded to an injured worker when they are working without any claim for a permanent partial disability award. Under *Taher,* cases would proceed through the workers' compensation system as they always have. When it came time for a finding of permanency the parties would now have to obtain reports of permanency that included not only severity rankings for non-schedulable sites but the report would also have to include opinions on the percentage of scheduled loss of use for any schedulable sites of injury. Testimony would be taken from the doctors and the claimant on loss of wage-earning capacity. The law judge would then fix a percentage of loss of wage-earning capacity that would entitle the claimant to a set number of weeks of benefits[7] under Workers' Compensation Law § 15(3)(w). Now the

law judge would have to also determine if the claimant was entitled to an award for the non-schedulable permanent partial disability. If the injured worker was not entitled to an award for the permanent partial disability, the law judge would have to make a determination as to the scheduled loss of use and award that benefit to the claimant at that time.

This affirmation of the principles in *Gallman* seemed simple enough and would change how these types of cases would be resolved at the Workers' Compensation Board. In the aftermath of *Taher,* injured workers began seeking awards in accordance with *Taher*. However, the Workers' Compensation Board did not agree with the decision in *Taher*[8] and has tried avoid its implications for the making of awards to injured claimants for their permanent schedulable injuries. When the issue arose, the Workers' Compensation Board tried to distinguish the subsequent cases from *Taher*.

The Workers' Compensation Board has stated that *Taher* does not mandate a finding of a scheduled loss of use if there is a permanent partial disability as a result of other injuries in the case.[9] This is a direct contradiction and rejection of the result in *Taher*. Post-*Taher*, a law judge must make both determinations as to permanent partial disability and scheduled loss of use. If a finding is made that the claimant has a permanent partial disability, then after a loss of wage-earning capacity determination is made and an additional finding that the injured worker is not entitled to a permanent partial disability award, they then are entitled as a matter of law to a scheduled loss of use award as a matter of law. The language used by the Workers' Compensation Board seems to argue that such findings are not to be made and in practice. This is also what some law judges are indicating to litigants before the Workers' Compensation Board.

The Workers' Compensation Board has sought to distinguish the subsequent cases from *Taher* because of the Workers' Compensation Board's new guidelines[10] to determine the percentage of a scheduled loss of use (hereinafter the *2018 Guidelines*) that an injured worker sustained. These new guidelines were mandated by the legislature in a bill to reform workers' compensation that was enacted in 2017.[1112]

In *Trevi Nail Corp*.,[13] the Workers' Compensation Board sought to use the *2018 Guidelines* as the basis for not applying *Taher*. The Board Panel in reaching its decision cited the *2018 Guidelines*' language about when a scheduled loss of use award could be made in a case when there were also injuries to nonschedulable injuries. The language in the *2018 Guidelines* cited by the Workers' Compensation Board is:

> No residual impairments must remain in the systemic area (i.e., head, neck, back, etc.) before the claim is considered suitable for schedule evaluation of an extremity or extremities involved in the same accident.[14]

The Workers' Compensation Board believes that this language is new to the determination of permanency and the findings of a scheduled loss of use. However, it is not new language. Prior to the *2018 Guidelines,* the Workers' Compensation Board used the *New York State Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity* (December 2012)[15] (hereinafter the *2012 Guidelines*). Before that, the Workers' Compensation Board used the *Medical Guidelines 1996* (hereinafter *1996 Guidelines*).[16]

The *2012 Guidelines* used the following language as to when a scheduled loss of use could be awarded if there were also nonschedulable injuries involved in a claim:

> No residual impairments must remain in the systemic area (i.e., head, neck, back, etc.) before the claim is considered suitable for schedule evaluation of an extremity or extremities involved in the same accident.[17]

In the original *1996 Guidelines,* the following language was used:

> No residual impairments must remain in the systemic area (i.e., head, neck, back, etc.) before the claim is considered suitable for schedule evaluation of an extremity or extremities involved in the same accident.[18]

One of the Workers' Compensation Board's ways to avoid implementing *Taher* is baseless as the new *2018 Guidelines* have only reused the *exact* same 33 words that the Workers' Compensation Board has used since 1996. Although the *2018 Guidelines* made significant changes in determining what the percentage loss of use for injuries is supposed to be, it made absolutely no changes as to when a scheduled loss of use can be awarded to a claimant.

On the same day that the Appellate Division decided *Taher*, it also decided *Tobin v. Finger Lakes DDSO*.[19] The issue in *Tobin* was totally different fromthe issue in *Taher*. The issue in *Tobin* was whether the claimant's injuries were subject to a scheduled loss of use finding or a permanent partial disability finding. The law judge in *Tobin* found that the claimant was entitled to awards for a scheduled loss of use and not for a permanent partial disability. That was appealed by the workers' compensation carrier and on appeal, the Board Panel found that the claimant's condition was not subject to a scheduled loss of use finding but that she had a permanent partial disability. When the Board Panel made the finding that the claimant had a permanent partial disability, they properly rescinded the scheduled loss of use findings and restored

the matter to the trial calendar for testimony on loss of wage-earning capacity. The court in *Tobin* favorably cited both *Taher* and *Gallman* in stating that the clamant cannot get both a permanent partial disability award and a scheduled loss of use award at the *same time*. In fact, depending upon the status of Ms. Tobin after the Workers' Compensation Board determines her loss of wage-earning capacity, she may in fact still be able to collect the scheduled loss of use awards as found by the law judge.

Going forward, to obtain a scheduled loss of use award under *Taher* it must be pointed out the to the Workers' Compensation Board that its subsequent interpretation and rejection of *Taher* is questionable. Arguments to the Workers' Compensation Board must be made to indicate that the language they cited from the *2018 Guidelines* is the exact same language that were in the prior *1996 Guidelines* and the *2012 Guidelines*. *Tobin* must also be distinguished by noting that the issue before the Board Panel and the Appellate Division was whether the conditions resulted in a permanent partial disability or whether a scheduled loss of use finding was appropriate. Until a determination is made in regard to loss of wage-earning capacity, it cannot be determined if the claimant will be entitled to receive the scheduled loss of use award as previously found by the law judge.

Taher was the logical continuation of the doctrine stabled in *Gallman* 45 years ago. There is no basis to try distinguishing its principles away by the Workers' Compensation Board. The Appellate Division has spoken, and its interpretation of the meaning of the Workers' Compensation Law is binding upon the Workers' Compensation Board.

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Endnotes

1. Workers' Compensation Law § 15(3)(t).
2. All references to the Appellate Division refer to the Third Department unless otherwise indicated because all appeals from the Workers' Compensation Board are filed in that Department per Workers' Compensation Law § 23.
3. *Gallman v. Walt's Tree Service*, 43 A.D. 2d 420 (1974).
4. *Gallman* at 421.
5. 162 A.D. 3d 1288 ,*motion for reargument or for leave to appeal denied,* 2018 NY slip OP 87845 (Unpublished) (2018).
6. *Taher* in footnote 2.
7. If the accident occurred before March 13, 2007 there was no durational cap on the length of time a claimant would be paid benefits if they were found to have a permanent partial disability and entitled to awards. They could be aid for the rest of their lives.
8. This can be seen by the fact that the Workers' Compensation Board filed a motion in the Appellate Division for reargument or for leave to appeal to the Court of Appeals. Both motions were denied by the Appellate Division.
9. See discussion of the *Trevi Nail* case below.
10. *Workers' Compensation Guidelines for Determining Impairment*, First Edition (November 22, 2017). The *Guidelines* are accessible at http://www.wcb.ny.gov/2018-Impairment-Guidelines.pdf. These new Guidelines are to be used in any case in which the first report of a scheduled loss of use was filed with the Workers' Compensation Board on or after January 1, 2018. See Subject Number 046-1011 (http://www.wcb.ny.gov/content/main/SubjectNos/sn046_1011.jsp) issued by the Workers' Compensation Board on December 28, 2017.
11. Workers' Compensation Law § 15(3)(x)
12. For a fuller analysis of the 2017 reforms, see Balter, Ronald, *Workers' Compensation Reform 2017: What? Again*? TICL Journal ,Vol 46, No. 1 page 13 (Fall 2017).
13. G156-8888 2018 WL 6132711, 2018 NY Wrk. Comp. LEXIS 11587 (November 15, 2018)
14. 2018 *Guidelines*, Chapter 15.
15. These are available at http://www.wcb.ny.gov/content/main/hcpp/ImpairmentGuidelines/2012ImpairmentGuide.pdf The *2012 Guidelines* are still used by the Workers' Compensation Board for determining severity rankings for non-schedulable injuries.
16. They are available at http://www.wcb.ny.gov/content/main/hcpp/mdguide.pdf.
17. *2012 Guidelines* Chapter 15.
18. *1996 Guidelines* Section C2.
19. 162 A.D. 3d 1286 (2018).

The Evolution of Contractual Indemnity in the Context of the New York Labor Law

By Sana Suhail

Claims for contractual indemnification often result in unavoidable actions involving third party practice in labor law. An example of a relatable scenario in this context may be outlined as follows: an owner and general contractor enter into a Construction Management Agreement for various renovation and installation work at a project site. The general contractor enters into subcontracts including a subcontract for the installation of HVAC systems. The subcontractor installer enters into yet another contract for HVAC insulation work. Each contract has indemnity provisions running in favor of the original contracting party with provisions requiring policies conferring additional insured status to the general contractor and the owner. This is done on the assurance that after endorsement, the additional insured will then be protected under the named insured's policy.[1] Plaintiff, an employee of the sub-subcontractor performing insulation work, falls from a ladder and brings a claim pursuant to Labor Law § 240(1) contending that he was not provided with a safe ladder. The general contractor and the owner are held strictly liable under Labor Law § 240(1) and seek to "pass through" that liability onto their subcontractor who seeks to do the same against the plaintiff's employer.

Due to Labor Law § 240's imposition of absolute liability on construction companies, property owners and/or contractors, regardless of fault, the attractive option for the insured is seeking contribution or indemnification from its contracting party, i.e., a pass through. A "flow-down," "flow-through" or "*pass-through*" clause is a contractual provision that incorporates by reference the terms of the prime contract into the subcontract. In other words, it is a risk-shifting tool. This article highlights some key cases on the subject, including recent cases from the First and Second Departments that reveal the direction courts will likely take going forward.

For purposes of this article, before summary judgment motion practice, insurers presumably have resolved whether a party qualifies for additional insured status. In the scenario presented above, theoretically, the subcontractor employer hired to perform the insulation work accepted tender of the general contractor and the subcontractor installer, perhaps with a reservations of rights, but nonetheless determined that the owner and general contractor qualify as additional insureds under the contract. The additional insureds would then be afforded the same protections as the named insured under the policy. A separate but related issue that will not be explored here is under what circumstances additional insured status may be assigned.[2] However, an often overlooked argument during summary judgment motion practice should be noted: when opposing a motion in which a general contractor seeks indemnification from a subcontractor despite the subcontractor's acceptance of the general contractor as an additional insured, it is always good practice to invoke the anti-subrogation rule, which prevents an insurance company from being subrogated to a claim against its own insured when the claim arises out of an incident covered under the policy which the insurer issued to the insured.[3]

A predecessor to the notable Court of Appeals decision in *Brooks v. Judlau*, 11 N.Y.3d 204, (N.Y.2008), the New York Appellate Division, Second Department in *Walsh v. Morse Diesel, Inc.* 143 A.D.2d 653 (2nd Dep't 1988) held that based on the language and purposes of the entire indemnification agreement between the scaffold manufacturer and the employer, the scaffolding manufacturer (Morse Diesel) was entitled to pursue a contractual indemnity claim against the employer (A&M). The indemnity clause in question provided "t]o the extent permitted by law [A & M] shall save and hold [Morse Diesel] harmless from and against all liability which arise[s] out of or [is] connected with any accident which happens about the place where the work is being performed (1) while [A & M] is performing the work, or (2) while any of [A & M's] personnel are in or about such place." In this case, then, the "intention to indemnify can be clearly implied from the language and purposes of the entire agreement." Following record evidence establishing that the accident of plaintiff occurred in an area where A&M's employees were working, the court determined there was no reason "not to enforce the indemnification agreement." Of particular note, the court held Morse Diesel should be allowed to benefit from its indemnification agreement *even in the absence of any proof of negligence on the part of A&M*. Yet, in line with *Brooks v. Judlau* and its progeny, the court determined it was A & M's burden to come forward with proof of facts sufficient from which one could infer actual negligence on the part of Morse Diesel, and in the absence of such proof, the limitation on the force of the parties' indemnification agreement stemming from General Obligations Law § 5-322.1 is inapplicable.

Requiring a causal connection between the proposed indemnitor's work and the accident is sound policy. Otherwise, indemnitors would be virtual insurers of all employees on the worksite, regardless of whether any action or inaction on their part contributed to the accident.[4]

In *Brown v. Two Exchange Plaza Partners*, 76 N.Y.2d 172, 556 N.Y.S.2d 1991 (1990), a general contractor was

held liable pursuant to Labor Law 240(1) as a result of a scaffold collapsing and the general contractor was found to be free of negligence, while another subcontractor, who erected the scaffold, was found to be negligent. The *Brown* court noted that it was interpreting a broad-based indemnification clause and in light of it, the subcontractor argued that the general contractor's indemnity clause was void and unenforceable under the General Obligations Law.

Brown can be distinguished from *Urbina v. 26th Ct. St. Assoc, LLC* 46 AD3d 268 (1st Dep't, Appellate Division, 2007), which involved an analogous, although not an identical fact pattern. In *Urbina*, the plaintiff was injured by the unexplained collapse of a scaffold erected by a subcontractor, but the inspection and upkeep of the scaffold was still the responsibility of the subcontractor after it left the site. When an indemnification provision in a construction contract provides that the obligation to indemnify is triggered by the "negligent acts, errors, and omissions" of the contractor, summary judgment against the contractor was denied, because it was necessary that the negligence of the contractor be established before indemnity was triggered.[5]

> "Requiring a causal connection between the proposed indemnitor's work and the accident is sound policy. Otherwise, indemnitors would be virtual insurers of all employees on the worksite, regardless of whether any action or inaction on their part contributed to the accident. "

What *Urbina* highlights is a significant category of indemnity agreement that includes agreements providing indemnity for accidents "arising out of" or "in connection with" the work to be performed irrespective of any fault on the part of the indemnitor. The Appellate Court, First Department, in *Urbina v. 26 Court Street Associates LLC,* 46 A.D.3d 268 (1st Dep't 2007) held that in order for a claim to "arise out" of a party's work, there must be a showing that a particular act or omission in the performance of such work was causally related to the accident.[6]

A related issue was presented in Velez v. Tishman Foley Partners, 666 N.Y.S.2d 591 (1997), in which the owner's liability to the injured plaintiff, an ironworker employed by a separate company, was based solely on its statutory liability under Labor Law § 240(1) with no factual showing whatsoever of any negligence on its part beyond the statutory liability. As was made clear in *Velez*, under the broadly worded indemnity provisions in question, once the owner was shown to be only statutorily liable, it became entitled to indemnity irrespective of whether the subcontractor indemnitor was negligent.

The next seminal case following *Brown* was *Itri Brick & Concrete Corp. v. Aetna Cas. & Sur Co.*, 89 N.Y.2d 786, 658 N.Y.S.2d 903 (1997), in which the Court of Appeals decided the issue of whether a general contractor, who had been found partially negligent, could enforce a broadly worded indemnification agreement under which full, rather than partial, indemnification was contemplated. The two agreements before the Court were both found to have been drafted in extremely broad terms. Under the facts of both cases decided by the Court of Appeals, the general contractor, who was seeking indemnity, was found to be partially negligent. Both indemnification clauses also required the subcontractor to indemnify the general contractor without limitation in the event that the general contractor was found to be negligent. The Court of Appeals noted that because both general contractors were found to be negligent, the indemnification agreements were unenforceab

As reflected by the Court of Appeals holding in *Brooks v. Judlau*, cited above, more recent cases have accepted broad indemnity provisions even though the injury to the plaintiff was caused, in part, by the active negligence of the party seeking indemnification, provided of course that the contract provides for indemnification "to the fullest extent permitted by law."

Appellate decisions on this topic can be cause for confusion. For example, in *Correia v. Professional Data Management Inc.*, 259 A.D.2d 60, 693 NYS2d 596 [1st Dep't 1999], the court stated that the "indemnitor's negligence . . . is irrelevant in the context of contractual indemnity . . ." This statement, although accurate in *Correia*, is not true for all cases. In *Correia*, the court was only dealing with the language of the indemnification agreement that did not require the indemnitor's fault as a necessary condition of the agreement. Thus, as stated by the Appellate Division, without full explication, the indemnitor's negligence in *Correia* was indeed irrelevant to its obligation to provide indemnity. The court precluded enforcement of a general contractor's indemnification clause which contained a savings clause, and required indemnification even if the general contractor was negligent in part for plaintiff's injuries.

With respect to partial indemnifications, appellate courts have also held that a provision stating "regardless of whether the claim is caused in part by a party indemnified hereunder" be included in a contract provision in order to permit partial indemnification. Such was the case in *Dutton v. Charles Pankow Builders, Ltd.*, 745 N.Y.S.2d 520 (1st Dep't 2002), where the First

Department, in a decision dated July 2, 2002, adopted a theory of partial contractual indemnification based on percentages of fault and the terms of the indemnity clause. A jury rendered a verdict in favor of two construction workers that apportioned liability as 20% against the general contractor and 80% against the subcontractor/employer. While the employer sought to void the indemnity clause on grounds that the clause impermissibly attempted to indemnify the general contractor for its own negligence in violation of the General Obligations Law, the court found that the clause called for "partial, not full, indemnification of the general contractor for personal injuries partially caused by its negligence, and is therefore enforceable."

The following will highlight some recent decisions on this topic to possibly forecast how courts may rule in the First and Second Departments. The Appellate Division, Second Department, in *Sullivan v. New York Athletic Club*, 2018 Slip Op. 04591, on June 20, 2018 held that a general contractor was entitled to dismissal of a claim for contractual indemnification and contribution insofar as the underlying causes of action asserted by the plaintiff were without merit (the general contractor was able to demonstrate through testimony that the means and methods of the work being performed by plaintiff was the responsibility of a subcontractor). The Second Department has more readily granted indemnity to parties based on a less stringent demonstration that the action arose without any active liability, than the First Department.[7]

Adopting the reasoning of *Correia, supra,* and its progeny of cases which require a finding of fault before indemnity is awarded, on May 22, 2018 the Appellate Court, First Department, held in *Radeljic v. Certified of N.Y.,* 161 A.D.3d 588, that in light of the issues of fact that exist as to the extent of defendant's liability for causing plaintiff's injuries, summary judgment on defendant's contractual indemnification claim against plaintiff's employer would be premature. Similarly, citing *Correia*, in a recent lower court case decided on July 6, 2018, *Saquicaray v. Consolidated Edison Co. of NY, Inc.,* 2018 N.Y. Misc. LEXIS 2825 (N.Y. Sup. Ct. 2018), the court declined to dismiss a contractual indemnity claim where it was unclear whether the party seeking indemnity was at fault. Similarly, in *Cleland v. Boricu Vil. Hous,* 2018 N.Y. Slip Op. 30763 on March 16, 2018, the lower court held that a grant of indemnity would be premature where questions of fact existed regarding where the accident occurred and consequently who was at fault for the accident in question.

The general takeaway, based on recent case law, is that for at least for the First and Second Departments, is that when seeking indemnification, courts place perhaps a higher burden in the First Department as opposed to the Second in submitting proof of freedom from negligence for the accident. Coincidentally, partial indemnity is more readily granted in the First Department as opposed to the Second. Both departments, however, continue to highlight seminal cases (summarized in this article) in their decisions, thereby requiring that there be a demonstration that the parties were not negligent before indemnity can be granted.

Not every indemnity agreement uses the same language, or requires the same factual predicates, in order to trigger the duty to indemnify. While every indemnity provision should be carefully examined pursuant to its own specific language and applicability to the facts, broadly speaking, courts have viewed indemnity agreements in consideration of statutory language, the public policy against indemnifying a party for its own negligence, and the general legal principle that a contract, particularly an indemnity contract, should be narrowly construed against its drafter.[8] Simply stated, a party who has been held liable to an injured plaintiff solely on the basis of the statutory liability imposed by Labor Law § 240(1) (as the owner in the HVAC case cited initially), without any fault on its part, will seek to recover under a contract of indemnity. As an aside and broadly speaking, standard AIA forms (A201 relating to Owner/Contractor agreements and A401 relating to Contractor/Subcontractor agreements) include both key phrases, i.e., "to the fullest extent permitted by law" and the "regardless if caused by a party indemnified hereunder." The above-referenced line of authorities hopefully provides some guidance.

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Endnotes

1. It is common for an owner's contract with the general contractor and the general contractor's contracts with its subcontractors to entitle the entity higher on the construction food chain to contractual indemnity, (a) for any liability arising from the latter's performance of the contract, or, (b) for any liability arising from the latter's negligence.
2. The general rule is that the duty to defend must be determined from the allegations against the insured and the terms of the policy. *BP Air Conditioning Corp. v. One Beacon*, 8 N.Y.3d 708, 715, 871 N.E.2d 1128, 840 N.Y.S.2d 302 (2007). For the best guidance on proper interpretation of additional-insured endorsement, one need look no further than the most impactful insurance coverage decisions, the 2017 Court of Appeals decision in Burlington Co. Ins. 29 N.Y.3d 313 (2017). *Burlington* addressed a commercial general

liability policy issued by Burlington Insurance Co. (Burlington) to Breaking Solutions Inc. (BSI). The Burlington policy contained an endorsement that listed the City of New York, MTA New York City Transit and New York City Transit Authority as additional insureds, but "only with respect to liability for 'bodily injury'. . . caused, in whole or in part, by" the "acts or omissions of the named insured BSI." During the policy period, an NYCTA employee fell from an elevated platform due to an explosion when BSI's machine contacted a live electrical cable buried in concrete at the excavation site. After the employee and his spouse brought an action against the city and BSI, the city impleaded NYCTA and MTA and asserted third-party claims for indemnification and contribution based on a lease between NYCTA and the city. NYCTA tendered these claims to Burlington, taking the position that it qualified as an additional insured under the policy Burlington issued to BSI. Burlington initially agreed to defend NYCTA subject to a reservation of rights, including the defense that NYCTA did not qualify as an additional insured. When discovery in the underlying case revealed that the BSI machine operator could not have known that the location of the cable or the fact that it was electrified, Burlington disclaimed coverage of NYCTA and MTA on the basis that they did not qualify as additional insureds. In deciding the issue, the court was faced with two arguments: NYCTA and MTA argued that the phrase "caused, in whole or in part," merely requires any act by BSI resulting in injury to confirm their additional-insured status, but Burlington contended that the phrase requires proximate causation (i.e., negligence by the named insured). The New York Court of Appeals sided with Burlington, holding that the phrase "caused, in whole or in part," means proximate causation, not "but for" causation. The Court reasoned that "caused, in whole or in part," must require proximate causation because "but for" causation cannot be partial — i.e., "an event may not be wholly or partially connected to a result, it either is or it is not connected."

3. *Pennsylvania Gen. Ins. Co. v. Austin Powder Co.*, 68 N.Y.2d 465, 471 (N.Y. 1986).

4. *Brown v. Two Exch. Plaza Partners*, 146 AD.2d 129, 136 (1st Dep't 1989), *aff'd*, 76 N.Y.2d 172 (1990) (plaintiff's accident did not arise out of or occur in connection with, or as a consequence of a subcontractor's work, even though the subcontractor had erected the scaffold from which the plaintiff fell).

5. *Iurato v. City of New York*, 6627/01, Supreme Court of New York, Bronx County, 2005 N.Y. Misc. LEXIS 3539; 234 N.Y.L.J. 105, December 1, 2005. *Vey v. Port Authority of New York and New Jersey*, 54 N.Y.2d 221, 226 (N.Y. 1981) (the broad language of the indemnification provision evidences a clear intent by the parties for [the plaintiff's employer] to assume all liability arising out of their work at the construction site"); *Beharovic v. 18 East 41st Street Partners, Inc.*, 123 A.D.3d 953, 956 (2d Dep't 2014) (where the provision provided for "arising out of", indemnity was owed even if indemnitor was not negligent); *Simone v. Liebherr Cranes, Inc.*, 90 A.D.3d 1014, 1019 (2d Dep't 2011) (where a contract required indemnity for claims arising out of or resulting from performance of an agreement, indemnification was not conditioned upon a finding of fault); *Tobio v. Boston Properties, Inc.*, 54 A.D.3d 1022, 1024 (2d Dept. 2008); *Pope v. Supreme-K.R.W. Construction Corp.*, 261 A.D.2d 523, 524-25 (2d Dep't 1999); *Bermejo v. New York City Health & Hosps. Corp.*, 119 A.D.3d 500 (2d Dep't 2014) ("arising in whole or in part" provisions do not require the subcontractor's negligence to trigger).

6. It is a well settled rule that in order to prevail on a contractual indemnity claim, a party must proof itself free of fault. *Posa v. Copiague Public School District*, 84 A.D.3d 770, 922 N.Y.S.2d 499, 502 (2nd Dep't 2011) (where a worker was injured when "two tabletops that were to be installed in the [defendant-] school's science laboratories fell on his foot," where defendants had a contractual right of indemnification from the subcontractor who supplied the tabletop, but where the defendants' own proof raised a triable issue as to whether defendants themselves were partially at fault in causing the accident, defendants could not be granted summary judgment; "'[A] party seeking contractual indemnification must prove itself free from negligence, because to the extent its negligence contributed to the accident, it cannot be indemnified therefor'"); *Martinez v. City of New York*, 73 A.D.3d 993, 901 N.Y.S.2d 339 (2nd Dep't 2010) (where the contract required GSF to indemnify the City for claims arising out of the negligence of GSF or its subcontractors, and where plaintiff had not been determined whether GSF was negligent, an award of summary judgment on the contractual indemnification cross claim would be premature); *Cava Construction Co., Inc. v. Gealtec Remodeling Corp.*, 58 A.D.3d 660, 871 N.Y.S.2d 654, 656 (2nd Dep't 2009) ("a party seeking contractual indemnification must prove itself free from negligence, because to the extent its negligence contributed to the accident, it cannot be indemnified therefor"); *McKeighan v. Vassar College*, *supra*, 53 A.D.3d 831, 833-834, 862 N.Y.S.2d 396, 399 (3rd Dep't 2008) (GC was not entitled to contractual indemnification as a matter of law where the proof as to its own negligence in causing the accident was "equivocal"); *see also Hirsch v. Blake Housing, LLC*, 65 A.D.3d 570, 884 N.Y.S.2d 141 (2d Dep't 2009) (defendant, the general contractor, was not entitled to contractual indemnification since, amongst other reasons, it "failed to establish, prima facie, that it lacked control over the work site or notice of the allegedly dangerous condition, thus precluding a finding, as a matter of law, that it was not negligent"); *DiFilippo v. Parkchester North Condominium*, 65 A.D.3d 899, 885 N.Y.S.2d 81, 82 (1st Dep't 2009) ("[b]ased on issues of fact as to who created the dangerous condition [water and debris on the floor] causing plaintiff's slip and fall, the motion for summary judgment and cross motion for summary judgment as to contractual indemnification were properly denied").

7. *See e.g., Farrington v. Structure Tone Inc.*, 2018 N.Y.Misc. LEXIS 2804 (N.Y. Sup. Ct. 2018).

8. *Cheng v. Madansky Leasing Co., Inc.*, 73 N.Y. 2d 453, 541 N.Y.S. 2d 742 (Ct. of Appeals, 1989).

Lights, Cameras, Action: Do Speed Cameras Save Lives?

By Alyssa Jordan Pantzer

Last July I took my usual route to New York County Supreme Court, exiting the Brooklyn Bridge subway station at the beautiful, arched municipal building located on the corner of Chambers and Centre streets. When I ascended from the subway station, I was met by a crowd—not particularly unusual in New York City. This crowd was different, however, because it included people holding television cameras as well as onlookers forming a nearly perfect semi-circle around a woman who was speaking. My curiosity was peaked. The woman was Lieutenant Governor Kathy Hochul, a fellow Hamburg, New York native (a/k/a Hamburgian), and the topic was speed-camera legislation affecting areas around New York City schools.

This article addresses and summarizes the state of the law and discusses last summer's debate surrounding the sunset provision that nearly brought an end to the school zone speed cameras this past August. Additionally, this article will discuss the case law involving speed cameras, as well as the also controversial red-light cameras.

The Controversy Surrounding the Use of Speed Enforcement Cameras in School Zones

On July 19, 2018, the Governor's office released an article stating that a New York State Department of Transportation (DOT) analysis "confirm[s]" that speed cameras save lives.[1] The DOT analysis states that "speed enforcement cameras have proven to be a highly effective tool for reducing pedestrian fatalities and injuries in New York City and throughout the country."[2] As of that July 19, 2018 date, there remained only six days left until the speed-camera legislation was set to expire on July 25, 2018.

That legislation was initially enacted in 2013 with Vehicle and Traffic Law Section 1180-b, which granted New York City the authority to pilot an automated speed enforcement program in 20 school speed zones.[3] Per this program, the first speed-camera violation was issued in January 2014, and in June 2014 the pilot program was expanded to a total of 140 school speed zones.[4]

Section 1180-b, titled "Owner Liability for Failure of Operator to Comply with Certain Posted Maximum Speed Limits," empowers the City of New York to implement "a demonstration program imposing monetary liability on the owner of a vehicle for the failure of an operator thereof to comply with posted maximum speed limits in a school speed zone within the city." In order to do so, the city was authorized "to install photo speed violation monitoring systems within no more than one hundred forty school speed zones within the city at any one time." In selecting the school speed zones where cameras were to be installed, the City was directed to consider "criteria including, but not limited to the speed data, crash history, and the roadway geometry applicable to such school speed zone." Violations may be issued only: "(A) on school days during school hours and one hour before and one hour after the school day, and (B) a period during student activities at the school and up to thirty minutes immediately before and up to thirty minutes immediately after such student activities."

A 2017 study found that the daily rate of violations issued for excessive speeding in school zones at the typical camera declined by over 60 percent in the program's first 18 months of Section 1180-b's implementation.[5] Additionally, total "crashes"[6] in school zones diminished by 15%, and the overall number of people killed or severely injured in crashes in school speed zones with speed-camera monitoring declined by over 21% in the period after the cameras were activated.[7]

On the day that the law was set to expire—July 25, 2018–the governor discussed the speed-camera legislation during a press conference.[8] He stated that the issue had been the subject of debate in Albany for months and warned that "when the law expires, the speed cameras go away," which would increase "speeding and recklessness" and "put lives in jeopardy." The bill, which called for the extension of the speed-camera pilot program law, passed in the State Assembly, but was unable to pass the Senate's muster.

On June 22, 2018, during the course of the debate as to whether 1180-b should expire as scheduled, Senate Republicans Andrew Lanza (24th District) and Martin Golden (22nd District) and Senate Democrat Simcha Felder (17th District) proposed their own speed-camera bill extending the use of speed cameras in school zones for six months past the July 25, 2018 expiration. During those six months, the revenue collected from traffic infractions issued was to be used to fund the installation of school zone stop signs and stop lights.

Essentially, this bill advocated for transitioning away from the use of speed cameras to the use of stop lights and traffic signals. In support of that transition, the proponents of the bill argued that "reducing the speed of motorists traveling through school zones is the most certain method to protect the safety and welfare of our children. Allowing for the extension of NYC's school

zone speed-camera program for six months provides time for such safety measures to be adopted[.]"[9] The bill additionally required the installation of signs warning motorists of the cameras and doubled fines for infractions in these areas.

A day after the bill was proposed, Speaker of the Assembly Carl Heastie (D, 83rd District) took to Twitter writing, "There is a simple solution: pass Assembly bill supported by advocates, Mayor & Governor & continue program that is a proven success." One commentator who disagreed with Speaker Heastie voiced his opposition with the hashtag "#Stop4Kids." The majority of the commentary on Speaker Heastie's tweet, however, was supportive of the continued use of the speed cameras, as opposed to stop signs and lights. One commentator who wrote in support of the use of speed cameras questioned, "[h]ow is it possible our senate couldn't agree on a simple bill that says 'keep kids safe with more speed cameras?'"[10]

An agreement was not reached, and the legislation expired on July 25, 2018. Political colloquy was exchanged on Twitter and elsewhere. Following the expiration of the law, the City kept the cameras running, but was stripped of its authority to issue tickets for violations.

On August 27, 2018, with just over a week before New York City's public schools were back in session, Governor Cuomo signed an Executive Order, declaring a public safety emergency, overriding the sunset clause in the speed-camera legislation.[11] The Executive Order states that "it is unacceptable to place school children at risk of serious physical harm and death in the very same place where they are to be educated, cared for, and protected, and that such school children have the right to safely access schools for the purpose of education and enrichment," and that "the New York State Police and the New York State Department of Transportation believe that the termination of New York City's speed-camera program results in an eminent disaster emergency that places at risk the health and safety of school children[.]"

The governor's August 27, 2018 Executive Order temporarily suspended the sunset provision on the law, and directed the Department of Motor Vehicles to share information with the City so it could match the license plates of speeding vehicles to their owners and assess fines—all without the need for a new state law.

Then, New York City's City Council led by Speaker Corey Johnson and Transportation Committee Chair Ydanis Rodriguez, worked to pass legislation that not only extends the city's camera program but also allows the city to operate more speed cameras at more schools for longer hours.[12] Mayor de Blasio signed the bill into law on September 4, 2018.[13]

New York City's Administrative Code, Title 19, Chapter 9 was titled "Photo Speed Violation Monitoring Program." The law is modeled after what was Vehicle and Traffic Law Section 1180-b. Now, as before, vehicles monitored speeding in school zones during certain times of the day and certain times of the year will be imposed a $50 fine recoverable before New York City's Office of Administrative Trials and Hearings.

Then, on Tuesday, March 19, 2019, the Democratic-led State Legislature voted to renew and significantly expand the speed camera program, in a nearly fivefold increase that city officials say will cover every elementary, middle and high school in the city. The *New York Times* reported on that date that Senator Andrew Gounardes of Brooklyn, the bill's sponsor, stated about the new law, "We are depoliticizing the issue of pedestrian safety."[14]

Red-Light Cameras

Living on Long Island, in Nassau County, you would be hard pressed to find a person who tends to be in a rush who has not been issued a red-light camera ticket. Pursuant to New York Vehicle and Traffic Law Section 1111, certain jurisdictions are empowered to install and operate traffic-control signal photo violation monitoring devices at a restricted number of intersections.[15] The subsections of Section 1111 pertain to the specific jurisdictions, which are empowered by the law to implement the red-light camera monitoring programs, and are titled "[o]wner liability for failure of operator to comply with traffic-control indications." Fines for red-light camera violations are limited to $50. All of the red-light camera programs empowered by Section 1111 have sunset provisions requiring repeal in late 2019.[16]

The legislation provides for ticketing of vehicle owners if such vehicle was "used or operated with the permission of the owner, express or implied" in violation of the red-light laws. The owner is not liable for the penalty imposed if the vehicle's operator already has been ticketed, and subsequently convicted.[17] The cameras are not permitted to capture images that identify the driver, passengers, or content of the vehicle.[18]

Several individuals and organizations have expressed criticism with regard to red-light cameras. Case Western Reserve University's November 17, 2017 analysis is research-based criticism of the red-light cameras, and that study concluded that "cameras changed the composition of accidents, but [there is] no evidence of a reduction in total accidents or injuries."[19] The study concedes that "there is clear evidence that installing a camera reduces the number of vehicles running a red light," but finds that "the predicted relationship between the number of vehicles running red lights and the total number of accidents is ambiguous." In other words, "[s]ome drivers who typically ran a red light before a camera program will choose to stop at the intersection and, in turn, fewer vehicles will be in the intersection when the cross-road light turns

green," thereby, decreasing "right-angle crashes between two vehicles." While "right angle crashes" may decrease with the implementation of red-light surveillance, the Case Western analysis finds that rear-end accidents may increase due to the presence of cameras. This is because "driver awareness of the cameras will lead some drivers to attempt to stop and accept a higher accident risk from stopping at the intersection, in order to avoid the expected fine from continuing to drive through the intersection."

In sum, the Case Western study implies that red-light camera implementation does not have the intended effect of decreasing the number of intersection accidents. Instead, rear-end accidents are more likely to occur at intersections where a red-light camera has been installed due to heightened driver awareness of the need to stop quickly to avoid a red-light ticket; whereas, right-angle accidents, or "T-Bone" accidents, may occur less frequently because drivers are less likely to disobey a red light and proceed through an intersection in oncoming traffic.

Justin Gallagher, one of the authors of the Case Western study, is quoted as stating that the "the predicted relationship between the number of vehicles running red lights and the total number of accidents is ambiguous—and certainly not compelling enough to justify some claims of proponents of these devices," and that "[d]ata on the types of injuries incurring in these traffic accidents (fatalities, incapacitating and non-incapacitating, and more minor) failed to provide a case the cameras increased the safety of intersections where they're installed."[20]

Traffic Surveillance and the Case Law

Both the red-light camera provision and the speed-camera provision contain statements that the surveillance recorded will be "prima facie evidence of the facts contained therein." Accordingly, during a nonjury trial in *People v. Davidowitz*, the court found prima facie evidence of defendant's liability based on the People's evidence consisting of: (1) photographs of defendant's vehicle at the scene; (2) a video; and (3) a certificate by a technician certifying that she had reviewed the video and photographs and had determined that defendant's vehicle had not stopped at a red light.[21] A finding of liability shall not be deemed a conviction; rather, red-light camera enforcement is a civil mechanism, not a criminal one.[22] The issuance of red-light camera violations has withstood constitutional due process challenges.[23]

A violation of the Vehicle and Traffic Law, if unexcused, constitutes negligence per se so that the violating party must be found negligent if the violation is proved. Negligence per se is not liability per se, however, because the plaintiff still must establish that the statutory violation was the proximate cause of the occurrence.[24] Whether a traffic camera violation qualifies under the negligence-per-se doctrine appears to remain undecided by the courts of the State of New York.

Even so, red-light cameras as well as speed cameras contain evidence that should be considered in defending or prosecuting a motor-vehicle negligence case. It has been held that attorneys must obtain traffic-camera surveillance directly from the vendor, rather than through a Freedom of Information Law ("FOIL") demand to the municipality.[25] Namely, a Nassau County Supreme Court identified that Public Officers Law Section 86 (i.e., the FOIL statute) was specifically amended to state that a municipality may deny FOIL access to "photographs, microphotographs, videotape or other recorded images prepared under authority of section eleven hundred eleven-b of the vehicle and traffic law." Therefore, the Court held that the party seeking red-light camera footage was not permitted to access it through a FOIL demand, and was required to subpoena the red-light camera vendor instead.

Whatever your opinion of the use of traffic cameras to monitor speeding and red-light violations, it looks like the cameras may be here to stay, and the programs implementing their use may be expanding.

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Safeguarding Children: Some Recommendations from the CPSC's *Public Playground Safety Handbook*

Kenneth A. Krajewski

Introduction

Playgrounds are a great place for children to enjoy needed exercise and to develop essential social and cognitive abilities;[1] however, they can also be dangerous. In fact, each year in the United States, according to the U.S. Consumer Product Safety Commission (CPSC), more than 200,000 children are sent to emergency rooms because of playground-related injuries. Many of these injuries, such as fractures, lacerations, and concussions, can be serious.[2] Fatalities, while not common, can also occur on playgrounds. From 2009 to 2014, there were 34 deaths associated with playground equipment, with the average victim being about 5 years old.[3] Of the 34 deaths, 19 of them were caused by hangings or asphyxiations, ten were associated with slides or swings, and eight were caused by head or neck impact injuries.[4]

In 1981, as a response to the growing number of serious accidents reported on playgrounds, the CPSC published its first *Public Playground Safety Handbook* (*Handbook*).[5] The *Handbook* has been revised several times over the years, with the latest revision occurring in 2010.[6] The goal of the *Handbook* is to promote greater safety awareness among those who purchase, install, and maintain public playground equipment. The *Handbook* is intended for use by childcare personnel, school officials, parks and recreation personnel, equipment purchasers and installers, playground designers, and members of the general public. The *Handbook*'s recommendations address the hazards that have caused playground injuries and deaths. Currently, several states,[7] including New York, have adopted all or part of the CPSC or American Society for Testing Materials (ASTM) guidelines.[8]

The CPSC believes that compliance with the *Handbook*'s recommendations along with other technical information in the ASTM standards[9] will contribute to greater playground safety. There is some evidence to suggest that the CPSC is correct. The National Program for Playground Safety (NPPS) conducted a study in which they graded playground safety in all 50 states.[10] The study took into account several factors such as supervision, age-appropriate design, fall surfacing, and equipment maintenance.[11] According to the study, states that adopted the CPSC guidelines, on average, scored higher than those that did not.[12]

This article provides a brief overview of the recommendations contained in the CPSC's *Public Playground Safety Handbook*. Nevertheless, not every recommendation in the *Handbook* is mentioned. The purpose of this article is only to give a general idea the recommendations provided in the *Handbook*. We begin with a brief summary of the general considerations that playground designers should take into account when designing a playground. Next, we summarize some of CPSC's recommendations regarding equipment related hazards, which were the leading cause of reported injuries on playgrounds from 2009 to 2014. The last two topics addressed are playground maintenance and the *Handbook*'s recommendations regarding the design of various playground parts.

General Playground Considerations

The *Handbook* begins by discussing general playground considerations, which are meant to provide park designers and architects with guidance for creating a safe playground. This section offers suggestions on site selection, playground layout, selecting equipment, surfacing, and equipment materials.

There are several important factors that park designers should consider when selecting a site for a new playground. For instance, the CPSC recommends that park designers select playground sites that are free from hazards, such as fallen tree limbs, puddles, or large rocks, that prevent children from moving freely about the playground. If the site contains such hazards, however, the *Handbook* recommends that they should be cleared. Next, playgrounds should be blocked off from nearby hazards, such as small bodies of water that children could easily wander into. The *Handbook* suggests creating barriers such as fences or dense hedges to contain children within the playground. Furthermore, playground sites should have proper drainage to prevent surfacing materials from washing away. Lastly, the *Handbook* advises that designers should take into account the amount of sun exposure in an area, as metal slides and platforms can heat up and burn children. Moreover, exposure to the sun during the most intense parts of the day may increase the risk that a child develops skin cancer.

Next, the *Handbook* discusses fundamental factors to remember when designing the layout of a playground. First, the *Handbook* recommends that playgrounds contain accessible surfaces in play areas that meet ASTM standards, and which ensure the opportunity for disabled children to use the playground. Second, playgrounds should be separated into distinct areas for children of different age groups. Third, the play area should be organized into different sections to prevent injuries caused by conflicting activities and children running between activities. Fourth, playgrounds should be laid out so that

playground supervisors can watch the children as they move throughout the playground. For example, a parent watching a child in the younger children's area should be able to see children playing in the older children's area. Lastly, a playground should contain signs that give parents and supervisors some guidance as to the age appropriateness of the equipment.

Selecting proper playground equipment is also important. When selecting playground equipment, the *Handbook* recommends that park designers know the age range of the children who will be using the equipment, as children of different ages and stages of development have different needs and abilities. Playgrounds should stimulate children and encourage them to develop new skills. To avoid serious injuries, however, the CPSC recommends that playground equipment should be tailored to children's sizes, abilities, and developmental levels.

Falls from, into, or onto playground equipment are one of the leading hazards on playgrounds, accounting for about 44 percent of reported incidents from 2001 to 2008, and about 17 percent from 2009 to 2014.[13] To mitigate harm caused by falls, the *Handbook* offers guidance on proper surfacing material that should be used on playgrounds. For example, playgrounds should never be installed over hard surfaces. Instead, the guidelines recommend installing loose-fill surfacing materials such as engineered wood fiber, shredded rubber mulch, wood chips[14] or unitary surfacing materials such as rubber mats or tiles, poured-in-place rubber, and rolled products like artificial turf.[15] Both loose-fill and unitary surfacing material may be used as long as they comply with ASTM guidelines.[16] The *Handbook* generally recommends never using less than 9 inches of loose-fill material. The *Handbook*'s guidelines also suggest that park designers and manufacturers test their surfacing material, using the testing methods described in the ASTM safety standards. For example, manufacturers should test their surfacing materials to determine the "critical height" rating of the surface. The critical height is the approximate fall height below which a life threatening head injury would not be expected to occur. By calculating the critical height rating of surfacing materials, park designers can design playground equipment, such as elevated platforms, at safer heights for children.

The CPSC also recognizes that certain materials such as metals, paints and finishes, and chemically treated wood may pose risks to children. The *Handbook* advises against using bare metal for platforms because metal equipment may heat up when exposed to sunlight and cause burn injuries. Regarding paints and finishes, park designers may use them. Nonetheless, if they contain preservatives or chemicals, manufacturers should ensure that a child cannot inhale or absorb hazardous amounts of those chemicals. Next, the *Handbook* advises that playgrounds with lead paints should be identified, and that strategies to prevent children from being exposed should be developed. With regard to wood-based materials, the guidelines state that creosote-treated wood[17] and wood coatings that contain pesticides should not be used on playgrounds. Older playgrounds, however, may contain wooden surfaces treated with a chemical called chromate copper arsenate, which contains arsenic (CCA). Several groups have suggested applying surface coatings to CCA-treated wood to reduce a child's exposure to arsenic from the wood surface. CPSC and EPA studies suggest that regular use of an oil or water based, penetrating sealant or stain can reduce arsenic exposure from CCA treated wood.

Equipment-Related Hazards

From 2009 to 2014, equipment-related hazards replaced falls as the most reported cause of injury on playgrounds.[18] The *Handbook* points out that playground equipment can crush, shear, entangle, impale, or entrap a child's limbs.[19] For that reason, the *Handbook* contains several guidelines on how to avoid injuries caused by playground equipment.

Head entrapment, in particular, is a major concern on playgrounds because it can cause strangulation and death, and because the hazard may not be patent or overt. Head entrapment occurs when a child's head becomes stuck in between an opening, such as the vertical bars of a barrier, and the child is unable to remove his head. To prevent head entrapment, the *Handbook* recommends that playgrounds should be designed so that parts or groups of parts should not form an opening that could entrap a child's head. Moreover, the *Handbook* provides a simple, step-by-step test that park designers, childcare workers, or other supervisors can use to test whether a piece of equipment poses an entrapment risk. The test involves using templates based on the torso of the smallest user at risk, and the largest dimensions on the head of the largest child at risk. To test an opening, a person must first attempt to place the small torso template into the opening. If the torso template cannot freely pass through the opening, then the opening does not pose an entrapment risk. If the torso template, however, can move freely through the opening, then the large head template should then be tested. If the opening admits the small torso template but does not admit the large head template, it poses an entrapment risk. Using this test to determine what pieces of equipment present entrapment risks could help playground supervisors prevent serious injuries as they can provide greater supervision to children using those pieces of equipment.

Protruding objects on playground equipment are another hazard addressed by the *Handbook*. The *Handbook* points out that a child may fall into, collide, or become entangled with a piece of equipment containing a protruding object such as a hook or bolt. To avoid such risks,

the guidelines recommend that playground equipment should not contain protruding objects large enough to entangle a child's clothing or to impale the child. To aid playground designers, the *Handbook* provides guidance on how to mitigate injuries from collisions with playground equipment. For instance, any hooks protruding from playground equipment should be closed so that there is no gap or space greater than 0.04 inches.

Lastly, children at play may be injured by sharp edges, suspended components such as cables, and by tripping hazards such as sudden changes in elevation. Thus, the CPSC also provides several recommendations on how to avoid these risks. For example, the CPSC recommends that all metal edges should be rolled or have rounded capping, and that slides should free from sharp objects. Regarding suspended hazards, the *Handbook* recommends, among other things, keeping them out of high traffic areas.

Playground Maintenance, Inspection, and Repair

CPSC recognizes that proper maintenance of playground equipment is crucial to playground safety. Thus, the *Handbook* recommends that all playground areas and equipment should be routinely inspected for wear, deterioration, and any potential hazards. Loose-fill surfacing[20] in particular should be checked frequently to ensure surfacing has not displaced significantly, especially under swings or slides.[21] The *Handbook* further advises playground maintenance workers to strictly follow the manufacturer's maintenance instructions and recommended maintenance schedules. If the manufacturer does not provide a maintenance checklist, the *Handbook* contains a checklist that may be used as a general guide for routine inspections of public playgrounds. Additionally, some insurance providers may provide general guidelines or checklists for proper playground maintenance on their websites.[22] Although the *Handbook* provides a maintenance checklist, it does not provide a fixed schedule for playground inspection. Instead, it recommends that playground maintenance workers either follow the manufacturer's instructions regarding the frequency of maintenance inspections or develop their own schedule based on actual or anticipated playground use. While important, maintenance inspections alone do not constitute a comprehensive maintenance program. The *Handbook* further advises that any issues found during an inspection should be noted and promptly repaired. Such repairs should be completed following the manufacturer's instructions. Lastly, the *Handbook* instructs that records of any maintenance inspections including the manufacturer's maintenance instructions should be retained.

Parts of the Playground

The final section of the *Handbook* contains many recommendations on how different parts of a playground should be designed to reduce injuries. It begins with guidelines for designing platforms, guard rails, and protective barriers. For example, the guidelines advise that guard rails and protective barriers should completely surround any elevated platform. Moreover, they should be designed to discourage children from climbing over or through the barrier, to prevent unintentional falls, to prevent the possibility of entrapment, and to facilitate supervision. Height requirements, which vary according to the age of the user, are also mentioned. For example, the recommended maximum height of a stepped platform (a platform layered so that a child may access higher platforms without steps or ladder) for toddlers is 7 inches, for preschool-age children 12 inches, and for school-age children 18 inches. Next, this section also provides recommendations on how access methods to play equipment such as ramps, stairways, and ladders should be designed to prevent injuries. For example, the *Handbook* recommends that stairways and rung ladders should be designed so that the spaces between the stairways or the rungs do not create an entrapment hazard. The *Handbook* also provides a chart with the recommended dimensions for access ladders, stairs, and ramps.

Lastly, this section of the *Handbook* provides recommendations for the design of "major" playground equipment. Major types of playground equipment include swings, slides, seesaws, balancing beams, merry-go-rounds, log rolls, and climbing equipment. For each piece of major equipment, the *Handbook* discusses how it should be designed, including the appropriate fall height. The fall height of a piece of equipment is the distance between the highest designated play surface on the piece of equipment and the protective surface beneath it. The *Handbook* also provides age recommendations for some pieces of equipment. For example, log rolls, which require greater balance and strength to use should have handholds for children to assist with balance and are not recommended for toddlers or preschool aged children.

Conclusion

Playground-related injuries are probably unavoidable. Steps can be taken, however, to reduce the frequency and seriousness of such injuries. The CPSC's *Public Playground Safety Handbook* offers many guidelines intended for park designers, teachers, schools, child care workers, and parents to use in order to reduce the chance that a playground-related injury will occur. The guidelines discuss several dangers that may be found on playgrounds and offers recommendations on how to avoid them. Such dangers include falls, equipment-related hazards, collisions, entrapment, and more. Most of the guidelines discuss ways to properly design playgrounds in order to prevent or reduce the amount and severity of playground related injuries. The CPSC believes and some evidence suggests that following the recommendation in the *Handbook* will contribute to greater playground safety. Thus, park

designers, parents, and childcare workers should use the *Handbook* as guidance or simply as a way to learn more about public playground safety.

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Endnotes

1. http://voiceofplay.org/benefits-of-play.
2. U.S. Consumer Product Safety Commission, Injuries and Investigated Deaths Associated with Playground Equipment 2009-2014 at 16, August 2016.
3. *Id.*
4. https://playworld.com/psi_files/web/dwnld/PlayworldAuditGuide.pdf.
5. U.S. Consumer Product Safety Commission, *Public Playground Safety Handbook*. Note: This is the source for information in this article unless otherwise noted.
6. http://www.playgroundsafety.org/standards/regulations.
7. NY Gen. Bus. § 399-dd.
8. The following ASTM standards have to do with to playground safety: ASTM F1487, F2373, F2075, F2223, F1292, F2479, F1951, F1816, F2049, F1148, and F1918.
9. http://www.playgroundsafety.org/research/state-report-cards.
10. http://www.playgroundsafety.org/sites/default/files/us.pdf.
11.. *Id.*
12. Injuries and Investigative Deaths Associated with Playground Equipment at 6.
13.. *Id.* at 9.
14. *Id.*, *see also* http://www.playgroundmedic.com/?surfacing, https://www.zeager.com/planning-resources/playground-ground-cover-materials.
15. Creosote is a wood preservative derived from the distillation of tar from wood or coal. *See* https://www.epa.gov/ingredients-used-pesticide-products/creosote.
16. Injuries and Investigated Deaths Associated with Playground Equipment 2009 to 2014, at 6.
17. *Id.* at 14, 15.
18.. E.g., wood chips or rubber mulch.
19. https://www.churchmutual.com/7428/Playground-safety-and-maintenance;https://www.markelinsurance.com/-/media/specialty/risk-management/safety-guides/safe-playgrounds-tip.pdf?la=en,:https://www.hanover.com/risksolutions/playground-inspection.html.

2017–2018 Review of UM/UIM/SUM Law and Practice

By Jonathan A. Dachs

It is my honor and pleasure to present this survey of recent developments in the area of Uninsured Motorist (UM), Underinsured Motorist (UIM), and Supplementary Uninsured/Underinsured Motorist (SUM) law and practice in New York covering the period of 2017 through the first half of 2018. As in the past, this period was marked by a great deal of significant activity in this highly litigated, ever-changing and complex area of the law.

GENERAL ISSUES

Residents

The definition of an "insured" in an insurance policy usually includes a resident relative of the named insured or spouse. The SUM Endorsement includes in the definition of an "insured" "you, as the named insured, and, while residents of the same household, your spouse and the relatives of either you or your spouse."

In *Nicotera v. Allstate Ins. Co.*,[1] involving a fire damage claim under a homeowner's policy, where the evidence established that the claimant resided at the residence of the insured, but the insured no longer resided there because she had moved to a nursing home, the court held that the claimant was not a resident of the insured's "household" at the time of the fire, and, therefore, was not an insured person under the policy, which covered any member of the [insured's] household if such person was a resident relative of the insured or a dependent person in the insured's care.

In *Craft v. New York Central Mut. Fire Ins. Co.*,[2] a dispute regarding insurance coverage for a fire loss, the plaintiff testified that when she moved into her fiancé's home, she did not intend to move out of her insured premises, which she owned and had lived in since 1975, and which were only ten minutes away. Rather, she never "totally" moved out, had a key to the insured premises and kept furniture, personal items and some clothing there. She obtained a post office box for her mail, kept the insured premises as her address on her driver's license, and either the telephone or electric bill at the premises was in her name. In contrast, none of the utility bills at her fiancé's house were in her name. Although she could not recall exactly how often she returned to the insured premises, she slept there "quite a bit" primarily to care for her grandchildren, who were still living there, and she explained that she went back and forth between the two houses to give her daughter-in-law and grandchildren some privacy. During the six months preceding the fire, the plaintiff estimated that she was at the insured premises "four, five, six times a month or more." Although there seemed to be general agreement that she primarily went to the premises to help and be with the grandchildren, the plaintiff confirmed that, even if the grandchildren were not in the insured house, she would have returned "periodically quite a bit" because it was her house and her "stuff was there." Upon these facts, the court concluded that it was "arguable that the reasonable expectations of the average insured" was that the plaintiff's occupancy of the premises, coupled with her claim that she never fully left the premises,"was enough to permit coverage pursuant to the terms of the policy." Thus, the court held that triable issues of fact existed sufficient to deny summary judgment in this case.

Relatives

In *Government Employee Ins. Co. v. Minton*,[3] Respondent was injured in an accident with a vehicle that carried bodily injury liability limits of only $25,000 per person. Respondent was unable to make a claim for SUM benefits under the policy covering the vehicle she was operating at the time of the accident because it, too, carried minimum limits of bodily injury and SUM coverage of $25,000 per person, which would be fully offset by the payments made by the tortfeasor's insurer. Consequently, she attempted to demand SUM arbitration under a policy issued by GEICO to her same-sex partner, with whom she resided.

In response, GEICO argued, in its Petition to Stay Arbitration, that Respondent was *not* a "resident relative" of the same-sex partner's household, and, therefore, was not entitled to SUM benefits under the partner's policy. In granting GEICO's Petition and permanently staying arbitration, the court first noted that it was undisputed that Respondent was not a named insured under the partner's GEICO policy, and then, that "despite their committed, 'as if' spouses, relationship," Respondent and her partner "were not legally married on the date of the accident."

Therefore, the court concluded that Respondent did not meet the definition of "insured" under the partner's GEICO SUM endorsement (i.e., "you [the partner], as the named insured and, while residents of the same household, your spouse and the relatives of either you or your spouse") "by virtue of a spousal relationship."

The court went on to reject Respondent's alternative attempt to find coverage under the GEICO policy by using the expansive definition of "family" set forth in *Braschi v. Stahl Assoc. Co.*, 74 N.Y.2d 201, 544, N.Y.S.2d 784 (1989), to argue that as the insured's same-sex partner, she was entitled to coverage as a "relative." As the court explained, "The expansive definition of `family' set forth in *Braschi* was applied to rent stabilized tenants, in the

context of rent stabilization laws being substantially the same as rent control laws, and has no bearing on interpreting statutes with different statutory purposes [citation omitted]. In fact, unlike *Braschi*, this case 'does not involve the interpretation of a statute at all, but rather a contractual provision, [and] there is no basis for applying the expansive definition of family set forth in *Braschi* [citation omitted]. Likewise, under the facts of this case, there is no basis to broaden the definition of `spouse' or 'relative' to include [Respondent] as an insured under the SUM provisions of [her same-sex partner's] GEICO policy [citation omitted]."

Since Respondent was neither a married spouse nor a relative of the insured at the time of the accident, she was not entitled to coverage under GEICO's SUM endorsement.

Accidents v. Intentional Collisions

In *Progressive Advanced Ins. Co. v. Widdecombe*,[4] Respondent Germain left a bar after consuming a number of alcoholic beverages, and got into the driver's seat of his parked car. Concerned that Germain was not fit to drive, Respondent Widdecombe, an acquaintance of Germain's, left the bar and tried to persuade Germain to return to the bar. Widdecombe attempted to stop Germain from operating the car by placing his foot inside the open driver's door and reaching to grab the keys from the ignition. However, Germain managed to start the engine and put the car in drive, causing it to move forward, trapping Widdecombe and dragging him for approximately 20 feet and causing injuries to his leg.

The critical issue before the court was whether Widdecombe's injuries were caused by an accident within the meaning of his policy with Progressive Advanced, which provided for payment of "all sums that the insured . . . shall be legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle because of bodily injury . . . *caused by an accident* arising out of such uninsureds motor vehicle's ownership, maintenance or use (emphasis added)." As the court noted, "The term 'accident' is not defined in the policy, and, thus, we must look to the definition provided by the Court of Appeals in *State Farm Mut. Auto. Ins. Co. v. Langan*, 16 N.Y.3d 349, 353 (2011)." In *Langan*, the Court held that, for purposes of an uninsured motorist endorsement, when an occurrence is—from the *insured's* perspective—"unexpected, unusual and unforeseen," it qualifies as an "accident."[5] The Court of Appeals further held in *Langan*, supra, that although the insured was also the victim, "the intentional assault of an innocent insured is an accident within the meaning of his or her own policy."[6]

Thus, the *Widdecombe* court held that "whatever Germain's intent and criminal liability, this incident was an accident from Widdecombe's perspective." As the court further explained, "As in *State Farm* [*Langan*], this event `was clearly an accident from the insured's point of view, since having his leg trapped and being dragged was sudden and `unexpected, unusual and unforeseen'."

However, in *Castillo v. Motor Veh. Acc. Indem. Corp.*,[7] the Court held "if the driver of the motor vehicle that injured the petitioner acted intentionally, the petitioner may not recover in an action against the MVAIC." The court rejected the petitioner's reliance upon *State Farm Mut. Auto. Ins. Co. v. Langan*, *supra*, because in this case the petitioner sought to recover from the state fund administered by the MVAIC, and not, as in *Langan*, from an insured under an insurance policy.

"Use or Operation"

In *Peter Pan Bus Lines, Inc. v. Hanover Ins. Co.,*.[8] the subject insurance policy provided coverage for damages owed because of, *inter alia*, "'bodily injury' . . . caused by an 'accident' and resulting from the ownership, maintenance, or use of a covered 'auto.'" In reversing the Supreme Court's Order denying the plaintiff/insured, Peter Pan's motion for summary judgment in a declaratory judgment, and granting Plaintiff's motion, the court held, "Regardless of whether the plaintiff in the underlying action, having arrived at her destination on a Peter Pan bus and seen the driver unloading the passengers' luggage, tripped over a suitcase while approaching her own suitcase or tripped on the curb while looking for her suitcase, her accident resulted from Peter Pan's use of the bus, a covered auto, and Defendant is obligated to defend and indemnify Peter Pan in the underlying action."

Exclusions

Owned Vehicle

In *Government Employees Ins. Co. v. Williams*,[9] Petitioner GEICO relied upon the exclusion in its SUM endorsement for "bodily injury to an insured incurred while occupying a motor vehicle owned by that insured, if such motor vehicle is not insured for SUM coverage by the policy under which a claim is made, or is not a newly acquired or replacement motor vehicle covered under the terms of this policy." As explained by the court, "This policy exclusion excludes from SUM coverage compensation for bodily injuries sustained by an insured when injured in a motor vehicle accident while occupying a motor vehicle he or she owns, which vehicle was not covered under the policy."

The court found that GEICO met its initial burden of demonstrating that a factual issue existed as to the applicability of this exclusion via the submission of a SUM benefits claim form, signed by the claimant and the policyholder, which disclosed that the claimant was operating his motorcycle at the time of the accident, and that the motorcycle was insured under a different GEICO policy.

The court held that a hearing should have been held to determine if the exclusion applied.

"Non-Owned Car – Furnished or Available for Regular Use"

In *Tuttle v. State Farm Mut. Auto. Ins. Co.*,[10] Plaintiff sought a judicial declaration that the defendant insurer was obligated to provide coverage under a policy issued to her former boyfriend, who fell asleep while operating a vehicle in which Plaintiff was a passenger. The vehicle was owned by Plaintiff and insured under a policy issued by a nonparty insurance company. Plaintiff's boyfriend owned a separate vehicle that was insured by Defendant. In the underlying personal injury action, Plaintiff obtained a judgment in the amount of $322,187. The nonparty insurer paid Plaintiff its policy limit of $25,000, and Plaintiff sought thereafter to recover the excess judgment from Defendant on the theory that her boyfriend was operating a "non-owned car" under Defendant's policy. Defendant disclaimed on the ground that Plaintiff's vehicle was not a 'non-owned car."

In holding that the trial court erred in granting Defendant's motion for summary judgment on the ground that Plaintiff's vehicle was not a "non-owned car" under the policy, the court found that

> The insurance policy defined a "non-owned car" as "a car not . . . furnished or available for the regular or frequent use of' the named insured." In determining whether a vehicle was furnished or available for the regular use of the named insured, "[f]actors to be considered . . . are the availability of the vehicle and frequency of its use by the insured' [citations omitted] . . . The applicability of the policy exclusion to a particular case must be determined in light of the "purpose of [the] provision [of coverage] for a nonowned vehicle not [furnished or available] for the regular use of the insured [, which] is to provide protection to the insured for the occasional or infrequent use of [a] vehicle not owned by him or her [,] and [which coverage] is not intended as a substitute for insurance on vehicles furnished for the insured's regular use"[citations omitted].

In support of its motion, Defendant submitted the deposition testimony of the boyfriend and plaintiff, both of whom testified that the boyfriend had a set of keys to the vehicle but drove it only on rare occasions. They both also testified that they had separate vehicles insured under separate policies, and they did not use those vehicles interchangeably. The court thus held that Defendant failed to establish as a matter of law that Plaintiff's vehicle was furnished or available for her boyfriend's regular use, and that issues of fact existed with respect to that issue.

Claimant/Insured's Duty to Provide Timely Notice

In *GuideOne Specialty Mutual Ins. Co. v. Cruz*,[11] the court stated,

> In the context of supplementary underinsured motorist (hereinafter SUM) claims, it is the claimant's burden to prove timeliness of notice, which is measured by the date the claimant knew or should have known that the tortfeasor was underinsured [citations omitted]. Timeliness of notice is an elastic concept, the resolution of which is highly dependent on the particular circumstances [citations omitted]. In determining whether notice was timely, factors to consider include, *inter alia*, whether the claimant has offered a reasonable excuse for any delay, such as latency of his/her injuries, and evidence of the claimant's due diligence in attempting to establish the insurance status of the other vehicles in the accident [citations omitted].

Here, the court held that the insured's counsel's letter, dated May 23, 2013, which advised that since she had not yet verified coverage for the alleged offending vehicle, there was a possibility that a claim would be made against either the uninsured or underinsured endorsement of the policy, "did not serve as effective notice of a SUM claim." Specifically, the court focused on the fact that the letter merely recited that a claim "may be made" for SUM benefits, and that the claim could be for either uninsured or underinsured without benefits. "Under these circumstances, any claim for underinsured motorist benefits was premature at that time, since Cruz had no knowledge that the offending vehicle was underinsured [citations omitted]."

Thus, the first effective notice provided by the insured was sent on March 18, 2015, over 22 months after the accident, and 21 months after the insured learned the coverage information for the vehicle. Such notice was untimely as a matter of law.

In *Ramlochan v. Scottsdale Ins. Co.*,[12] a direct action under Ins. L. § 3420(a)(2) to recover the amount of an unsatisfied judgment against Scottsdale's insured, the insurer had denied coverage based on late notice of an occurrence. The court affirmed the grant of summary judgment to the insurer, declaring that it was not obligated to satisfy the judgment, noting that "Where an insurance policy requires that notice of an occurrence be given `as soon as practicable,' notice must be given within a reasonable time in view of all of the circumstances [citations omitted]. 'The insured's failure to satisfy the

notice requirement constitutes a failure to comply with a condition precedent which, as a matter of law, vitiates the contract.'" The court further noted that an insured's late notice may be excused if the insured had a reasonable belief in nonliability. The burden of proof is on the insured to establish that it had such a reasonable belief.

Here, Scottsdale demonstrated that its insured knew of the occurrence immediately and received a letter of representation from the plaintiff's attorney in June 2008, but waited until September 25, 2009, to notify Scottsdale. Since the subject policy was issued prior to the amendment to Ins. L. § 3420, Scottsdale was not required to show that it was prejudiced by the failure to give it timely notice in order to meet its *prima facie* burden. The Plaintiff judgment creditor failed to raise a triable issue of fact as to whether the insured's delay in notifying Scottsdale was reasonable based upon its good faith belief in nonliability.

In *Neighborhood Partnership Housing Development Fund Company, Inc. v. Everest National Ins. Co.*,[13] the court held that notification to the defendant insurer of the underlying accident approximately four months after the plaintiff learned of the accident "does not comply with the requirement of the insurance policy that defendant be notified of an occurrence 'as soon as practicable'; it constitutes late notice as a matter of law."

In *Min Ling Tang v. Public Service Mutual Ins. Co.*,[14] the court noted that where a policy of liability insurance requires that notice of an occurrence be given as soon as practicable, such notice must be given to the carrier within a reasonable period of time. "However, the insured's failure to give timely notice may be excused if the insured has a good-faith belief in nonliability, provided that belief is reasonable. The insured bears the burden of establishing the reasonableness of the proffered excuse. 'Ordinarily, the question of whether the insured had a good faith belief in nonliability, and whether that belief was reasonable, presents an issue of fact and not one of law.'"

Here, the insurer made a *prima facie* showing of entitlement to judgment as a matter of law based on the plaintiff's approximately two-year delay in notifying it of the underlying incident. In opposition, however, the insured plaintiff raised a triable issue of fact as to whether the delay was reasonably based on a good-faith belief in non-liability.

In *Evanston Ins. Co. v. P.S. Bruckel, Inc.*,[15] the insurer contended that the insured failed to comply with the condition in the policy that required it to "immediately" forward to the insurer copies of any legal papers received in connection with a lawsuit. Although the underlying action was commenced against the insured in March 2012, the insurer did not receive a copy of the summons and complaint until March 2013. Since the policy was issued prior to the amendment to Ins. L. § 3420, the insurer was not required to show that it was prejudiced by the failure to give it notice of the commencement of litigation.

In *Glanz v. New York Marine and General Ins. Co.*,[16] another pre-prejudice statute case, the court noted that under Ins. L. § 3420(a)(3), an injured party must demonstrate that he or she acted diligently in attempting to ascertain the identity of the insurer, and thereafter expeditiously notified the insurer. "In determining the reasonableness of an injured party's notice, the notice required is measured less rigidly than that required of the insureds [citations omitted]." Further, "The injured person's rights must be judged by the prospects for giving notice that were afforded him [or her], not by those available to the insured."[17] "What is reasonably possible for the insured may not be reasonably possible for the person he [or she] has injured. The passage of time does not of itself make delay unreasonable."[18]

Here, New York Marine made a *prima facie* showing that Glanz failed to act diligently in attempting to ascertain New York Marine's identity and in expeditiously notifying it of his claim, and Glanz offered nothing in response. Further, Glanz's argument that New York Marine's disclaimer was ineffective against him was without merit. "[W]here the insured is the first to notify the carrier, even if that notice is untimely, any subsequent information provided by the injured party is superfluous for notice purposes and need not be addressed in the notice of disclaimer issued by the insurer." Here, Glanz did not notify New York Marine of his claim until after the insured, Penn, had done so. Thus, New York Marine was not required to cite Glanz's failure to provide notice in its disclaimer letter.

In *BN Partners Assoc., LLC v. Selective Way Ins. Co.*,[19] the court held that where the policy unambiguously requires an insured to provide the insurer with *written* notice of a claim or lawsuit, a telephonic voicemail message left with the insurer's agent "does not constitute the requisite notice in writing."

Proceedings to Stay Arbitration

CPLR 7503(c) provides, in pertinent part, that "[a]n application to stay arbitration must be made by the party served within twenty days after service upon him of the notice [of intention to arbitrate] or demand [for arbitration], or he shall be so precluded."

Filing and Service of Petition to Stay

In *Matter of Ameriprise Insurance Company v. Sandy*,[20] Respondent Oral Sandy ("Sandy") filed a claim for UM benefits claiming that he was injured in a hit-and-run accident on May 4, 2014. On May 13, 2015, Sandy's insurer, Ameriprise, commenced an Article 75 proceeding to permanently stay arbitration, claiming that the accident was excluded under the policy.

On November 2, 2015, Sandy's attorney sent Ameriprise a certified letter, return receipt requested, requesting payment in full of the entire amount of the supplementary uninsured motorist (hereinafter SUM) coverage under the policy. The fourth paragraph of the letter contained a notice of intention to arbitrate, and stated that unless Ameriprise applied to stay arbitration within 20 days after receipt of the notice, Ameriprise would be precluded from objecting, *inter alia*, that a valid agreement to arbitrate was not made or complied with. On January 26, 2016, Sandy's attorney sent Ameriprise an American Arbitration Association request for arbitration form, dated January 25, 2016. On February 12, 2016, Ameriprise commenced this proceeding to stay arbitration on the grounds, *inter alia*, that there was an action pending in New York County and that the underlying incident was not covered under the insurance policy.

In denying the Petition to Stay Arbitration, the court noted, "Where an insurance policy contains an agreement to arbitrate, CPLR 7503(c) requires a party, once served with a [notice of intention to arbitrate], to move to stay such arbitration within 20 days of service of such [notice], else he or she is precluded from objecting.'" Here, the proceeding was not commenced within 20 days of the receipt of the November 2, 2015 notice of intention to arbitrate. The court further noted that in order for the 20-day limitation period to be enforceable, the notice of intention to arbitrate must comply with the requirements of CPLR 7503(c). Here, contrary to Ameriprise's contention, Sandy's November 2, 2015 notice of intention to arbitrate complied with all the statutory requirements. Ameriprise failed to establish that the notice was deceptive and intended to prevent it from timely protesting the issue of arbitrability.

In *Allstate Ins. Co. v. Howell*,[21] the court held that "the time restrictions set forth in CPLR 7503(c) do not apply where, as here, respondent waived her right to arbitrate by initiating litigation on the same claims." Moreover, "[O]nce waived, the right to arbitrate cannot be regained, even by the respondent's failure to [timely] seek a stay of arbitration." Indeed, the court went further to state that the fact that Allstate participated, under objection, in the arbitration was immaterial. Indeed, "Even if the arbitration had been completed and an award issued, the award would be subject to vacatur on the ground that the arbitrator lacked authority to conduct the arbitration."

Burden of Proof

In *Government Employees Ins. Co. v. Tucci*,[22] the court stated, "The party seeking a stay of arbitration has the burden of showing the existence of sufficient evidentiary facts to establish a preliminary issue which would justify the stay," and "Thereafter, the burden shifts to the party opposing the stay to rebut the *prima facie* showing." More-

over, "where a triable issue of fact is raised, the Supreme Court, not the arbitrator, must determine it in a framed-issue hearing, and the appropriate procedure under such circumstances is to temporarily stay arbitration pending a determination of the issue."[23]

In *Government Employees Ins. Co. v. Tucci*, *supra*, the court held that the "unsupported, conclusory assertions" of Petitioner's counsel regarding the claimant's failure to satisfy the hit-and-run reporting requirement or whether there was physical contact with a hit-and-run vehicle were insufficient to meet its *prima facie* burden on its Petition. This reversed the Supreme Court's order that granted a temporary stay and directed a framed issue hearing.

In *Hereford Ins. Co. v. Vazquez*,[24] Petitioner alleged that the offending vehicle, which had left the scene of the accident, was not only identified but also insured by State Farm. In opposition, State Farm neither admitted nor denied the allegations pertaining to coverage, but asserted that the petitioner failed to meet its initial burden on its petition because it did not submit any documents to support its claim of coverage. It was only upon reply that Petitioner was able to submit the documentary proof it had been waiting for, which established that the vehicle had been sold three days before the accident and was insured by State Farm. The lower court granted the petition to the extent of a framed issue hearing on the issue of coverage, and the First Department affirmed, holding, "Absent any surprise or prejudice to State Farm, which was aware that [Petitioner] alleged that it had insured the [offending vehicle] under a specified policy and which did not seek to submit a sur-reply, the motion court providently exercised its discretion in considering the documents submitted by [Petitioner] in reply." The court added that the petitioner "could have sought leave to amend the petition based on the same documents, leading to the same outcome."

In *Unified Windows Systems, Inc. v. Endurance American Specialty Ins. Co.*,[25] the court noted, "The initial burden of demonstrating a valid cancellation of a policy is on the insurance company which disclaimed coverage [citations omitted]."

In *Matsil v. Utica First Ins. Co.*,.[26] the insurer, Utica First, purported to disclaim coverage by letter addressed to the insured, with a copy to plaintiff's counsel. After successfully moving for a default judgment against Utica First's insured in the underlying personal injury action, the plaintiff commenced an action, pursuant to Ins. L. § 3420(a) against Utica First and its insured, to enforce the judgment, in which they alleged, *inter alia*, that they did not receive the notice of disclaimer.

In support of its motion for summary judgment in that enforcement action, Utica First attempted to show that it had a standard office practice in place at the time the disclaimer was allegedly sent for the mailing of disclaimer letters. The Supreme Court denied that motion, and the Appellate Division affirmed, noting, "Generally, 'proof that an item was properly mailed gives rise to a rebuttable presumption that the item was received by the addressee' [citations omitted]. 'The presumption may be created by either proof of actual mailing or proof of a standard office practice or procedure designed to ensure that items are properly addressed and mailed' [citations omitted]. '[I]n order for the presumption to arise, office practice must be geared so as to ensure the likelihood that a notice . . . is always properly addressed and mailed' [citation omitted]."

Here, the court found that Utica First's submissions were insufficient to establish, *prima facie*, that the disclaimer letter was timely and properly mailed to Plaintiff's counsel, and, thus, to establish proper mailing of the notice of disclaimer.

Appeal from Denial of Petition to Stay

In *Country-Wide Ins. Co. v. Montero*,[27] during the pendency of Petitioner's appeal from the denial of its Petition to Stay Arbitration of an SUM claim, the matter proceeded to arbitration and Petitioner executed a stipulation of settlement with Respondent settling the matter, which resulted in the issuance of a consent to award by the arbitrator. Under those circumstances, the court held that the appeal "must be dismissed as academic, since the rights of the parties cannot be affected by the determination of this appeal, and no exception to the mootness doctrine is warranted herein."

Arbitration Awards

Scope of Review

In *O'Neill v. GEICO Ins. Co.*,[28] which involved a proceeding to vacate a SUM arbitration award, the court stated,"Judicial review of arbitration awards is extremely limited [citations omitted]. Pursuant to CPLR 7511(b)(1)(iii), a court may vacate an arbitration award if the arbitrator `exceeded his powers or so imperfectly executed it that a final and definite award upon the subject matter submitted was not made." However, vacatur of an award pursuant to this provision is warranted "only if it violates a strong public policy, is irrational, or clearly exceeds a specifically enumerated limitation on the arbitrator's power"[citations omitted]. "An award is irrational when there is no proof whatever to justify the award' [citations omitted]."

Moreover, where "an arbitration award is the product of compulsory arbitration, the award 'must satisfy an additional layer of judicial scrutiny–it must have evidentiary support and cannot be arbitrary and capricious' [citations omitted]."

In this case, the court held that the arbitrator's determination that the complained of injury was not the result of the subject motor vehicle accident, and, therefore, the SUM claim should be dismissed— was "rational, supported by evidence, and not arbitrary and capricious" —rejecting the claimant's contentions to the contrary. The court also rejected the claimant's assertion that the arbitrator exceeded the scope of authority by disregarding GEICO's prior inconsistent position, taken in the no-fault context, noting that any such error "was, at most, an error of law which would not warrant vacatur of the arbitration award."

In *Allstate Ins. Co. v. MVAIC*,[29] a proceeding to vacate an arbitration award, the court observed that where there is a review of a compulsory arbitration award (as compared to a voluntary arbitration), the court has a greater power of review, and "An arbitration award in a mandatory arbitration proceeding will be upheld if it is supported by the evidence and is not arbitrary and capricious" [citations omitted]. Here, contrary to Allstate's contention, the court found that the arbitration award had evidentiary support in the record, and was not arbitrary and capricious.

Self-Insurance

In *Strauss v. EAN Holdings, LLC*,[30] the court stated that "'[S]elf-insurance is not insurance but an assurance—an assurance that judgments will be paid' (*Guercio v. Hertz Corp.*, 40 NY2d 680, 684 [1976])."

In *Contact Chiropractic v. New York City Transit Authority*,[31] the Court of Appeals held that the three-year statute of limitations set forth in CPLR 214(2) applied to no-fault claims against a self-insurer. (The six-year contract statute of limitations still applies to UM claims against self-insured entities).[32]

Equitable Estoppel

In *U.S. Specialty Ins. Co. v. Beale*,[33] the court held that even though the subject policy, which was issued to the Town of Poughkeepsie, did not include SUM coverage for the Town's police vehicles, the insurer was equitably stopped from denying coverage where: it knew, as a result of inspecting and photographing the police car operated by Claimant shortly after the accident, that a police vehicle was involved and that Claimant was making a claim for SUM benefits for damages she sustained while operating a police vehicle; its claims adjuster engaged in numerous telephone and written communications regarding Claimant's SUM claim, assigned a claim number for use in the SUM claim process, inquired about the underlying lawsuit and advised that there was one million dollars in applicable SUM coverage; its attorney sent Claimant's attorneys a letter acknowledging the SUM claim and demanding compliance by Claimant with the discovery provisions of the SUM endorsement and requiring Claimant to obtain its consent to any settlement with the tortfeasor; it provided written consent to Claimant's settlement with the tortfeasor for the tortfeasor's minimal ($25,000) bodily injury coverage and the issuance of a general release and stipulation of discontinuance; it proceeded with discovery for the SUM claim, including obtaining and processing medical authorizations and participating in an examination under oath and a physical examination of Claimant; it participated in a mediation of the SUM claim; it made an (unsuccessful) offer to settle the SUM claim; and it participated in a pre-arbitration telephone conference call with the SUM arbitrator assigned to the matter, before filing a petition seeking a declaration that there was no SUM coverage under the policy.

As summarized by the court, the insurer in this case "acted in all respects since 2011 through the commencement of this proceeding as if [Claimant] had SUM coverage for her police vehicle as of the date of the 2011 accident." In reliance upon affirmative representations as to SUM coverage, and after having obtained the insurer's consent, she settled her negligence action against the tortfeasor for $25,000 and released the tortfeasor in order to pursue her SUM claim. As a result, she is now foreclosed from pursuing claims against the tortfeasor for damages she believed were available through SUM coverage. Under the particular, and compelling, facts of this case, the court applied the doctrine of equitable estoppel to preclude the insurer from denying SUM coverage, rejecting the notion (asserted by the insurer) that the doctrine of equitable estoppel may never be employed to create coverage not provided for in an insurance policy.

On the other hand, in *U.S. Specialty Ins. Co. v. Denardo*,[34] another case involving a SUM claim by a police officer under the same municipality's insurance policy, where the insurer acknowledged receipt of Respondent's "potential SUM claim,"requested certain additional information, and alleged that any settlement of Respondent's claim against the driver of the other vehicle would require the insurer's consent, respondent subsequently settled the claim with the insurer's consent, provided the insurer with requested medical authorizations and documents, and was deposed, the court held that equitable estoppel did not apply to prevent the insurer from disclaiming SUM coverage based upon the Court of Appeals' holding in *State Farm Mut. Auto. Ins. Co. v. Fitzgerald*, 25 N.Y.3d 799, 16 N.Y.S.3d 796 (2015), that a police vehicle is not a "motor vehicle" for purposes of SUM coverage and, therefore, the respondent was not an insured under the terms of the SUM endorsement— notwithstanding that the insurer failed to disclaim SUM coverage until two years after it received notice of the claim.

As explained by the court:

> To be sure, where coverage exists under a particular insurance policy in the first instance and the carrier unreasonably de-

> lays in denying coverage for disclaiming liability based upon a policy exclusion or defense, estoppel may apply to prevent the carrier from doing so—provided the insured can demonstrate that he or she relied upon the carrier's actions to his or her detriment and was prejudiced by the carrier's delay in denying or disclaiming coverage [citations omitted]. That said, where, as here, the denial of the claim is based upon lack of coverage, estoppel may not be used to create coverage regardless of whether or not the insurance company was timely in issuing its disclaimer [citations omitted]. Succinctly stated, the failure to disclaim coverage does not create coverage which the policy was not written to provide [citations omitted] and a disclaimer is unnecessary when a claim does not fall within the coverage terms of [the] insurance policy [citations omitted]. Applying the cited cases to the matter before us, it is clear that equitable estoppel is of no aid to respondent, who was not an insured under the policy issued by petitioner to the Town. Simply put, inasmuch as respondent was not an insured under the policy issued by petitioner and petitioner did not in fact provide SUM coverage to respondent under the terms of the subject policy, petitioner was under no concomitant obligation to disclaim [citation omitted]. In light of this conclusion, we need not reach the issue of whether respondent suffered any prejudice as a result of petitioner's actions—as detrimental reliance and prejudice are implicated only where equitable estoppel may be invoked in the first instance.

The court further held that Respondent's waiver claim was equally unavailing because "[W]here there is no coverage under the policy, the doctrines of waiver and estoppel may not operate to create such coverage, and where the issue is the existence or nonexistence of coverage, the doctrine of waiver is simply inapplicable [citations omitted]."

The court also specifically rejected as lacking in merit Respondent's promissory estoppel claim, as well as his assertion that the insurer engaged in conduct that would preclude it from seeking to permanently stay arbitration.

Discovery

In *Liberty Mutual Ins. Co. v. Kadah,*[35] Petitioner sought a permanent stay of the SUM arbitration demanded by Respondent on the ground that it had no responsibility to provide SUM coverage because the underlying insurance policies had not been exhausted. In the alternative, Petitioner sought a temporary stay to allow for discovery (e.g., an IME and disclosure of medical records). Supreme Court denied the Petition to Stay, without explicitly addressing the alternative request for a temporary stay.

The Fourth Department argued that there was no basis for a permanent stay, and noted that at oral argument of the appeal, Respondent's counsel stated that he was amenable to conducting some discovery prior to arbitration. Accordingly, the court modified the Supreme Court's Order by reinstating the petition insofar as it sought a temporary stay of arbitration, and remitted the matter to the Supreme Court "for a determination whether petitioner is entitled to a temporary stay based on the conditions precedent."[36]

Uninsured Motorist Issues

Mandatory Coverage

In *Strauss v. EAN Holdings, LLC,*[37] the court, *inter alia*, noted that "*Matter of Country-Wide In. Co. (Manning)*, (96 AD2d 471, 472 [1st Dep't 1983], *affd*. 62 NY2d 748 [1984]) recognized [that] 'as a matter of public policy,' the City [of New York] is required to provide uninsured motor vehicle coverage."

In *County of Suffolk v. Johnson,*[38] the court rejected the county's contention that it was exempt from providing uninsured motorist coverage on its vehicles (other than police or fire vehicles) pursuant to VTL § 370. As explained by the court, "'[T]he Legislature has specifically declared its grave concern that motorists who use the public highways be financially responsible to ensure that innocent victims of motor vehicle accidents be recompensed for their injuries and losses'" (*Matter of State Farm Mut. Auto Ins. Co. v. Amato*, 72 N.Y. 2d 288, 292 [1988], quoting *Matter of Allstate Ins. Co. v. Shaw*, 52 N.Y. 2d 818, 819 [1980]). Thus, although the Legislature authorized municipalities to be self-insured pursuant to the exception in Vehicle and Traffic Law § 370(1), it did not exculpate them from the responsibility of providing uninsured motorist protection (*see Matter of Country-Wide Ins. Co. [Manning]*, 96 AD2d 471, 472 [1983], *affd*. 62 N.Y. 2d 748 [1984]; *Matter of State Farm Mut. Auto. Ins. Co. v. Olsen*, 22 A.D. 3d 673, 673-674 [2005]; *see also Matter of State Farm Mut. Auto. Ins. Co. v. Fitzgerald*, 25 N.Y. 3d 799, 810 [2015])

Insurer's Duty to Provide Prompt Written Notice of Denial or Disclaimer

(Ins. L. § 3420[d][2])

Insurance Law § 3420(d)(2) provides, "If under a liability policy issued or delivered in this state, an insurer shall disclaim liability or deny coverage for death or bodily injury arising out of a motor vehicle accident or

any other type of accident occurring within this state, it shall give written notice as soon as reasonably possible of such disclaimer or liability or denial of coverage to the insured and the injured person or any other claimant." As the Court of Appeals observed *in Keyspan Gas East Corp. v. Munich Reinsurance America, Inc.*,[39]

> The Legislature enacted section 3420(d)(2) to "aid injured parties" by encouraging the expeditious resolution of liability claims [citations omitted]. To effect this goal, the statute 'establishe[s] an absolute rule that unduly delayed disclaimer of liability or denial of coverage violates the rights of the insured [or] the injured party' [citation omitted]. Compared to traditional common-law waiver and estoppel defenses, section 3420(d)(2) creates a heightened standard for disclaimer that "depends merely on the passage of time rather than on the insurer's manifested intention to release a right as in waiver, or on prejudice to the insured as in estoppel [citations omitted]." In *Vargas v. City of New York,*[40] the court observed that "when a putative insured first makes a claim for coverage in a complaint, the insurer may disclaim via its answer."

In *Battisti v. Broome Coop Ins. Co.*,[41] the court stated, "The insurer has an obligation not only to promptly provide notice of disclaimer once it has reached that decision, but to promptly investigate and reach a decision on whether to disclaim."

In *Carlson v. American Int'l. Group, Inc.*,[42] the Court of Appeals, by a 4-3 vote, gave a broad interpretation to the phrase "issued or delivered" in New York, which appears in several places in Insurance Law § 3420 ("Liability insurance; standard provisions; right of injured persons"), thereby expanding the scope and applicability of such provisions contained within that statute that provide a right of direct action against an insurer to an injured person seeking to enforce a judgment in his or her favor (Ins. L. § 3420[a][2] and [b][1]), and pertain to disclaimers or denials of coverage (Ins. L. § 3420[d][2]). In so doing, and holding that the policy in that case, which was issued in New Jersey and delivered first in Washington, and then in Florida, but covered an insured and risks located in New York, was governed by Ins. L. § 3420 because the phrase "issued or delivered" in New York "encompasses situations where both insureds and risks are located in this state even though the policy was signed and delivered outside the state, the majority (Judges Wilson, Rivera, Feinman and Eng [sitting for Judge Fahey]) relied upon both legislative history and intent, and the Court of Appeals' own previous precedent of *Preserver Ins. Co. v. Ryba*, 10 N.Y. 3d 635 (2008).[43]

In *Harco Construction, LLC v. First Mercury Ins. Co.*,[44] the court noted, "A disclaimer is unnecessary when a claim does not fall within the coverage terms of an insurance policy [citations omitted]," and that "conversely, a timely disclaimer pursuant to Insurance Law § 3420(d) is required when a claim falls within the coverage terms but is denied based on a policy exclusion [citations omitted]." Moreover, pursuant to Insurance Law § 3420(d), "an insurance carrier is required to provide its insured and any other claimant with timely notice of its disclaimer or denial of coverage on the basis of a policy exclusion, and will be stopped from disclaiming or denying coverage if it fails to do so [citations omitted]."[45]

Here, where the notice of the occurrence was given to the insurer by another insurer on behalf of the insured, together with a demand that the first insurer assume the plaintiff's defense and indemnification, that did not make the second insurer the plaintiff's agent for all purposes, or for the specific purpose of receipt of notice of disclaimer.[46] The tendering insurance company's interests were not necessarily the same as the insured's because the insured had its own interests at stake, separate from that of the insurer. As such, the insured was entitled to notice of disclaimer delivered to it.

In *American Country Ins. Co. v. Umude,*[47] the court held that a disclaimer on the ground of non-permissive use constitutes a denial based on the non-existence of coverage, and, therefore, is not subject to the timeliness rules of Ins. L. § 3420(d)(2).

In *Ability Transmission, Inc. v. John's Transmission, Inc.*,[48] the court noted that when an insurer disclaims coverage for death or bodily injury arising out of an accident, "the notice of disclaimer must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated.[49] "An insurer's justification for denying coverage is strictly limited to the ground stated in the notice of disclaimer" and the failure to raise a ground for disclaimer results in a waiver of that ground, even if it would otherwise have merit.

In its disclaimer letter, the insurer here stated, in relevant part, that Ability was not named as an additional insured under the insurance policy, a statement that was factually incorrect. Contrary to the insurer's contention, the exclusion upon which it subsequently relied was not mentioned in its disclaimer letter and, therefore, any argument based on that exclusion was deemed waived.

In *Unified Window Systems, Inc. v. Endurance American Specialty Ins. Co.*,[50] the court held that the insurer waived its right to disclaim coverage based upon the Employer's Liability and Designated Ongoing Operations exclusions because it failed to include those grounds for disclaimer in the original disclaimer letter. Moreover, and in any

event, the disclaimer based on those exclusions was untimely as a matter of law.[51]

In *Neighborhood Partnership Housing Development Fund Company, Inc. v. Everest National Ins. Co.*,[52] the court held that a disclaimer that stated that "Coverage is denied based upon your violation of the notice provisions and conditions of the policy since the loss was not reported to [defendant] as soon as practicable" was "sufficiently specific in its explanation."

In *Ramlochan v. Scottsdale Ins. Co.*,[53] the court noted, "While Insurance Law § 3420(d)(2) requires an insurer to give written notice of a disclaimer of coverage 'as soon as is reasonably possible' [citation omitted], an investigation into issues affecting the decision whether to disclaim may excuse a delay [citation omitted]." Here, the court held that the insurer demonstrated that, under the circumstances of this case, its delay in issuing the disclaimer of coverage was reasonably related to the completion of a necessary, thorough, and diligent investigation into issues affecting its decision to disclaim, and, therefore, the disclaimer was timely.

In *Evanston Ins. Co. v. P.S. Bruckel, Inc.*,[54] the court observed that "[t]he failure of an insured to timely notify the insurer of a claim does not excuse the insurer's failure to timely disclaim coverage [citations omitted]. The timeliness of an insurer's disclaimer is measured from the point in time when the insurer first learns of the grounds for disclaimer of liability or denial of coverage [citations omitted]."

Here, the defendants raised triable issues of fact as to whether the insurer acquired knowledge of the commencement of the underlying action in April 2012, a month after it was commenced, or, at the latest, October 2012, and, thus, whether it timely disclaimed coverage in March 2013 on the basis of late receipt of a copy of the Summons and Complaint. Accordingly, summary judgment was denied to the insurer with regard to its duty to defend and/or indemnify.

In *BN Partners Associates, LLC v. Selective Way Ins. Co.*,.[55] the court observed that "[n]otice requirements are to be liberally construed in favor of the insured, with substantial, rather than strict, compliance being adequate [citation omitted]."

In this case, the policy unambiguously required an insured to provide the insurer with written notice of a claim or lawsuit brought against an insured and to send the insurer copies of any legal papers received in connection with the claim or lawsuit. The court held that the insurer met its initial burden of establishing the insured's failure to provide timely notice of the claim or lawsuit as a matter of law insofar as the insurer's employee averred that the insurer did not receive notice of the lawsuit until nearly 17 months after the undisputed latest date when the insureds learned of the underlying lawsuit, and where no excuse was offered for the delay. The court further held that Plaintiffs did not adequately rebut that showing in order to avoid summary judgment, rejecting the contention that they provided the insurer with timely notice via a voicemail message left with an insurance agent and a letter sent to the insured, informing each of the underlying lawsuit. The court explained that "[t]he inadmissible double hearsay submitted by plaintiffs with respect to the letter is, standing alone, insufficient to defeat" the insurer's motion, and that since the policy expressly required "written notice" of the claim, "a telephone voicemail message does not constitute the requisite notice in writing." Finally, the court rejected the Plaintiff's further contention that the insured's insurance agent was an agent of the insurer.

In *Neighborhood Partnership Housing Development Fund Company, Inc. v. Everest National Ins. Co.*, *supra,* the court held that a disclaimer issued two weeks after the insurer received the written statement in connection with its investigation was "reasonable and timely."

In *DeLuca v. RLI Ins. Co.*,[56] the court observed, "An insurer who seeks to disclaim coverage on the ground of noncooperation is required to demonstrate that (1) it acted diligently in seeking to bring about the insured's cooperation, (2) its efforts were reasonably calculated to obtain the insured's cooperation, and (3) the attitude of the insured, after its cooperation was sought, was one of willful and avowed obstruction"[57] "'[M]ere efforts by the insurer and mere inaction on the part of the insured, without more, are insufficient to establish non-cooperation.'"[58]

In this case, the insurer contended that after cooperating with counsel for approximately five years of litigation, including appearing for a deposition, the insured stopped cooperating. The court held that the insurer failed to meet its *prima facie* burden of demonstrating the insured's noncooperation because its principal proof consisted of letters from the attorneys then defending the insured and investigation reports and emails from a company hired by the insurer to perform investigative services, which purported to demonstrate the insured's unwillingness to cooperate but which constituted inadmissible hearsay. An affidavit from the president of the investigation company, which contained a conclusory assertion that its efforts to obtain the insured's cooperation were unsuccessful, was held by the court to be insufficient to meet the insurer's "heavy burden" of demonstrating noncooperation.

In *AutoOne Ins. Co. v. Negron*,[59] the court held that the Proposed Additional Respondent insurer's letters to the Petitioner raised issues of fact as to whether the proposed Additional Respondent validly disclaimed coverage on the ground of noncooperation.

In *West Street Properties, LLC v. American States Ins. Co.*,[60] the court stated that "An insurer that seeks to disclaim coverage based on its insured's alleged noncooperation is required to demonstrate that 'it acted diligently in seeking to bring about its insured's cooperation, that its efforts were reasonably calculated to obtain its insured's cooperation, and that the attitude of its insured, after the cooperation of its insured was sought, was one of "willful and avowed obstruction'"[citations omitted]. "The insurer has a `heavy' burden of proving lack of cooperation [citation omitted]," and the inference of noncooperation must be 'practically compelling' [citations omitted]."

Based on the evidence adduced at trial, the court found that American States met its heavy burden of proving that its insured breached the subject policy by failing to cooperate in the defense of the underlying action. American States made diligent efforts, through written correspondence, numerous telephone calls, and a visit to the insured's home, that were reasonably calculated to bring about the insured's cooperation. Further, its insured's attitude, after his cooperation was sought, was one of willful and avowed obstruction. Among other trial evidence, there was testimony from an investigator who met with the insured at the insured's home. The insured, while acknowledging that he knew that he had attorneys defending him and that a default judgment could be entered against him if he failed to appear at a deposition, made statements to the effect that he would cooperate only if he were paid for certain work he claimed to have performed, and that the plaintiff could "just get in line" were it to obtain a judgment against him. Accordingly, the court dismissed the action insofar as asserted against American States.

In *Government Employees Ins. Co. v. Fletcher,*[61] the court added, "[M]ere efforts by the insurer and mere inaction by the insured, without more, are insufficient to establish non-cooperation as the 'inference of non-cooperation must be practically compelling.'" Here, the court found that the Additional Respondent insurer established that it made diligent efforts that were reasonably calculated to obtain the insureds' cooperation, but failed to demonstrate that the conduct of the insureds constituted willful and avowed obstruction."

In *Neighborhood Partnership Housing Development Fund Co., Inc. v. Everest National Ins. Co.*, *supra*, the court held that the defendant's disclaimer of coverage on the ground of late notice was "reasonable and timely" where it was issued two weeks after the insurer received the written statement in connection with its investigation. Moreover, the court held that the disclaimer was also "sufficiently specific in its explanation," stating that "coverage is denied based upon your violation of the notice provisions and conditions of the policy since the loss was not reported to [defendant] as soon as practicable."

In *J.P. Morgan Sec. Inc. v. Vigilant Ins. Co.*,[62] the court noted that "an insurer's repudiation of liability for an insured's claims excuses the insured from performance of his or her obligations under the policy."

In *Hereford Ins. Co. v. McKoy,*[63] the Additional Respondent insurer disclaimed coverage for the alleged offending rental vehicle based upon the renter's failure to cooperate in the investigation of the subject accident. The court noted, "In order to establish a proper disclaimer based on an insured's alleged non-cooperation, an insurer must demonstrate that 'it acted diligently in seeking to bring about its insured's cooperation, that its efforts were reasonably calculated to obtain its insured's cooperation, and that the attitude of its insured, after the cooperation of its insured was sought, was one of "wilful and avowed obstruction,'" quoting *Thrasher v. United States Liab. Ins. Co.*, *supra*. Further, the court noted that "The burden of proving lack of cooperation is a 'heavy one' and is on the insurer." In this case, the disclaimer letter and an affirmation from the attorney assigned by the insurer to represent the insured driver demonstrated that the driver had not made contact with either the insurer or the attorney as of the date of the disclaimer letter. The court held that while those submissions by the insurer did not establish that the disclaimer was valid and timely as a matter of law, they were sufficient to raise a triable issue of fact.

Hit-and-Run

UM/SUM coverage is available to victims of accidents involving a "hit-and-run," i.e., an unidentified vehicle that leaves the scene of the accident after making "physical contact" with the Claimant's vehicle or person.

In *Allstate Ins. Co. v. Deleon,*[64] the court noted that "'Physical contact is a condition precedent to an arbitration based upon a hit-and-run accident involving an unidentified vehicle' [citation omitted]. 'The insured has the burden of establishing that the loss sustained was caused by an uninsured vehicle, namely, that physical contact occurred, that the identity of the owner and operator of the offending vehicle could not be ascertained, and that the insured's efforts to ascertain such identity were reasonable' [citations omitted]."

There, the court held that the petitioner, by submitting the police accident report containing the claimant's statement that his vehicle was "*cut off*" by an unknown vehicle with a red trailer, raised a triable issue of fact as to whether physical contact occurred between the claimant's vehicle and the alleged unidentified hit-and-run vehicle, and, thus, the court below properly directed a framed issue hearing to determine whether a hit-and-run vehicle was involved in the accident.

In *Government Employees Ins. Co. v. Tucci,*[65] the court held that the insurer failed to show the existence of evidentiary facts regarding the claimant's failure to satisfy the reporting requirement (report to police within 24

hours) or whether there was physical contact with a hit-and-run vehicle, since, as to those issues, it only provided "the unsupported, conclusory assertions of its attorney." Thus, the court denied the petition to stay arbitration as a matter of law.

In *Ameriprise Auto & Home Ins. Co. v. Li Cao*,[66] the court reversed the determination of the trial court, made following a framed issue hearing, on the issue of whether the insured vehicle came into "contact" with the respondent pedestrian, finding that the court's conclusion that there was no direct contact was not supported by a fair interpretation of the evidence. Notably, the court found that the driver's version of events—that the respondent was a bicyclist and not a pedestrian, "defies logic and was contradicted by his admissions at the scene." Moreover, the court found, *inter alia*, "given the differing versions of events, the hearing court should have accepted the 'very credible' testimony of the disinterested nonparty witness, which was consistent in all material respects with that of respondent pedestrian, rather than the irreconcilable testimony of a party found to be 'inconsistent.'"

Policy Cancellation

In *Unified Window Systems, Inc. v. Endurance American Specialty Ins. Co.*, *supra*, the insurer disclaimed coverage on the ground that the policy had been canceled for nonpayment of premiums. In support of their motion for summary judgment, the plaintiffs submitted evidence establishing, *prima facie*, that the notice of cancellation produced by the insurer did not comply with the terms of the policy requiring that notice of cancellation be mailed at least 15 days before the effective date of the cancellation, and that the cancellation notice purportedly mailed to the insured failed to reference the pertinent subparagraph of Ins. L. § 3426(c)(1)(A), as required by Ins. L. § 3426(h). In opposition to the motion, the insurer failed to raise a triable issue of fact because it failed to submit a copy of the notice of cancellation it purportedly mailed, or any competent proof of mailing.

In *Global Liberty Ins. of New York v. Cedillo*,[67] a special proceeding to stay arbitration, at a framed issue hearing, the evidence showed that the respondent, National Continental Ins. Co., issued a policy to its insured effective October 23, 2008 through October 23, 2009, but that on November 5, 2008, at "6:00," it mailed to the insured a notice of cancellation for nonpayment of premium, which advised that the policy would be cancelled effective November 20, 2008, at 12:01 a.m. Under the terms of the subject policy, and pursuant to VTL § 313(1)(a), National was required to give a minimum of 15 days' notice for cancellation of coverage for nonpayment. In granting the petition, the court observed, "In the absence of an express agreement to do so, the law does not recognize fractions of a day [citation omitted]." Thus, the 15 days specified in the statute "means 15 times 24 hours." Here, National failed to give the full 15 days' notice, and the court held that the notice of cancellation was invalid.

Stolen Vehicle

In *State Farm Fire & Cas. Co. v. Sajewski*,[68] the court noted that "Vehicle and Traffic Law § 388(1) 'makes every owner of a vehicle liable for injuries resulting from negligence in the use or operation of such vehicle . . . by any person using or operating the same with the permission, express or implied, of such owner'"[citations omitted].[69] Under the statute, there is a presumption that the operator of a vehicle operates it with the owner's permission [citations omitted]. The presumption may be rebutted by substantial evidence that the owner did not give the operator consent [citations omitted].

Furthermore, "The uncontradicted testimony of a vehicle owner that the vehicle was operated without his or her permission, does not, by itself, overcome the presumption of permissive use" [citations omitted]. Additionally,

> [i]f the evidence produced to show that no permission has been given has been contradicted or, because of improbability, interest of the witnesses or other weakness, may reasonably be disregarded by the jury, its weight lies with the jury [citations omitted]….
>
> Although the rule is not absolute or invariable, in most cases uncontradicted disavowals of permission by both the owner of the vehicle and the driver will constitute substantial evidence negating permissive use and entitle the owner to summary judgment [citations omitted].
>
> However, "disavowals by both the owner and the driver, without more, should not automatically result in summary judgment for the owner" [citations omitted]. Ultimately, "whether summary judgment is warranted depends on the strength and plausibility of the disavowals [of permission], and whether they leave room for doubts that are best left for the jury."

Under the circumstances of this case, the court held that the Supreme Court properly determined that the appellant failed to sufficiently rebut the strong presumption pursuant to Vehicle and Traffic Law § 388 that the insured's son was operating the vehicle with the insured's permission. The son had access to the insured's residence. Further, the key to the vehicle was kept in a "central location" inside a bin located in the kitchen of the insured's residence. Additionally, on previous occasions, the son

had been permitted by the insured to drive other vehicles owned by him.

In *Carlson v. American Int'l. Group, Inc., supra*, the Court of Appeals stated: "There is a well-understood meaning of permission in the context of motor vehicle liability insurance, which turns not on whether the driver had permission to use the vehicle for the particular activity at issue, but on whether the driver had permission to use the vehicle *at all* (i.e., the distinction between a permissive user and a thief)."[70]

MVAIC

In *Baker v. Motor Veh. Acc. Indem. Corp.*,[71] the court noted that the maximum limit of MVAIC's liability under Insurance Law § 5210(a)(1) is $25,000, exclusive of interest calculated from the date of the unpaid underlying judgment against the uninsured defendant, and costs. The court also noted that 'MVAIC is not obligated to pay disbursements pursuant to Ins. L. § 5210."

Underinsured/Supplementary Uninsured Motorist Issues

Amount of Coverage

The New SUM Limits Law

Effective June 2018, an amendment to Ins. L. § 3420(f) makes a dramatic change with regard to the purchase of supplementary uninsured/underinsurd motorist (SUM) coverage by requiring the sale by insurers of SUM coverage to those who request such coverage with limits equal to the bodily injury liability limits under the policy, unless the insured affirmatively elects lower SUM coverage.[72]

Tranportation Network Companies (TNC)

Effective June 29, 2017, the VTL was amended to add an entirely new Article (Article 44-B) devoted to Transportation Network Company Services, to deal with the proliferating phenomenon of such services as Uber, Lyft, Gett, and the like.[73]

As pertains to the amount of coverage, the new law requires TNC to insure their drivers through a group policy, to "maintain insurance that recognizes that the driver is a TNC driver and provides financial responsibility coverage: (a) while the TNC driver is logged onto the TNC's digital network; and (b) while the TNC driver is engaged in a TNC prearranged trip." See VTL § 1693(1)(a)(6). The new statute then sets forth the specific automobile financial responsibility insurance requirements that apply: (a) while a TNC driver is logged onto the TNC's digital network but is *not* engaged in a TNC prearranged trip; and (b) while a TNC driver *is* engaged in a TNC prearranged trip.

Pursuant to VTL § 1693(2)(a), the following insurance requirements apply while the TNC driver is *not* engaged in a TNC prearranged trip: liability insurance for damages, including damages for care and loss of services, because of bodily injury or death, and/or property damage, arising out of the use of a vehicle in New York or elsewhere in the U.S. or Canada; with limits of coverage (exclusive of interests and costs) of at least $75,000 for bodily injury or death of one person/$150,000 for bodily injury or death of two or more persons, and $25,000 for property damage. In addition, insurance coverage in satisfaction of the requirements set forth in Ins. L. §§ 3420 (UM) and Article 51 (No-Fault) must be provided.

Pursuant to VTL § 1693(3)(a), the following insurance requirements apply while the TNC driver is engaged in a TNC prearranged trip: liability insurance for damages, including damages for care and loss of services, because of bodily injury or death, and/or property damage arising out of the use of a vehicle in New York or elsewhere in the United States or Canada, with limits of coverage (exclusive of interest and costs) of at least $1,250,000 for bodily injury, death and/or property damage (single limit). In addition, supplementary uninsured/underinsured motorist coverage in the amount of $1,250,000 must also be provided for bodily injuries or death of "any person in any one accident," as well as coverage in satisfaction of Ins. L. § 3420 (UM) and Article 41 (No-Fault).

In both situations, these coverage requirements may be satisfied by: (a) insurance maintained by the TNC driver; (b) insurance provided through a group policy maintained by for TNC; or (c) a combination of the above.

Trigger of SUM Coverage

Varon v. Country-Wide Ins. Co.[74] was a declaratory judgment action brought by Plaintiff for a declaration that the defendant insurer, Country-Wide, was obligated to tender the full amounts under two separate auto liability policies issued to the owner of the insured vehicle and to the driver of that vehicle (covering a different vehicle), before Plaintiff could pursue a first party claim against his own insurer for supplementary uninsured/underinsured (SUM) benefits.

The underlying action involved a two-vehicle accident that took place when a 1999 Mercedes owned by Orlo Kolenovic and operated by Adria Reckovic struck Plaintiff's 2000 Mercury vehicle. Country-Wide was, coincidentally, the insurer for both Kolenovic and Reckovic, with separate policies each with liability limits of $25,000 per person/$50,000 per accident. Perhaps adding to the confusion was the fact that Plaintiff's SUM policy was issued by High Point, a New Jersey insurer not authorized to do business in New York, and, thus, was a New Jersey policy, not subject to New York law. That policy contained a provision that stated,"We will subtract from the amount otherwise payable under this part, the amount of damages paid or payable by or on behalf of anyone responsible for the bodily injury or property damage to uninsured or additional insured."

All parties agreed that the driver's policy was excess to the owner's. The question remained whether the driver's policy was also excess to the SUM policy, or vice versa. Country-Wide tendered the $25,000 policy limit for the owner's policy but refused to similarly tender the $25,000 under the driver's policy.

Plaintiff contended that in order to trigger his right to recover SUM benefits from High Point, Country-Wide was required to tender both $25,000 limits. Country-Wide, on the other hand, argued that the "other insurance" clause in the driver's policy, which provided that "any insurance we provide for a vehicle you do not own, including any vehicle while used as a temporary substitute for 'your covered auto' shall be excess over any other collectible insurance," made the policy excess to the policy issued to the owner, as well as other collectible insurance, and was not required to be tendered in order to trigger the plaintiff's right to seek SUM coverage from High Point.

"In *Liberty Mutual Insurance Co. v. Doherty* . . . the court specifically held that the underinsured motorist coverage was triggered when the insured exhausted, via settlement, the bodily injury limits of the offending vehicle's policy.... "

As the trial judge, Justice Peter H. Moulton, noted it has long been the law that "an insured individual is not required to exhaust the liability coverage limit under a separate insurance policy for the operator of an offending vehicle (assuming that the owner of the vehicle is not the operator of the vehicle) prior to pursuing a claim for under-insured motorist benefits." Indeed, in *Liberty Mutual Insurance Co. v. Doherty*[75] (a case cited by the trial court but not by any of the parties on the appeal), the court specifically held that the underinsured motorist coverage was triggered when the insured exhausted, via settlement, the bodily injury limits of the offending vehicle's policy, and pertinently stated that "the petitioner's insured was not also required to exhaust the liability coverage limits under a separate policy for the operator of the offending vehicle prior to pursuing a claim for underinsured motorist benefits." (Similarly, in *Hertz Claim Management Corp. v. Kulakowich*[76] [not cited by either the court or the parties], the court stated, "The petitioner's insured was not required to exhaust the liability coverage limits under a separate insurance policy of the operator of the offending vehicle prior to pursuing a claim for underinsured motorist benefit from the petitioner [citing *Liberty Mutual v. Doherty*, supra]." It is not clear why these cases were not determinative, or why, given the existing state of the law, the plaintiff did not simply file a Demand for Arbitration with High Point after the primary limits of the owner's policy were tendered and permission was granted to accept the offer made on behalf of the owner, and thus put the burden on the SUM carrier, High Point, to seek a stay of arbitration rather than commencing and litigating the DJ action himself It is also unclear on what basis the plaintiff believed that he could, under any circumstances, compel Country-Wide to offer more than the $25,000 under its owner's policy to settle the plaintiff's claim?

In any event, upon Plaintiff's motion for summary judgment and Country-Wide's cross-motion for summary judgment in the DJ action, Justice Moulton held that it is only the policy limit of "primary insurers" that must be tendered in order to trigger UM benefits, that, therefore, it was only the owner's policy that was required to be tendered, but not the driver's policy because the latter was "excess" to the owner's policy and did not constitute a primary policy within the meaning of Insurance Law section 3420. (Although I do not believe it was necessary or appropriate to do so) Justice Moulton went on to add that the driver's policy was also excess to the plaintiff's High Point SUM policy. Accordingly, he denied the Plaintiff's motion for summary judgment and granted Country-Wide's cross-motion for summary judgment, declaring that the driver's policy "need not be tendered in order to trigger plaintiff's right to seek underinsured benefits from High Point."

On Plaintiff's appeal from Justice Moulton's order, the Appellate Division, First Department, unanimously affirmed. In its very brief decision, the court noted that "the excess coverage clause in the offending driver's policy states, in relevant part, that the driver's coverage 'shall be excess over any other collectible insurance.'" The motion court correctly refused to interpret the phrase 'any other collectible insurance' to mean 'any other collectible primary insurance,' and correctly determined that the driver's coverage is 'excess 'to High Point's insurance.

Consent to Settle

In *Travelers Indemnity Co. of America v. McGloin*,[77] Respondent was injured in an automobile accident while driving a vehicle owned and insured by her employers. Through counsel, she notified Petitioner, the insurer of the vehicle, of her intent to seek underinsured motorist benefits, and she commenced an action against the driver of the other vehicle involved in the accident. She subsequently settled the action against the other driver for the limits of his insurance policy *without seeking Petitioner's consent*. Petitioner disclaimed coverage on the ground that the settlement of the action without its consent, in

violation of the SUM endorsement of the policy, impaired its right to subrogation.

In opposition to Petitioner's Petition to Stay the arbitration demanded by Respondent, Respondent asserted that she was not aware, and could not have been aware, of provisions of the policy, including the consent-to-settle requirement, which were never provided to her. The court rejected that argument, noting that "The SUM endorsement is mandated by regulation[78] and Rules of Professional Conduct (22 NYCRR 1200.0) rule 1.1 requires an attorney to possess the requisite legal knowledge and skill reasonably necessary to represent a client. Moreover, at the framed-issue hearing before the Referee on the issue of whether Respondent should have had knowledge of such provisions, Petitioner's technical specialist who handled the claim testified, *inter alia*, that on claims he has handled in the past, attorneys would call and seek consent before settling cases at the limits of an adverse driver's insurance policy."

In addition, the court noted that Respondent's counsel, who handled her underinsurance claim and lawsuit against the adverse driver, did not testify at the hearing in this case despite being present at the hearing. Accordingly, the court held that the Referee conducting the hearing did not err in drawing an adverse inference against Respondent on the factual issue of whether her attorney/agent had actual knowledge of the provisions of the SUM endorsement,[79] or in determining that her attorney/agent should have and actually did have such knowledge. Thus, the Petition to Stay Arbitration was granted.

Offsets

In *New York Central Mutual Fire Ins. Co. v. Baker,*[80] Respondent was injured in an accident while riding as a passenger in a vehicle that was rear-ended by another vehicle, and then propelled into oncoming traffic, where his vehicle was struck again by a third vehicle. Respondent, the driver of the host vehicle, and the driver of the third vehicle all pursued personal injury claims against the owner and operator of the second vehicle. The $100,000 per accident limits of the second vehicle's bodily injury liability coverage were offered to the three claimants (including Respondent), to be divided in equal shares of $33,333.33 each. When Respondent subsequently sought SUM benefits from the insurer of the host vehicle, that insurer, New York Central Mutual, argued that it was entitled to aggregate the amounts received by Respondent and the driver of the host vehicle from the second vehicle's insurer in calculating the offset for SUM benefits under its policy, and that since that amount, i.e., $66,666.66, was greater than the SUM limit of $50,000 per accident, the arbitration demanded by Respondent should be permanently stayed.

The Supreme Court granted New York Central Mutual's petition to stay arbitration based upon the offset permitting SUM limits to be reduced by the motor vehicle liability payments made on behalf of the tortfeasor. The Appellate Division affirmed, holding that once the second vehicle insurer tendered the policy limit, "the exclusion in the SUM endorsement that limited SUM payments to the difference between the limits of SUM coverage and the insurance payments received [by the host driver and the Respondent] from any person legally liable for bodily injuries applied." Inasmuch as New York Central property offset the $66,666 received by its insureds against its $50,000 SUM limits, "respondent was precluded from any recovery under the SUM endorsement."

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Endnotes

1. 147 A.D.3d 1474, 47 N.Y.S.3d 830 (4th Dept. 2017).
2. 152 A.D.3d 940, 59 N.Y.S.3d 183 (3d Dept. 2017).
3. 58 Misc.3d 601, 66 N.Y.S.3d 597 (Sup. Ct. Suffolk Co. 2017).
4. 157 A.D.3d 1047, 68 N.Y.S.3d 576 (3d Dept. 2018).
5. 16 N.Y.3d at 355.
6. *Id.*, 16 N.Y.3d at 356.
7 161 A.D.3d 937, 78 N.Y.S.3d 162 (2d Dept. 2018).
8. 157 A.D.3d 610, 67 N.Y.S.3d 455 (1st Dept. 2018).
9. 157 A.D.3d 953, 70 N.Y.S.3d 523 (2d Dept. 2018).
10. 149 A.D.3d 1477, 53 N.Y.S.2d 426 (4th Dept. 2017).
11. 149 A.D.3d 839, 51 N.Y.S.3d 195 (2d Dept. 2017).
12. 150 A.D.3d 1166, 55 N.Y.S.3d 369 (2d Dept. 2017).
13. 152 A.D.3d 420, 58 N.Y.S.3d 356 (1st Dept. 2017).
14.. 149 A.D.3d 722, 49 N.Y.S.3d 636 (2d Dept. 2017).
15. 150 A.D.3d 693, 54 N.Y.S.3d 57 (2d Dept. 2017).
16. 150 A.D.3d 704, 54 N.Y.S.3d 50 (2d Dept. 2017).
17. *Lauritano v. American Fid. Fire Ins. Co.*, 3 A.D.2d 564, 568, *affd.*, 4 N.Y.2d 1028.
18. *Id.* at 568.
19. 148 A.D.3d 1592, 50 N.Y.S.3d 701 (4th Dept. 2017).
20. 158 A.D.3d 623, 70 N.Y.S.3d 554 (2d Dept. 2018).

21. 151 A.D.3d 461, 56 N.Y.S.3d 89 (1st Dept. 2017).

22. 157 A.D.3d 679, 69 N.Y.S.3d 330 (2d Dept. 2018).

23.. See also *Allstate Ins. Co. v. Deleon*, 159 A.D.3d 895, 74 N.Y.S.3d 52 (2d Dept. 2018); *Government Employees Ins. Co. v. Williams*, 157 A.D.3d 953, 70 N.Y.S.3d 523 (2d Dept. 2018); *Fiduciary Ins. Co. of America v. Greenidge*, 147 A.D.3d 1050, 48 N.Y.S.3d 219 (2d Dept. 2017).

24. 158 A.D.3d 470, 70 N.Y.S.3d 489 (1st Dept. 2018).

25. 149 A.D.3d 1009, 53 N.Y.S.3d 646 (2d Dept. 2017).

26. 150 A.D.3d 982, 55 N.Y.S.3d 304 (2d Dept. 2017).

27. 153 A.D.3d 816, 61 N.Y.S.3d 109 (2d Dept. 2017).

28. 162 A.D.3d 776, 79 N.Y.S.3d 236 (2d Dept. 2018).

29. 150 A.D.3d 1098, 52 N.Y.S.3d 666 (2d Dept. 2017).

30. 156 A.D.3d 571, 65 N.Y.S.3d 707 (1st Dept. 2017).

31. N.Y.3d 187, 75 N.Y.S.3d 474 (2018).

32. See Dachs, Jonathan A., Self-Insurance and the Statute of Limitations, N.Y.L.J., May 16, 2018, p.3, col. 1.

33. 54 Misc.3d 880, 42 N.Y.S.3d 562 (Sup. Ct. Dutchess Co. 2016).

34. 151 A.D.3d 1520, 57 N.Y.S.3d 743 (3d Dept. 2017).

35. 51 A.D.3d 1594, 56 N.Y.S.3d 699 (4th Dept. 2017).

36.. For a discussion of recent cases on the issue of discovery of attorney communications pertaining to the decision by an insurer of whether to accept or reject a claim, and the insurers' claims of the attorney-client privilege and/or "material prepared for litigation privilege," see Dachs, J., Discoverability of Attorney-Generated Documents in Insurance Company Files, N.Y.L.J., November 14, 2017, p. 3, col. 1. See also, *Cascade Builders Corp. v. Rugar*, 154 A.D.3d 1152, 63 N.Y.S.3d 543 (3d Dept. 2017). For an excellent discussion and analysis of the attorney-client work product, and material prepared for litigation privileges, *see Nyahsa Services, Inc., Self-Insurance Trust v. People Care Incorporated*, 155 A.D.3d 1208, 64 N.Y.S.3d 725 (3d Dept. 2017).

37. 156 A.D.3d 571, 65 N.Y.S.3d 707 (1st Dept. 2017).

38. 157 A.D.3d 949, 70 N.Y.S.3d 216 (2d Dept. 2018).

39. 23 N.Y.3d 583, 992 N.Y.S.2d 185 (2014).

40. 158 A.D.3d 523, 71 N.Y.S.3d 415 (1st Dept. 2018).

41. 163 A.D.3d 1091, 79 N.Y.S.3d 765 (3d Dept. 2018).

42. 30 N.Y.3d 288, 67 N.Y.S.3d 100 (2017).

43. See Dachs, J., `Issued or Delivered' Redefined, N.Y.L.J., January 17, 2018, p. 3, col. 1; Kohane, Dan D., Out-of-State Insurers Take Heed As Danger Lurks, N.Y.L.J., December 22, 2017, p. 3, col. 1.

44. 148 A.D.3d 870, 49 N.Y.S.3d 495 (2d Dept. 2017).

45. See *Kemper Independence Ins. Co. v. Brennan*, 155 A.D.3d 953, 64 N.Y.S.3d 125 (2d Dept. 2017); *American Country Ins. Co. v. Umude*, 56 Misc.3d 1204(A), 63 N.Y.S.3d 304 (Sup. Ct. Bronx Co. 2017).

46. See *Sierra v. 4401 Sunset Park, LLC*, 24 NY3d 514, 578, 2 N.Y.S. 3d 8 (2014).

47. 56 Misc.3d 1204(A), 63 N.Y.S.3d 304 (Sup. Ct. Bronx Co. 2017).

48. 150 A.D.3d 1056, 55 N.Y.S.3d 367 (2d Dept. 2017).

49. *General Acc. Ins. Group v. Cirucci*, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512.

50. 149 A.D.3d 1009, 53 N.Y.S.3d 646 (2d Dept. 2017).

51. See *Tuttle v. State Farm Mut. Auto. Ins. Co.*, 149 A.D.3d 1477, 53 N.Y.S.3d 426 (4th Dept. 2017).

52. 152 A.D.3d 420, 58 N.Y.S.3d 356 (1st Dept. 2017).

53. 150 A.D.3d 1166, 55 N.Y.S.3d 369 (2d Dept. 2017).

54. 150 A.D.3d 693, 54 N.Y.S.3d 57 (2d Dept. 2017).

55. 148 A.D.3d 1592, 50 N.Y.S.3d 701 (4th Dept. 2017).

56. 153 A.D.3d 662, 60 N.Y.S.3d 291 (2d Dept. 2017).

57. *Utica First Ins. Co. v. Arken, Inc.*, 18 A.D.3d 644, 645; *see Thrasher v. United States Liab. Ins. Co.*, 19 N.Y.2d 159, 168.

58. *Matter of Government Employees Ins. Co. v. Fletcher*, 147 A.D.3d 940, 940, quoting *Matter of Country-Wide Ins. Co. v. Henderson*, 50 A.D.3d 789, 791.

59. 148 A.D.3d 534, 50 N.Y.S.3d 51 (1st Dept. 2017).

60. 150 A.D.3d 792, 53 N.Y.S.3d 674 (2d Dept. 2017).

61. 147 A.D.3d 940, 48 N.Y.S.3d 173 (2d Dept. 2017).

62. 151 A.D.3d 632, 58 N.Y.S.3d 38 (1st Dept. 2017).

63. 160 A.D.3d 734, 75 N.Y.S.3d 267 (2d Dept. 2018).

64. 159 A.D.3d 895, 74 N.Y.S.3d 52 (2d Dept. 2018).

65. 157 A.D.3d 679, 69 N.Y.S.3d 330 (2d Dept. 2018).

66. 148 A.D.3d 507, 49 N.Y.S.3d 432 (1st Dept. 2017).

67. 146 A.D.3d 778, 45 N.Y.S.3d 164 (2d Dept. 2017).

68. 150 A.D.3d 1297, 56 N.Y.S.3d 204 (2d Dept. 2017).

69. 99 N.Y.2d 375, 379, quoting Vehicle and Traffic Law § 388[1].

70. *Motor Veh. Acc. Indem. Corp. v. Continental Nat'l. Am-Group Co.*, 35 N.Y.2d 260, 263-265 [1974]; and *Murdza v. Zimmerman*, 99 N.Y.2d 375, 381 (2003).

71. 161 A.D.3d 1070, 78 N.Y.S.3d 186 (2d Dept. 2018).

72. See Dachs, J., The New SUM Limits Law, N.Y.L.J., March 21, 2018, p. 3., col. 1; and Recent Legislature, Regulatory Amendments Pertaining to Auto Insurance, Part II, N.Y.L.J., September 21, 2017, p. 3, col. 1, for additional details about the contents of this significant new law.

73. See Dachs, J., Recent Legislature, Regulatory Amendments Pertaining to Auto Insurance Part I, N.Y.L.J., July 19, 2017, p. 3, col. 1, annexed.

74. 146 A.D.3d 709, 45 N.Y.S.3d 904 (1st Dept. 2017).

75. 13 A.D.3d 629 (2d Dept. 2004).

76. 53 A.D.3d 578 (2d Dept. 2008).

77. 156 A.D.3d 467, 67 N.Y.S.3d 143 (1st Dept. 2017).

78. See 11 N.Y.C.R.R. 60-2.3; *see also New York Cent. Mut. Fire Ins. Co. v. Danaher*, 290 A.D.2d 783, 736 N.Y.S.2d 195 (3d Dept. 2002).

79. See generally *People v. Gonzalez*, 68 N.Y.2d 424, 427, 509 N.Y.S.2d 796, 502 N.E.2d 583 (1986).

80. 156 A.D.3d 1456, 68 N.Y.S.3d 245 (4th Dept. 2017).

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